

Medicare:

6 things you need to know now

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A Special Guide
for Subscribers in
Your State

**TAKE ADVANTAGE
OF NEW BENEFIT
CHANGES**

Get the most from your Medicare benefits



If you or a loved one is eligible for Medicare, you need to know about important new services and changes to the program, available right now, mostly due to the Affordable Care Act passed in 2010. That's true whether you are currently on Medicare, about to become eligible, or helping a parent or loved one who is on the program.

CONSUMER REPORTS developed this brief guide and included an updated version in this magazine to let you know how the new health-care law will affect Medicare and your benefits in 2012. Since our founding 75 years ago, we have focused on providing easy-to-understand comparative information to help consumers make the best decisions in the marketplace.

In addition to the benefits this guide covers, there are numerous other changes taking effect in the Medicare program that are intended to reduce costs by improving the quality and safety of the way services are delivered. Those changes don't directly affect individual benefits, but they are designed to strengthen Medicare and improve health outcomes.

You can play a part in helping to keep Medicare costs down: Carefully review your bills and report any errors. Also report any unusual or suspicious offers to get Medicare services. To find out more about preventing misleading and costly practices, go to www.stopmedicarefraud.gov.

We also ask that you share this guide with others. It is available for download on our website at ConsumerReportsHealth.org/freeguides and in Spanish at espanol.ConsumerReports.org/salud.

And as always, we welcome your feedback, your partnership, and your collaboration as we work together to address the concerns and advance the interests of America's health-care consumers.

A handwritten signature in black ink that reads "Jim Guest". The signature is written in a cursive, flowing style.

Jim Guest
PRESIDENT
CONSUMER REPORTS

How to use this guide



IF YOU'RE WONDERING HOW key changes to Medicare in the 2010 health-reform law will affect you, you're not alone. Some 36 million Americans are covered by original Medicare, and 11 million are enrolled in private Medicare Advantage plans. This CONSUMER Reports publication is your guide to the information you need for understanding today's Medicare.

Are you ...

- Turning 65? Here's what you need to know before you sign up for Medicare (page 12).
- Hard-hit by prescription drug costs? (page 4).
- Paying for (or skipping) preventive care? Get your new free annual wellness visit (page 6).
- Feeling the pinch of co-pays in Medicare Advantage? (page 8).
- Thinking it's time to change plans? Check the dates for Medicare open enrollment (page 11).
- Need more info? See contact information for key agencies in the back of this booklet.

First things first: Know what kind of Medicare you have

About one in four Medicare recipients now belongs to a private Medicare Advantage plan instead of original Medicare. Your costs and benefits might vary significantly depending on which type of Medicare you have, so it's important to know the difference.

Original Medicare is the familiar program that has been around since 1965, in which the government pays Medicare's share of your medical bills directly to doctors, hospitals, and other health-care providers. You can go to any provider anywhere in the country who accepts Medicare reimbursement.

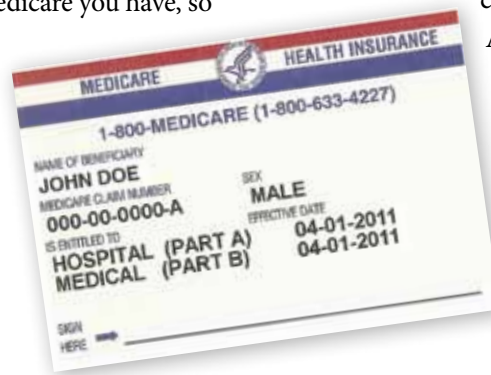
Medicare Advantage plans are private plans that you can choose in place of original Medicare. The vast majority require you to get your care within a local provider network. You will also be responsible for the plan's deductibles and co-pays. You cannot buy a Medigap plan if you are on Medicare Advantage.

Medigap plans (a type of Medicare supplement) are private plans that you can buy to cover all or part of original Medicare's deductibles and co-insurance.

Medicare Part D plans are private plans that cover prescription drugs. Most Medicare Advantage plans include Part D coverage. If you are on original Medicare or have a Medicare Advantage plan that does not include Part D, you can buy a separate stand-alone Part D plan.

