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ConsumerReports®

Medicare: 6 things you need to know now

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**A Special Guide
from the Editors of
*Consumer Reports***

**TAKE ADVANTAGE
OF NEW BENEFIT
CHANGES**

Get the most from your Medicare benefits



While the long-term future of the Medicare program is part of a national debate, you need to know about the important new services and changes to the program, available right now, that were part of 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 has developed this brief guide to let you know how the new health-care law has affected Medicare and your benefits in 2011. 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 individual 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. These changes don't directly affect individual benefits, but they are designed to strengthen Medicare and improve health outcomes.

In the meantime, 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, visit www.stopmedicarefraud.gov.

We also ask that you share this guide with others. Copies are available for download on our Web site, at ConsumerReportsHealth.org, 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

Learn about changes to your benefits, whether you're enrolled in original Medicare or Medicare Advantage



IF YOU'RE WONDERING HOW the 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 more are enrolled in private Medicare Advantage plans. This Consumer Reports publication is your guide to the information you need for understanding today's Medicare system.

Are you...

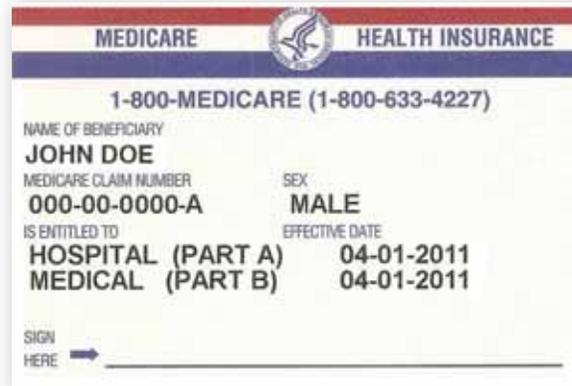
- Turning 65? Here's what you need to know before you sign up for Medicare (page 12).
- Hard-hit by prescription drug costs? Now, seniors who reach the doughnut hole (the Medicare drug coverage gap) will get sizable discounts. (page 4).
- Paying for (or skipping) preventive care? Get your new, free annual wellness visit (page 6).
- Feeling the pinch of co-pays in Medicare Advantage? Now, there's a limit on your annual out-of-pocket costs (page 8).
- Thinking it's time for a change? Check the new dates for Medicare open enrollment (page 11).
- In need of more info? The resources section in the back of this booklet lists contact information for key agencies that can answer your specific questions about Medicare.

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.

Not sure which one you 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.



Here's how to find out which Medicare plan you have:

- Call 800-MEDICARE (800-633-4227)
- The system will ask you to say your "Medicare number." That's the number on your red, white, and blue Medicare card. Everyone has this card, even those enrolled in Medicare Advantage plans.
- When the representative comes on the line, you will be asked for your Medicare number again, and some other identifying information such as date of birth and full address.
- Once your identity has been confirmed, ask the rep: "Could you tell me whether I have original Medicare or Medicare Advantage?" You will be told either: "There's no Medicare Advantage plan on file" or the name of your Medicare Advantage plan. Caregivers can make this call on behalf of the beneficiary, if they have the requested information.

1 Drug discounts

Your prescription medicine may be more affordable

YOU MAY BE FAMILIAR WITH the “doughnut hole.” That’s the point in Medicare drug plans where your costs increase and you have to start paying the full amount for your medications.

What’s new?

If you hit the doughnut hole in 2011, you’ll receive a 50 percent discount on brand-name drugs and a 7 percent discount on generic drugs. You will get those discounts automatically, without having to apply or sign up.

