



# SHIIP

NC DEPARTMENT OF  
**INSURANCE**

# Medicare Basics

Seniors' Health Insurance Information Program

North Carolina Department of Insurance

**Mike Causey, Commissioner**

**855-408-1212 • [www.ncshiip.com](http://www.ncshiip.com)**

## What is SHIIP?

Seniors' Health Insurance Information Program (SHIIP) is a consumer information division of the North Carolina Department of Insurance that assists people with Medicare, Medicare Part D, Medicare supplements, Medicare Advantage, and long-term care insurance questions. We also help citizens recognize and prevent Medicare billing errors and possible fraud and abuse through our NC Senior Medicare Patrol (NCSMP) Program.

## How does SHIIP work?

SHIIP provides education and assistance to North Carolinians in three ways:

- by operating a nationwide toll-free consumer information phone line Monday through Friday from 8 a.m. until 5 p.m.
- by training volunteers to counsel Medicare beneficiaries within their community about Medicare, Medicare Part D, Medicare supplements, Medicare Advantage and long-term care insurance, and
- by providing helpful information on the SHIIP Web site, [www.ncshiip.com](http://www.ncshiip.com).

## When was SHIIP established?

The program was founded in 1986 by the Department of Insurance in direct response to the growing concerns about health insurance for the more than one million Medicare beneficiaries in North Carolina. Numerous insurance companies sell Medicare supplements, Medicare Advantage, long-term care insurance and other medical insurance products to people in North Carolina. Because there are so many companies, and because the Medicare system is so complex, SHIIP was founded to provide people who are eligible for Medicare with an objective information service.

## How do North Carolinians contact SHIIP?

You can contact SHIIP by dialing the nationwide toll-free consumer number, **855-408-1212**, visiting the SHIIP Web site, [www.ncshiip.com](http://www.ncshiip.com), or e-mailing [ncshiip@ncdoi.gov](mailto:ncshiip@ncdoi.gov). Trained SHIIP Volunteer Counselors are available in all 100 counties of North Carolina and are coordinated through an existing human service agency such as the Council on Aging, senior centers or the Cooperative Extension offices. If your problem is too complex to handle over the phone, you will need to contact your local SHIIP Coordinator for a one-on-one appointment with a SHIIP Volunteer Counselor or contact the Raleigh SHIIP office at the toll-free number shown below.

## Can I get more information about SHIIP?

Yes! Contact SHIIP nationwide at **855-408-1212** or **(919) 807-6900**, visit [www.ncshiip.com](http://www.ncshiip.com) or e-mail [ncshiip@ncdoi.gov](mailto:ncshiip@ncdoi.gov) for further information and ask for more details on the Seniors' Health Insurance Information Program and how it can help you.

SHIIP counselors are not licensed insurance agents, and they do not sell, endorse, or oppose any product, plan, or company. If you have questions about your specific plan, we encourage you to contact your insurance agent or the insurance company.

# Don't be a target of healthcare fraud.



## Protect. Detect. Report.

# NC Senior Medicare Patrol (NCSMP)

The NCSMP is housed within the SHIP Division at the North Carolina Department of Insurance. NCSMP is a preventive educational program whose goal is to reduce Medicare error, fraud and abuse through statewide coordinated educational efforts, partnerships and outreach activities.

NCSMP's purpose is to educate Medicare beneficiaries and caregivers about Medicare benefits in order to understand Medicare Statements such as Medicare Summary Notices (MSN), Medicare Part D Prescription Drug Plans (PDP) Explanation of Benefits (EOB) and other related health care statements. Through this knowledge, a person can identify, resolve and/or report possible billing errors, fraud, abuse and waste to NCSMP.

Did you know that:

- 60 billion dollars of taxpayers' money is lost annually to billing discrepancies, fraud, abuse and waste in the Medicare program?
- "fraud and abuse" in the Medicare program often times are actual billing errors or discrepancies?
- the process of reporting suspected fraud abuse and waste is to contact the provider to seek resolution; to contact their Medicare carriers and insurance companies and to file an appeal by following the appeal instructions found on the back of the Medicare Summary Notices? And if your situation is not resolved satisfactorily, you should contact the NCSMP Program at the nationwide toll-free number, 855-408-1212.