What type of Medicare do I have?

If you're in a Medicare Advantage plan, your insurance card will probably not say "Medicare Advantage." Instead, the name of the plan, such as "Secure Horizons," will appear on your insurance card.



To find out which type of Medicare you have, call 800-MEDICARE (800-633-4227) and provide your "Medicare number." That's the number on your red, white, and blue Medicare card (pictured at left). All Medicare enrollees have this card, including those in Medicare Advantage plans. When you reach a representative, ask whether you are in original Medicare or are enrolled in a Medicare Advantage plan.

1 Drug discounts

Your prescription medicine may be more affordable

YOU MAY BE FAMILIAR WITH the “doughnut hole.” That’s the point in Medicare Part D drug plans where you have to start paying more for your medications. In 2012, that’s once you and your drug plan together have paid \$2,930 in drug costs, not counting your Part D premiums. The average plan pays about 25 percent of this initial amount but some are more generous, including some Medicare Advantage plans.

What’s new?

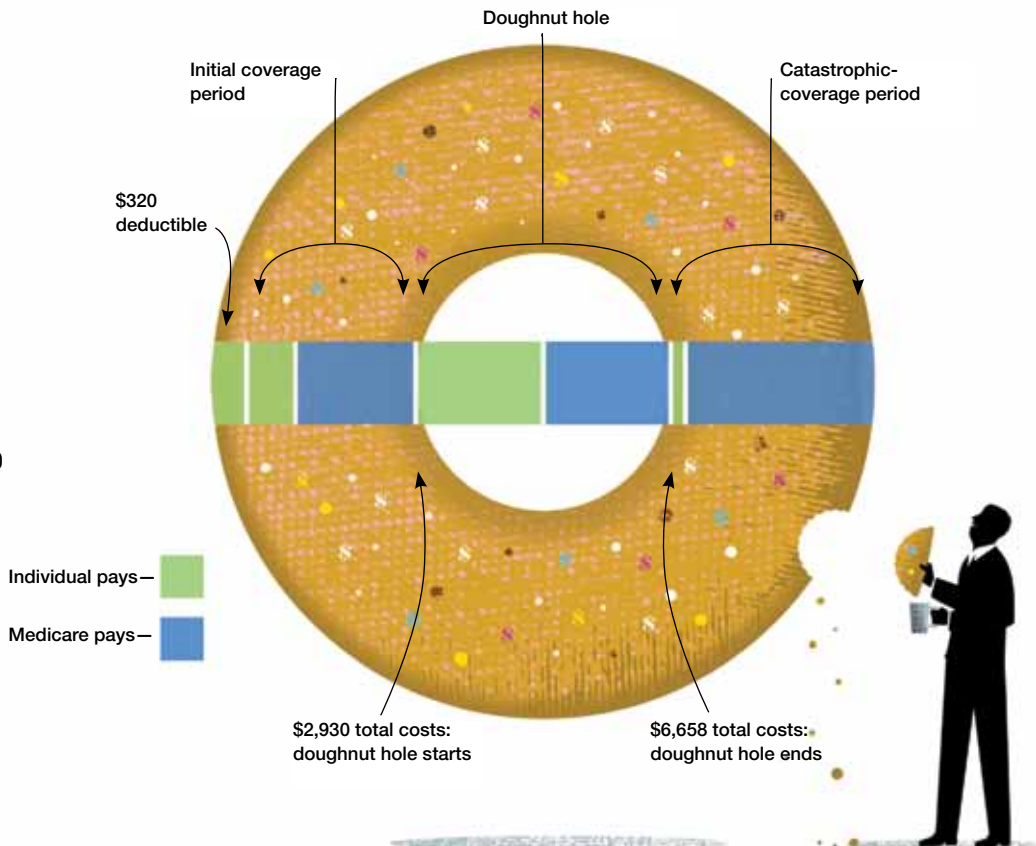
If you hit the doughnut hole in 2012, you’ll receive an automatic 50 percent discount on brand-name drugs and a 14 percent discount on generic drugs.