How it works

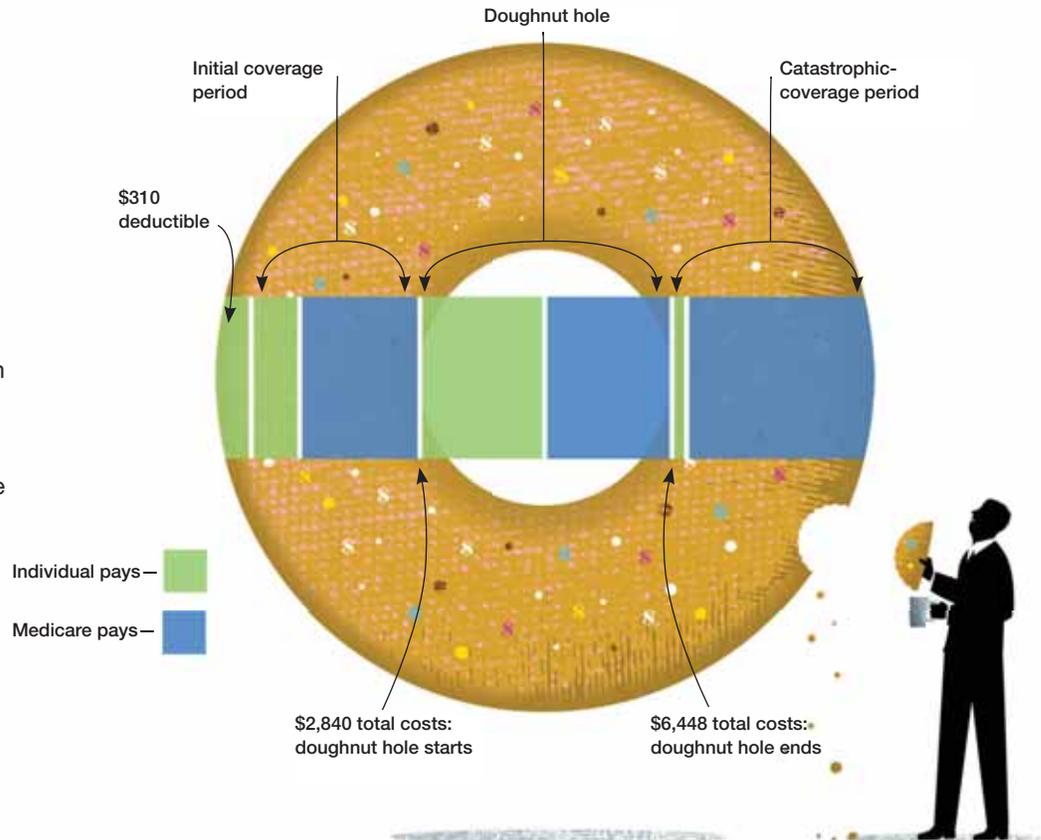
You become eligible for the discounts once you and your drug plan together have paid \$2,840 in drug costs. This

is not counting your Part D premiums. Your share will depend on your plan’s deductibles and co-pays.

Once you’re in the doughnut hole, you’ll automatically start getting the discount at your pharmacy. The discount will apply until you and your drug plan together have paid an additional \$3,608. You’ll then become eligible for catastrophic coverage for the rest of the year, meaning you’ll pay only 5 percent of your remaining 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 25 percent, the same share as you pay, on average, for drugs before entering the doughnut hole.

Taking a bite out of drug costs

Many 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. In 2011, Medicare is covering half the cost of brand-name drugs in the doughnut hole, and by 2020, the hole will be closed and there will be no gap in drug coverage.





DAVID PEZZAT

“My 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 about Part D plans at Medicare’s Web site, *Medicare.gov*. This 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 Web site, 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

IF YOU'RE IN THE ORIGINAL MEDICARE PLAN, starting in 2011 you're 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 with him or her on a plan to stay as healthy as possible.

Who is covered?

Everyone enrolled in original Medicare is eligible for preventive services such as flu and pneumococcal vaccines; bone-mass measurements; smoking-cessation

counseling; and screenings for cancer (colorectal, prostate, and breast) and HIV. Some preventive services, such as aortic-aneurysm, glaucoma, or diabetes screening, and hepatitis B vaccines, are covered only if you meet certain risk criteria. See the table on the next page for more details.