Remember:

- review your Medicare statements (MSN's, EOB's and/or PDP EOB's)
- protect your Medicare number
- do not be influenced by advertising for services, medications or products that sound "too good to be true"
- educate yourself about your Medicare benefits
- rarely are Medicare services "free"
- Medicare does not solicit door-to-door



### PROTECT. DETECT. REPORT.

**You CAN make a difference.**

Protect yourself from Medicare errors, fraud and abuse.

Learn how to **detect** potential errors, fraud and abuse.

If you suspect you have been a target of errors, fraud or abuse, **report** it.

# Your Medicare Coverage Choices at a Glance

When you become eligible for Medicare, you will be able to choose between:

1. Parts A & B (Original Medicare), Part D (Prescription Drug Benefit), and potentially Medicare Supplement Insurance
2. Part C (Medicare Advantage Plan)

When comparing coverage, it's important to look at the two core options first: Original Medicare and Medicare Advantage. Medicare Advantage plans come in many types (the most common are HMOs and PPOs). They must cover the same benefits as Parts A & B of Original Medicare and often include prescription drug coverage. You must have Parts A & B to enroll into a Medicare Advantage Plan.

It's also important to consider the potential to add a Medicare Supplement (or Medigap) policy to your Original Medicare to help cover all or some of the costs of Parts A & B. Remember, you cannot have *both* a Medicare Supplement policy *and* a Medicare Advantage Plan. If you need help comparing Original Medicare and Medicare Advantage Plans, use these steps to help you decide.

<b>Original Medicare</b> (Parts A & B)	<b>OR</b>	<b>Medicare Advantage Plan</b> (Part C)
 <b>Part A</b> Hospital Insurance		 <b>Combines Hospital &amp; Medical</b> (Managed Care plans offered by private insurance companies)
<b>Part B</b> Medical Insurance		<b>Available with or without Prescription Coverage.</b>
<b>Do you need to add supplemental coverage?</b>  <b>Medicare Supplement Insurance</b> (also called Medigap plans)		<b>NOTES:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
<b>Do you need to add drug coverage?</b>		
 <b>Part D</b> Prescription Drug Coverage (PDP Plan)		

\*A **benefit period** begins on the first day you receive services as an **inpatient** in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 consecutive days.

<b>Services</b>	<b>Benefit</b>	<b>Medicare Pays <sup>(1)</sup></b>	<b>You Pay <sup>(1)</sup></b>
<b>INPATIENT HOSPITALIZATION (admitted)</b> Semi-private room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but <b>\$1,736</b> deductible	<b>\$1,736</b> deductible
	61st to 90th day	All but <b>\$434</b> per day	<b>\$434</b> per day
	91st to 150th day <sup>(2)</sup>	All but <b>\$868</b> per day	<b>\$868</b> per day
	Beyond 150 days	Nothing	All costs
<b>POST-HOSPITAL SKILLED NURSING FACILITY CARE</b> You must have been an inpatient in a hospital for at least 3 days, enter a Medicare-approved facility generally within 30 days after hospital discharge, and meet other program requirements. <sup>(3)</sup>	First 20 days	100% of approved amount	Nothing
	21st to 100th day	All but <b>\$217</b> per day	Up to <b>\$217</b> per day
	Beyond 100 days	Nothing	All costs
<b>HOME HEALTH CARE</b> (also see Part B) Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay for visits 1-100.	100% part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for Durable Medical Equipment.	Nothing for services; 20% of approved amount for Durable Medical Equipment.
<b>HOSPICE CARE</b> Full scope of pain relief and support services available to the terminally ill.	As long as doctor certifies need.	All but limited costs for outpatient prescription medications and inpatient respite care.	Limited cost sharing for outpatient prescription medications and inpatient respite care.
<b>BLOOD</b>	Blood	All but first three pints per calendar year	For first three pints <sup>(4)</sup>

<sup>1</sup> These figures are for 2026 and are subject to change each year.

<sup>2</sup> Lifetime reserve days may be used only once.