How it works

The doughnut hole lasts until you have spent \$3,728. The good news is that the 50 percent brand-name discount is counted as if you had spent it out of pocket. But that’s not true of the generic discount. If you purchase a \$10 generic, only your share of it, \$8.60, will count toward getting you out of the doughnut hole. Once out of the hole, you will pay 5 percent of your drug costs until the end of the year. In coming years, your share of costs within the doughnut hole will gradually decrease until it is no more than the 25 percent share you pay, on average, for drugs before entering the hole.

Taking a bite out of drug costs

Some seniors, especially those who take multiple or very expensive medications, have been caught in the “doughnut hole,” meaning they reached a coverage gap and had to pay drug bills from their own pockets until they became eligible for catastrophic coverage. Now half the cost of brand-name drugs in the doughnut hole is covered, and by 2020 the hole will be closed and there will be no gap in drug coverage.





DAVID PEZZAT

“My drug plan doesn’t cover much and I have big co-pays for my insulin and blood pressure medication. This doughnut hole discount will help.”

—Benita Martinez, 71, of McAllen, Texas, is headed for the doughnut hole and is worried about being able to afford her medications.

How to choose a Medicare drug plan

If you are already enrolled in a Part D “stand-alone” plan or a Medicare Advantage plan that incorporates drug coverage, you can switch plans for the coming calendar year during the annual open-enrollment period. In 2011 open enrollment runs from October 15 to December 7.

Depending on where you live, you might have dozens of private plans to choose from, with differing premiums, co-payments, and levels of coverage, including which drugs are covered. The difference between picking a plan that is right for you and choosing one that isn’t can be thousands of dollars per year in premiums and out-of-pocket expenses.

QUESTIONS?



You can find the basics of Part D plans at Medicare’s website, Medicare.gov. The site can answer most questions. It also links to the Medicare Part D Plan Finder, which can be used to compare offerings and coverage options in your area. This feature includes an easy-to-use interactive tool that allows you to compare plans based on what you would pay for your personalized list of drugs. Also consult the Medicare Rights Center website, at medicareinteractive.org, as you explore your options. The site also has a good discussion of the basics of the Medicare Part D benefit.

2 Free preventive care

No need to put off some exams because of cost

EVERYONE on Medicare is now entitled to free or low-cost coverage of selected preventive services, including an annual “wellness visit,” where you can go over the general state of your health with your doctor and work on a plan to stay as healthy as possible. When you call for an appointment, be sure to say it’s for your “annual wellness visit.” If you ask for a “checkup” or “physical,” the office person might not use the correct billing code, causing you to be charged for the visit.

This benefit started in 2011 for people in original Medicare and is starting in 2012 for people in Medicare

Advantage. Some Medicare Advantage plans voluntarily added this benefit early, so check with your plan.

What is covered?

A long list of preventive services that experts have judged to be worthwhile. They include flu and pneumococcal vaccines, bone-mass measurements, smoking-cessation counseling, and screenings for cancer (colorectal, prostate, and breast) and HIV. A partial list is at right. Some preventive services, such as aortic-aneurysm, glaucoma, and diabetes screenings, and hepatitis B vaccines, are covered only if you are in certain risk groups.

How it works

If your doctor or clinic participates in Medicare (and most do), you don’t have to do anything to take advantage of the benefit other than make an appointment for the preventive care. In other words, you won’t have to pay up front and get reimbursed later.

Some of these services are covered only once every few years and others are covered only if you meet specific criteria, so be sure to follow Medicare guidelines.

Although you will pay nothing for the tests or screenings, you may be charged a co-pay for the associated office visit or if the test turns up something that needs to be diagnosed right away (such as a polyp removed during a colonoscopy).

“I was glad to hear the new plan would give me a free wellness exam so I can have a better idea of what’s going on with my health.”

—Larry Gibbons, 68, of Fuquay Varina, N.C., is entitled to a free annual wellness visit starting in 2011 because of changes to Medicare.



SCOTT DINGMAN

“I haven’t been to my family doctor in many years. I just couldn’t afford it.”

—Bessie Fields, 74, of Manchaca, Texas, can now get preventive care with no out-of-pocket costs along with millions of others who are on Medicare.