How it works

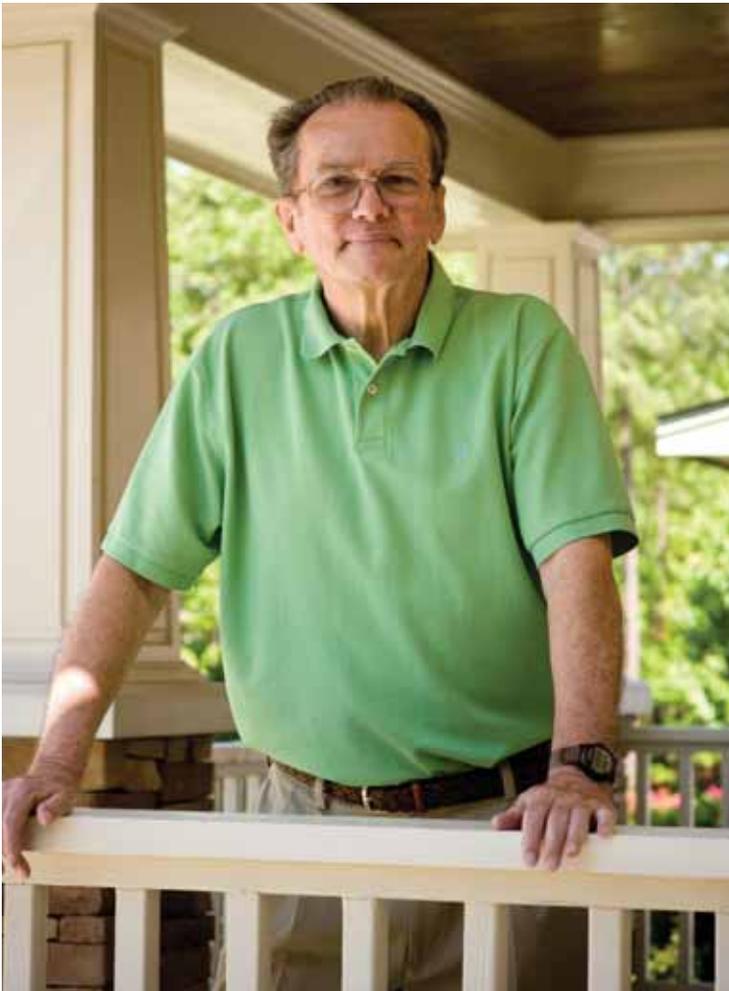
If your doctor or clinic participates in Medicare (and most do), you don't have to do anything to take advantage of the benefit other than make an appointment for the preventive care. In other words, you won't have to pay up front and get reimbursed later.

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 that's removed during a colonoscopy).

What if I'm in a Medicare Advantage plan?

Medicare Advantage plans do not have to provide that free preventive care until 2012, but most do. Double-check with your plan to make sure that you are covered.



SCOTT DINGMAN

“I was glad to hear the new plan would give me a free physical 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 this year because of changes to Medicare.

“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 access preventive care with no out-of-pocket costs along with millions of other Medicare recipients.



BLAKE HUTSON

What’s covered?

SERVICE	STARTING THIS YEAR, ORIGINAL MEDICARE COVERS...
"Welcome to Medicare" physical 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 got a major new financial protection this year. 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. And it's against the law for insurers to sell you a supplemental policy, known as Medigap, to pick up those costs, the way they can with original Medicare.

What's new?

Starting in 2011, the Medicare program requires Medicare Advantage plans to put a cap on your total out-of-pocket expenses. The most you'll have to pay this year is \$6,700, though plans have the option of setting an out-of-pocket cap as low as \$3,400. It's important to note that the out-of-pocket limit doesn't apply to care you receive outside the plan's network.

4 Medicare Advantage benefits may shrink

Excess payments to private insurers are being reduced

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. These overpayments cost taxpayers and Part B premium payers extra money. The excess payments will phase out over the next several years. Starting in 2012, payments to the plans will gradually decrease until they're getting the same amount of money, on average, that original Medicare spends per enrollee. That may change your benefits or out-of-pocket costs if you are in one of these plans.