<sup>3</sup> Neither Medicare nor Medicare Supplement (Medigap) insurance will pay for most nursing home care.

<sup>4</sup> To the extent the blood deductible is met under one part of Medicare during the calendar year it does not have to be met under the other part.

NOTE: The Medicare Part A premium is **\$0** for eligible beneficiaries. For those who are ineligible, the Medicare Part A premium is **\$565** per month for those who worked fewer than 30 quarters, or **\$311** per month for those who worked between 30 and 40 quarters.

# MEDICARE PART B (MEDICAL INSURANCE) – COVERED SERVICES PER CALENDAR YEAR

2026

Services	Benefit	Medicare Pays	You Pay <sup>(5)</sup>
<b>MEDICAL EXPENSE</b> Physicians' services, outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, ambulance services, outpatient mental health services, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after <b>\$283</b> deductible)	<b>\$283</b> deductible <sup>(6)</sup> 20% of approved amount and charges above approved amount <sup>(7)</sup>
<b>CLINICAL LABORATORY SERVICES</b>	Blood tests, biopsies, urinalysis, etc.	Generally 100% of approved amount.	Nothing
<b>PREVENTIVE BENEFITS</b>	Preventive services & screenings	100% for most; or 80% of approved amount (after <b>\$283</b> deductible), depending on test	Nothing for most; or <b>\$283</b> deductible 20% of approved amount, depending on test
<b>HOME HEALTH CARE</b> (also see Part A) Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay beginning with visit 101 or beginning day one if there is no previous hospital stay.	100% part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount	Nothing
		80% of approved amount for Durable Medical Equipment	<b>\$283</b> deductible <sup>(6)</sup> 20% of approved amount for Durable Medical Equipment
<b>OUTPATIENT HOSPITAL TREATMENT</b> Reasonable and necessary services for the diagnosis or treatment of an illness or injury. (for inpatient see Part A)	Unlimited if medically necessary	80% of approved amount (after <b>\$283</b> deductible)	<b>\$283</b> deductible <sup>(6)</sup> 20% of approved amount
<b>BLOOD</b>	Blood	80% of approved amount (after <b>\$283</b> deductible and starting with the 4th pint)	<b>\$283</b> deductible <sup>(6)</sup> First 3 pints plus 20% of approved amount for additional pints <sup>(8)</sup>

The monthly Part B premium for 2026 is **\$202.90** (Premiums will be higher for individuals with annual incomes of **\$109,000** or more and married couples with annual incomes of **\$218,000** or more.)

<sup>5</sup> These figures are for 2026 and are subject to change each year.

<sup>6</sup> Once you have paid **\$283** for covered services, the Part B deductible does not apply to any other covered service(s) you receive for the rest of the calendar year.

<sup>7</sup> The amount by which a physician's charge can exceed the Medicare approved amount is limited by law.

<sup>8</sup> To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

# Standardized Medicare Supplement Plan Comparison Chart

The chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. (✓ = 100% of benefit is paid)

BENEFITS	PLANS AVAILABLE TO ALL APPLICANTS								MEDICARE FIRST ELIGIBLE BEFORE 2020 ONLY	
	A	B	D	G <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ <sup>3</sup>	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit in 2026 <sup>2</sup>					\$8,000 <sup>2</sup>	\$4,000 <sup>2</sup>				

<sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

## Online Medicare Supplement Premium Comparison Database

Medicare’s interactive website allows you to compare Medicare supplement (Medigap) plans and find companies in your area that sell policies. To use the tool, enter your ZIP code and click Start. Answer the questions on the next page and then click “Update Prices.”

Select “Plan Details” to review the coverage for each standardized Medigap plan, or “View Policies” to review the premium costs and find a list of companies selling that plan. This site has the most up-to-date information of plans available in North Carolina and is located at [www.medicare.gov/medigap-supplemental-insurance-plans](http://www.medicare.gov/medigap-supplemental-insurance-plans).