BLAKE HUTSON

What’s covered?

SERVICE	MEDICARE COVERS ...
One-time "Welcome to Medicare" exam	100% of the Medicare-approved amount (no Part B deductible)
Annual wellness visit	100% of the Medicare-approved amount (no Part B deductible)
Prostate cancer screening	100% for PSA test (no Part B deductible); 80% of the Medicare-approved amount for digital rectal exam (after Part B deductible)
Colon cancer screening	100% for fecal occult blood test, flexible sigmoidoscopy, and colonoscopy (no Part B deductible); 80% of the Medicare-approved amount for barium enema (no Part B deductible)
Screening mammograms	100% of the Medicare-approved amount (no Part B deductible)
Diabetes screening	100% of the Medicare-approved amount (no Part B deductible)
Pap smears, pelvic exams, and clinical breast exams	100% for Pap lab test, Pap test collection, pelvic exam, and clinical breast exam (no Part B deductible)
Blood tests for heart disease	100% of the Medicare-approved amount (no Part B deductible)
Flu shot	100% of the Medicare-approved amount (no Part B deductible)
Pneumonia vaccine	100% of the Medicare-approved amount (no Part B deductible)
Hepatitis B vaccine	100% of the Medicare-approved amount (no Part B deductible)
Medical nutritional therapy	100% of the Medicare-approved amount (no Part B deductible)
Glaucoma screening	80% of the Medicare-approved amount (after Part B deductible)

3 Ceiling on Medicare Advantage

Costs are limited if you stay in the network

CONSUMERS IN PRIVATE Medicare Advantage plans have a major new financial protection. Previously, if you elected to get your Medicare benefits through Medicare Advantage, there was no limit to what you might owe in co-insurance or co-payments. Original Medicare also has no limit on out-of-pocket costs, but you can buy

a supplemental policy to take care of them. You're not allowed to do that with a Medicare Advantage plan.

What's new?

The Medicare program now requires Medicare Advantage plans to put a cap on your total out-of-

4 Medicare Advantage benefits may change

Payments to plans will be adjusted to reward quality

AN EXPERT BOARD that advises Congress has noted for several years that the federal government essentially overpays Medicare Advantage plans for the services they provide to enrollees. The overpayments cost taxpayers and Part B premium payers extra money. The excess payments will phase out starting in 2012 until plans receive about the same amount of money that original Medicare spends per enrollee. That may affect benefits or out-of-pocket costs for plan members.

Rewarding quality

At the same time, Medicare is giving bonuses to plans that do a better job of keeping beneficiaries healthy and provide superior customer service. Plans are ranked on a five-star system, and those with three or more stars will get a bonus, which must be used to provide extra services or reduce premiums. You can look up a plan's rating on Medicare.gov, Medicare's consumer website.

What to do

Study your options carefully during your next open-enrollment period, when you can switch from one Medicare Advantage plan to another, or go back into original Medicare if you choose (see page 11 for new open-enrollment dates).

“I shopped around and now we have a better Medicare Advantage plan than we did before. You really have to look at what the benefits are and stay educated.”

—Joy Johnson, 67, of Las Vegas, Nev., found a Medicare Advantage plan that covered a motorized wheelchair for her husband, Dwayne, 69, whose mobility is limited by multiple sclerosis. Their previous plan denied coverage because he could still walk a short distance on his own.

pocket expenses (not counting premiums). The most you'll have to pay in 2012 for the care you receive *within* your plan's network is \$6,700, though plans have the option of setting this cap as low as \$3,400. PPO plans, which allow you to go out of network by paying a larger share of the cost, must cap your total out-of-pocket costs for both in-network and out-of-network care at \$10,000, though they have an option of setting a lower cap of \$5,100. These caps do not apply to Part D drug coverage if your Medicare Advantage plan has that benefit.

What to do

Whenever possible, arrange to get your care from providers in your plan's network. Even if a hospital is in the network, some of the doctors who practice there might not be, so be sure to ask for in-network doctors if you are hospitalized.