What to do

Within limits, Medicare Advantage plans can change their prices and benefits each year, so a plan that currently fits your needs may not be the best choice next year. 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 because of multiple sclerosis. Their previous plan denied coverage.

Nor does it apply to drug coverage, if your Medicare Advantage plan has that benefit.

Review your plan

Most Medicare Advantage plans require you to get your care within a local provider network, whereas with original Medicare you can get your care from any doctor in the country who sees and accepts new Medicare patients.

Every Medicare Advantage plan substitutes for Part A, the Medicare hospital benefit, and Part B, which covers most other health expenses except for prescription drugs. Most of the plans also include Part D drug coverage. You'll probably pay a lower monthly premium for Medicare Advantage than for Part B plus separate Medigap and Part D plans. But Medicare Advantage plans also have deductibles and co-pays that you'll be paying out of your own pocket, and you still must pay your Part B premium.



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 continue 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? How do the premium (if any) and projected out-of-pocket health expenses compare with the cost of original Medicare plus a supplemental 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 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 personal counseling from your State Health Insurance Assistance Program (see the list of programs 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 BENEFICIARIES 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; that is, it rose every year.

What’s new?

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. Starting in 2011, higher-income beneficiaries are also paying more for their Part D prescription drug coverage, based on the income levels used to calculate Part B premiums. 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, SWITCH, OR DROP a Medicare Advantage or Part D plan between October 15 and December 7 in 2011. Your coverage will begin on January 1, 2012.

What else is new?

What if you want to make changes to your coverage after December 31, 2011? 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.

During this period, you are not permitted to:

- Switch from original Medicare to a Medicare Advantage plan
- Switch from one Medicare Advantage plan to another
- Switch from one Medicare prescription drug plan to another

What to do

It's important to review your plan each year before open enrollment to make sure it still meet your needs. For example, all Part D plans have a formulary, a list of covered drugs. But drug plans can change. Not only can your drug drop off the formulary, but it could also move to another payment tier. Plans can also put new restrictions on drugs, such as requiring your doctor to get approval from the insurer before prescribing them. During open enrollment, you can change to a new plan if

your old one made changes you don't like.

Use Medicare's interactive formulary 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 Advantage health plan or prescription drug coverage for 2012.
January 1, 2012	New coverage begins if you switched or joined a plan. New costs and coverage changes begin if you kept your existing coverage.

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.gov can answer just about any question you have about Medicare (and probably a lot you haven't thought of).

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 last three months, 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, your whole schedule shifts backward a month.

If you're still working when you turn 65 *and* your employer has 20 or more employees, you can wait to sign up for one part of Medicare: Part B, which covers physician services and for which you are charged a premium.

How to sign up

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.

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 in extra premiums and out-of-pocket costs over your lifetime. Here's how to avoid the pitfalls:

- **Do sign up for Medicare Part B when you stop working.** "This is the biggest trap in the Medicare program," says Joe Baker, president of the Medicare Rights Center, a

nonprofit consumer advocacy group. 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). But there's a monthly premium (\$115.40 is the standard amount for 2011) for Part B, which covers most other medical expenses except prescription drugs.

If you didn't sign up for Part B when you should have, 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 stop working, whichever comes later.

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, 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. Nobody tells them."

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.**

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

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 and change your mind.

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. Your employer must give you an annual notice of whether your plan is creditable.

- **Do find out how your retiree plan works with Medicare.**

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 administrators 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 shuts down 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 a pre-existing condition or develop a condition that would prevent you from switching to or buying another insurance plan, depending on the laws of your state.

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*, a handbook published by the Centers for Medicare and Medicaid Services:

800-MEDICARE (800-633-4227)
877-486-2048 (TTY)
www.medicare.gov

For information about Medicare enrollment and eligibility:

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
www.medicareinteractive.org

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and

people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

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 reform's impact on older adults:

U.S. Department of Health and Human Services
www.healthcare.gov
En español: ciudadodesalud.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.idi.state.la.us/Health/SHIIP/index.html

Maine

800-262-2232
800-606-0215 (TTY)
www.maine.gov/dhhs/oes/hiap/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/WSHIP.htm

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