The screenshot shows the Medicare.gov website interface for finding a Medigap policy. At the top, there are navigation links for "Basics", "Health & Drug Plans", and "Providers & Services". The main heading is "Find a Medigap policy that works for you". Below this, a text box explains that Medicare Supplement Insurance (Medigap) is extra insurance you can buy from a private company. At the bottom, there is a search bar with the placeholder text "ENTER YOUR ZIP CODE" and a "Start" button.

## Medicare Part D: Prescription Drug Plans Benefit

The Medicare Prescription Drug Plans, also called PDPs, are provided by private companies that sell plans approved by Medicare. You can identify an approved plan by the MedicareRx logo. All people who are new to Medicare have a seven month window to enroll in a Medicare Part D drug plan – three months before, the month of, and three months after their Medicare becomes effective. Remember, the month you enroll will affect the month your PDP is effective.

All people with Medicare are eligible to enroll in a PDP, regardless of income or assets; however, unless they are new to Medicare or are entitled to a Special Enrollment Period, they must enroll during the Open Enrollment Period (OEP) which is October 15 through December 7 each year. For assistance in understanding and enrolling in a Medicare PDP, you may visit the Medicare Web site at [www.medicare.gov](http://www.medicare.gov) or contact SHIP at **855-408-1212**.



**NOTE: If you do not enroll in a Medicare PDP when you first become eligible, and you do not have creditable drug coverage in place, in most cases you will pay a penalty for life when you do enroll in a PDP during the OEP.**

**The Extra Help Program is available for people with Medicare who have limited incomes and resources.** If you qualify, you can receive assistance with **premiums, deductibles and co-payments** for your prescriptions. You can visit your local Social Security office, call Social Security toll free at **1-800-772-1213**, visit [www.socialsecurity.gov](http://www.socialsecurity.gov), or request an Extra Help application by contacting SHIP. People who qualify for any level of Medicaid automatically qualify for Low Income Subsidy (LIS) and do not need to apply.

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## Medicare Part C: Medicare Advantage Plans

Medicare Advantage Plans are health care options provided under Medicare Part C of the Medicare program. These plans are approved by Medicare but sold and serviced by private companies. There are several plan options available under Medicare Advantage such as managed care plans that involve a provider network (HMOs and PPOs) to those that are specially designed for people with certain chronic diseases and other specialized health needs (SNPs) and some that may or may not have a provider network (PFFS) requirement. Most Medicare Advantage plans include Medicare prescription drug coverage.

To enroll in any Medicare Advantage plan option you must have both Medicare Part A and Medicare Part B. Once you enroll into a Medicare Advantage plan, you will not use your Original Medicare (red, white and blue) card as your Medicare Advantage plan will replace Original Medicare. Instead the Medicare Advantage plan will provide you with a member ID card to use when visiting your medical provider. Please note, you will continue to pay the Medicare Part B premium, and you might also have to pay an additional monthly premium charged by the Medicare Advantage plan.

**It is important to remember to check with your healthcare providers before making any change to your Medicare coverage to make sure they will accept the Medicare Advantage plan you are considering.**

# Did you know that Medicare now covers more preventive services to help you stay healthy?

## These Medicare-covered preventive services are:

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening and Counseling
- Bone Mass Measurements
- Cardiovascular Behavioral Therapy and Cardiovascular Disease Screening
- Cervical and Vaginal Cancer Screening
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- Tobacco-caused Disease
- COVID-19 Vaccines
- Depression Screening
- Diabetes Screening
- Diabetes Self-management Training
- Flu Shots
- Glaucoma Screening
- Hepatitis B Shots, Hepatitis B Virus Infection
- Screening and Hepatitis C Virus Infection Screening
- HIV Screening
- Lung Cancer Screening
- Mammogram Screening
- Medical Nutrition Therapy Services
- Medicare Diabetes Prevention Program
- Obesity Behavioral Therapy
- Pneumococcal Shots
- Prostate Cancer Screening
- Sexually-transmitted Infection Screening and Counseling
- “Welcome to Medicare” Preventive Visit
- Yearly “Wellness” Visit

**All Medicare beneficiaries with Part B are entitled to these preventive services. Contact SHIP, the Seniors’ Health Insurance Information Program, to learn more.**



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