SAMPSEL PRESTON PHOTOGRAPHY



Nancy Metcalf is
CONSUMER REPORTS'
*expert on insurance, health
care, and health reform.*
Contact her at [asknancy@
ConsumerReportsHealth.org](mailto:asknancy@ConsumerReportsHealth.org).

Ask Nancy:

What's going to happen to my Medicare Advantage plan?

Question: I'm currently enrolled in a Medicare Advantage health plan. With the changes to these plans, would I be better off enrolling in original Medicare or continuing with the Medicare Advantage plan?

Answer: There's no single answer to whether you're better off sticking with your current Medicare Advantage program or switching to something else. Medicare Advantage plans can and do frequently change their benefit structures.

The best course of action is what you should be doing every year anyway: During the fall open-enrollment period, look carefully at your options. Has your current plan changed? Are your doctors and drugs still on its list? Try to estimate how the premium (if any) and your projected out-of-pocket health-care expenses compare with the cost of original Medicare plus a Medigap plan and a Part D plan.

Don't rely solely on the glossy brochures you get in the mail to make your choice. Go to the Medicare program's interactive Medicare Plan Finder at Medicare.gov, where you can compare plans (including original Medicare) on the basis of quality, cost, and benefits, and even click through to look at a plan's provider network. You can also get free counseling from your State Health Insurance Assistance Program (listed starting on page 14).



CHRIS HAMILTON

“I don’t object to paying a higher premium. It’s a means test, and everyone should be willing to participate. But our premiums keep going up each year—that’s the thorn in my side.”

—Thomas Schwarzer, 72, and his wife, Marie, 73, of Atlanta, Ga., pay higher premiums for Part B and Part D because of their income level.

5 Seniors with large incomes may pay more

Premiums for prescription drug coverage are now affected

HIGHER-INCOME PEOPLE have had to pay larger Part B premiums, the portion that covers doctor’s fees, since 2007. But the income level at which the increase kicked in was indexed to inflation, so it rose every year.

What’s new?

Starting in 2011, higher-income beneficiaries are also paying more for their Part D prescription drug coverage.

The health-care-reform law freezes the income threshold at \$85,000 for individuals and \$170,000 for couples until 2019. In 2011, people making more than the limits pay Part B premiums of \$161.50 to \$369.10 a month, depending on income and tax filing status. Those with incomes under the limit pay \$115.40 a month or less, depending on when they signed up. For more information, go to www.socialsecurity.gov/pubs/10161.pdf.

6 New dates for changing plans

The open-enrollment period is starting and ending earlier, beginning in 2011

YOU CAN JOIN, DROP, OR SWITCH a Medicare Advantage or Part D plan between October 15 and December 7 in 2011. You can also switch from Medicare Advantage to original Medicare, or vice versa. Your coverage will begin on January 1, 2012.

What else is new?

For the first time, you will have a special opportunity outside the regular open-enrollment period to switch to a Medicare Advantage or Part D plan that has an overall five-star quality rating from Medicare. You can look up a plan's star rating on Medicare.gov. This "special election period" will start on December 8, 2011, the day after open enrollment ends, and run through November of 2012. You can use this option once per calendar year.

Also, between January 1 and February 14, 2012, you can leave your Medicare Advantage plan and switch to original Medicare. If you make this switch, you also will have until February 14 to add drug coverage. Changes made during this period go into effect the first day of the following month.

What to do

It's important to review your plans each year before open enrollment to make sure they still meet your needs. For example, all Part D plans have a formulary, a list of covered drugs. But drug plans can change. Your drug could drop off the formulary or be subject to higher cost-sharing. Use Medicare's interactive plan finder at

Medicare.gov to find out which plans in your area cover your drugs and what type of cost-sharing you'll face.

MEDICARE: IMPORTANT DATES	
October 15, 2011 – December 7, 2011	You can change your Medicare health plan or prescription drug coverage for 2012.
January 1, 2012	New coverage begins if you joined a new plan. New costs and benefit changes begin for existing coverage.
December 8, 2011 – November 30, 2012	You can join a Medicare Advantage or Part D drug plan that has a five-star quality rating. Coverage runs through the end of 2012.

QUESTIONS?



The Medicare Rights Center is a noncommercial, nonprofit organization whose only purpose is to help consumers get the most out of Medicare. Its free Medicare Interactive service at medicareinteractive.org can answer your questions.

The government's official site, Medicare.gov, is easy to use if you are comfortable with interactive online sites, and will walk you through the basics. You can also look at and download to your computer the book *Medicare & You 2011*. Seniors wanting help over the phone can call 800-MEDICARE (800-633-4227).

Starting right with Medicare

If you are about to turn 65, educate yourself about the ins and outs of Medicare

When to sign up

The initial enrollment period for Medicare consists of the three months before, the month of, and the three months after your 65th birthday.

If you want your coverage to start by your 65th birthday, you must sign up during the first three-month period. If you sign up during your birthday month, coverage starts at the beginning of the following month. But if you sign up in the three months after your birthday, you'll face increasingly lengthy delays in the start of your coverage. So, for instance, if your birthday is June 15 but you sign up in September, your coverage won't start until December 1. If your birthday is on the first of a month, the schedule shifts backward a month.

If you or your spouse is still working and has health insurance when you turn 65, *and* your employer has 20 or more employees and offers a health plan, you can wait to sign up for one part of Medicare: Part B, which covers physician services and charges you a monthly premium.

ABCD's of Medicare

If you are already on Social Security, Medicare will automatically sign you up and send you a notice. If not, you must enroll on your own either online or by visiting the nearest Social Security office.

Medicare Part A covers hospital expenses and is free to anyone who has paid Medicare taxes for more than a decade (or is married to someone who has).

For Medicare Part B, which covers most other medical expenses except prescription drugs, there's a monthly premium (\$115.40 is the standard amount for 2011; costs for 2012 were not available when we went to press).

Medicare Part C is Medicare Advantage—private HMOs or PPOs. It combines Parts A and B, and may include a Part D plan.

Medicare Part D, the prescription-drug benefit, is delivered exclusively through private plans with an average premium of about \$41 a month in 2011.

Do's and don'ts

If you're not careful when signing up for Medicare, you can blunder into decisions that could lock you out of certain types of coverage down the road and cost you thousands extra over your lifetime. Here's how to avoid the pitfalls:

- **Do sign up for Medicare Part B on time.**

Failing to sign up for Part B in time is “the biggest trap in the Medicare program,” says Joe Baker, president of the Medicare Rights Center, a nonprofit consumer advocacy group. If you don't sign up for Part B when you should, you will be hit with a harsh penalty: a permanent increase in your premium of 10 percent for every year that you could have signed up but didn't. Most people should sign up either when they turn 65 or when they or their spouses stop working or lose employee health insurance.

There are special considerations for certain groups, however, such as federal government employees. Check with your employee benefit manager to find out whether you are in such a group, then confirm that information with Medicare and Social Security, and take notes on what everyone tells you.

There is one circumstance under which most people can delay enrolling in Part B without penalty: when they have health insurance through either their own or a spouse's current job at a workplace with 20 employees or more. “Unless you or your spouse is actively employed and insured, you need Part B, period,” said Bonnie Burns, a Medicare policy specialist with California Health Advocates,

a nonprofit consumer organization in Sacramento, Calif. “You’d be surprised at how many people don’t know about this rule.”

If your workplace has fewer than 20 employees, you should sign up for Part B as soon as you turn 65. Your employee health plan then becomes a secondary plan that kicks in after Medicare has paid its share of the bills.

Consumer counselors warn about these situations that often trip people up:

You or your spouse retired before 65 and was covered by a company retiree plan. You must sign up for Part B when you turn 65, even if you are keeping your same retiree plan. After you go on Medicare, the retiree plan becomes a secondary plan.

The younger spouse stopped working and went on COBRA. “A typical situation is that the older spouse is on Medicare but doesn’t need Part B because the younger spouse is still working,” Burns said. “Then the younger spouse stops working and goes on COBRA, and nobody tells them that the Medicare-aged spouse now has to go get Part B.”

- **Do sign up for Part D when you’re eligible.**

As with Part B, you will pay a permanent premium penalty for late enrollment, but for Part D it’s 1 percent extra for every month that you could have enrolled but didn’t. If you have low drug bills, you might feel that you don’t need Part D right now, but you must weigh those savings against incurring a penalty later if you end up needing costly prescriptions as you age.

Your employee or retiree coverage will exempt you from the penalty if it has “creditable” drug coverage, meaning it’s at least as good as a Part D plan. All VA drug coverage is creditable. Your employer must give you an annual notice of whether your plan is creditable. Save that letter and put it where you can find it.

- **Do learn how your retiree plan works.**

Retiree health plans can take many forms, according to Rich Fuerstenberg, a partner in the health and benefits practice of Mercer, an international benefits consulting firm. Some employers offer stand-alone retiree plans, and some are the same as the active-employee plan; either type will pay secondary to Medicare. Some

employers offer additional options such as private Medicare Advantage plans. They can interact with Medicare in many complicated ways.

If you have a retiree plan, check with its administrator before making any decisions about your Medicare benefits.

- **Don’t accidentally lock yourself out of Medigap coverage.**

If you have a Medicare Advantage plan and are 65 or older, federal law allows you to change to a new one every year without worrying about pre-existing conditions. But it’s different for Medigap. State laws vary, but in most locations, your premium would reflect your medical history, unless it is during certain protected enrollment periods. Those include when you first sign up for Medicare Part B, when you lose your Medicare Advantage coverage because the plan closes or you move out of its service area, or when you lose your retiree coverage. If you left your Medigap plan to join a Medicare Advantage plan, you can switch back to Medigap without medical screening only if you have been in the plan for less than a year. After that, you might be shut out of Medigap for good if you have certain medical conditions, depending on state laws.

To find out the rules for Medigap in your state, check with your State Health Insurance Assistance Program (see page 14).



Still have questions?

Contact an agency listed below about your plan

For basic information about Medicare, Medicare Advantage, and the Medicare drug benefit, or to obtain a copy of *Medicare & You*:

800-MEDICARE (800-633-4227)

877-486-2048 (TTY)

www.medicare.gov

To apply for Medicare benefits:

Social Security Administration

800-772-1213

800-325-0778 (TTY)

www.ssa.gov

For help understanding your rights and benefits, and navigating the Medicare system:

Medicare Rights Center

800-333-4114

www.medicareinteractive.org

For information about how Medicare works with VA benefits:

U.S. Department of Veterans Affairs

877-222-VETS (8387)

www.va.gov/healtheligibility/costs/MedicareDEligibility.asp

For Medicare inquiries from Spanish speakers:

National Hispanic Council on Aging (NHCOA)

866-488-7379

www.nhcoa.org

For comprehensive information on the health insurance options available to consumers, including a section on health-care reform's impact on older adults:

U.S. Department of Health and Human Services

www.healthcare.gov

En español: cuidadodesalud.gov

If you suspect fraud:

**U.S. Department of Health and Human Services
Office of Inspector General**

800-447-8477

800-377-4950 (TTY)

www.stopmedicarefraud.gov

Help from your state

For information and free counseling about Medicare, Medigap, Medicare Advantage, and long-term care, contact your **State Health Insurance Assistance Program (SHIP)**. These federally funded programs are not connected to any insurance company or health plan. SHIPs were established to help beneficiaries with plan choices, billing problems, complaints about medical care or treatment, and Medicare rights.

Alabama

800-243-5463

www.alabamaageline.gov

Alaska

800-478-6065

or 907-269-3680

www.hss.state.ak.us/dsds/medicare

Arizona

800-432-4040

or 602-542-4446

www.azdes.gov

Arkansas

800-224-6330

or 501-371-2782

insurance.arkansas.gov/seniors/homepage.htm

California

800-434-0222

www.aging.ca.gov/HICAP

Colorado

888-696-7213

www.dora.state.co.us/insurance/senior/senior.htm

Connecticut

800-994-9422
www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032

Delaware

800-336-9500 or 302-674-7364
www.delawareinsurance.gov/departments/elder/eldindex.shtml

District of Columbia

202-739-0668
dcoa.dc.gov/DC/DCOA/Our+Programs/Health+Insurance+Counseling

Florida

800-963-5337
www.floridashine.org

Georgia

866-552-4464
aging.dhr.georgia.gov/portal/site

Hawaii

888-875-9229
866-810-4379 (TTY)
www.hawaii.gov/health/eoa/SAGEP.html

Idaho

800-247-4422
www.doi.idaho.gov/shiba/shwelcome.aspx

Illinois

800-548-9034
217-524-4872 (TDD)
insurance.illinois.gov/ship

Indiana

800-452-4800
866-846-0139 (TDD)
www.in.gov/idoi/2495.htm

Iowa

800-351-4664
www.shiip.state.ia.us/

Kansas

800-860-5260
www.agingkansas.org/SHICK/shick_index.html

Kentucky

877-293-7447
www.chfs.ky.gov/dail/ship.htm

Louisiana

800-259-5301
www.lidi.state.la.us/Health/SHIP/index.html

Maine

800-262-2232
800-606-0215 (TTY)
www.maine.gov/dhhs/oes/hiapl/index.shtml

Maryland

800-243-3425 or 410-767-1100
www.aging.maryland.gov/senior.html#SeniorHealth

Massachusetts

800-243-4636 or 617-727-7750
800-872-0166 (TDD/TTY)
www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Eelders

Michigan

800-803-7174
www.mmapinc.org

Minnesota

800-333-2433
www.mnaging.org/advisor/SLL_SHIP.htm

Mississippi

800-345-6347 or 601-359-4929
www.mdhs.state.ms.us/aas_info.html

Missouri

800-390-3330
www.missouriclaim.org

Montana

800-551-3191
www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml

Nebraska

800-234-7119 or 402-471-2201
800-833-7352 (TDD)
www.doi.ne.gov/shiip

Nevada

800-307-4444 or 702-486-3478
www.nvaging.net/ship/ship_main.htm

New Hampshire

866-634-9412
www.nh.gov/servicelink

New Jersey

800-792-8820

www.state.nj.us/health/senior/ship.shtml

New Mexico

800-432-2080 or 505-476-4846

www.nmaging.state.nm.us/Resource_Center.html

New York

800-701-0501

www.aging.ny.gov/HealthBenefits/HIICAPIndex.cfm

North Carolina

800-443-9354

or 919-807-6900

www.ncdoi.com/shiip/default.asp

North Dakota

888-575-6611 or 701-328-2440

800-366-6888 (TTY)

www.nd.gov/ndins/consumer/shic

Ohio

800-686-1578

www.insurance.ohio.gov/Consumer/Pages/ConsumerTab2.aspx

Oklahoma

800-763-2828

[www.ok.gov/oid/Consumers/Information_for_Seniors/Senior_Health_Insurance_Counseling_Program_\(SHIP\)/index.html](http://www.ok.gov/oid/Consumers/Information_for_Seniors/Senior_Health_Insurance_Counseling_Program_(SHIP)/index.html)

Oregon

800-722-4134

www.oregon.gov/DCBS/SHIBA

Pennsylvania

800-783-7067

www.portal.state.pa.us/portal/server.pt?open=514&objID=616587&mode=2

Rhode Island

401-462-4000

www.dea.ri.gov/insurance

South Carolina

800-868-9095

aging.sc.gov/seniors/medicare/Pages/index.aspx

South Dakota

800-536-8197

www.shiine.net

Tennessee

877-801-0044

www.state.tn.us/comaging/ship.html

Texas

800-252-9240

www.tdi.state.tx.us/consumer/hicap/hicaphme.html

Utah

800-541-7735

www.hsdaas.utah.gov/insurance_programs.htm

Vermont

800-642-5119

www.medicarehelpvt.net

Virginia

800-552-3402

or 804-662-9333

www.vda.virginia.gov

Washington

800-562-6900

www.insurance.wa.gov/shiba/index.shtml

West Virginia

877-987-4463

or 304-558-3317

www.wvship.org/

Wisconsin

800-242-1060

www.dhs.wisconsin.gov/aging/SHIP.htm

Wyoming

800-856-4398

www.wyoming seniors.com/WSHIIP.htm