



Medicare and the State Health Plan for Teachers and State Employees in North Carolina

How does Medicare work with the State Health Plan when YOU ARE NO LONGER EMPLOYED?

- You **must enroll** in Medicare Part A and Part B upon eligibility.
- **Medicare will become your primary insurance**, and the State Health Plan will become your secondary health plan.
- The State Health Plan offers two different Preferred Provider Options (PPO) health plans from which you may choose. **Your coverage level depends on the health plan you choose.** The two plans are the 70/30 Basic Plan and 80/20 Standard Plan.
- In-network physician¹ office services require only a copayment (no deductible or coinsurance). Copayments vary by plan. Most other services are subject to the yearly deductible, coinsurance and in some instances the difference between the allowed amount and the actual charge.
- You must meet the State Health Plan's yearly deductible for those services that are subject to the deductible, even though you are on Medicare. However, you will **pay the lesser of the two deductibles (Medicare and the State Health Plan)**. The State Health Plan yearly deductible period remains the same as when you were actively employed -- July 1 through June 30.
- The **State Health Plan will pay coinsurance**, which varies by plan, on the remaining covered charges after Medicare has paid the Medicare covered charges, and you have met the State Health Plan deductible.
- There is an **out-of-pocket (coinsurance) maximum**, which varies by plan, per fiscal year (July 1-June 30) with the State Health Plan. After the out-of-pocket maximum has been met, the State Health Plan will pay the remaining Medicare approved charges at 100%.
- **Copayments do not count** toward the yearly deductible or coinsurance out-of-pocket maximum.
- For questions regarding your coverage call **1-888-234-2416** for PPO plan questions.

How does Medicare work with the State Health Plan when you are STILL ACTIVELY WORKING AND EMPLOYED BY THE STATE?

- Upon eligibility for Medicare, **you should enroll in Medicare Part A** as it is typically premium-free.
- You can **delay enrollment in Medicare Part B** as the State Health Plan will remain primary for actively employed workers.
- **It is important to remember to enroll in Medicare Part B when you decide to retire/stop actively working.**

Will I need additional health insurance?

Most Medicare beneficiaries purchase a **Medigap** (Medicare Supplement) plan, because they **do not** have access to a Retiree Employer Group Health Plan such as the North Carolina State Health Plan. An additional Medigap plan is generally not needed when you have the State Health Plan as secondary coverage to Medicare. If you have high medical expenses with high out-of-pocket costs, a Medigap plan may be an option to consider.

¹PPO Options: In-network hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to see if your physician's practice is hospital owned or operated.

Here are a few items to consider when thinking about purchasing a Medigap plan:

- Evaluate Cost – Will the additional premium cost outweigh the State Health Plan coverage and out-of-pocket expenses?
- Pre-existing Conditions – Will the company impose a pre-existing condition waiting period or increase premium due to past health history?
- Guarantee Issue Right – Are you eligible under a Guarantee Issue basis?
- Networks – There are no networks involved under a Medigap plan.

You will have the same State Health Plan prescription drug coverage as a retiree as when actively working. You will not have to obtain a Medicare prescription drug plan (Medicare Part D).

- However, if you have limited income and resources, you may be eligible for the federal Extra Help program for Medicare prescription drug coverage. This would allow you to have lower prescription copays if you enroll in a Medicare Part D plan. You can still retain your SHP prescription drug coverage if you enroll in a Medicare Part D plan but may only use one coverage. Call SHIP for additional information about Extra Help.

Another option you may consider would be a **Medicare Advantage Plan** which is a Medicare health plan choice you may have as part of Medicare. These plans are also sometimes called “Medicare Part C” or “MA Plans” and are offered by private companies contracted directly with Medicare. If enrolled in a Medicare Advantage Plan, you still have Medicare and you will get Medicare Part A and Medicare Part B coverage from the Medicare Advantage plan instead of Original Medicare. However, it is important to understand that Medicare Advantage plans do not automatically submit claims information to the State Health Plan. Any Medicare Advantage plan member who also has coverage with the State Health Plan will need to manually submit claims to BlueCross BlueShield of NC and include the copy of the Explanation of Benefit or denial (if applicable). **Remember before enrolling in any Medicare Advantage plan, it is important to check with ALL medical providers to ensure they accept and are participating with the plan. There may be provider network restrictions with some Medicare Advantage plans.**

What about a Medicare-eligible spouse of a State retiree?

You will want to evaluate all potential options for the **Medicare-eligible spouse**. What is the cost of the monthly premium for a Medicare-eligible spouse to be covered under the State Health Plan versus having the Medicare-eligible spouse dropped from the State Health Plan and obtaining a Medigap (Medicare Supplement) plan along with a Medicare Prescription Drug plan? Although you will pay a monthly premium for each (Medigap and Medicare Prescription Drug plan), typically there is a savings. Currently the State Health Plan policy is that if a retiree’s Medicare-eligible spouse is dropped, they can be added back to the State Health Plan during any State Health Plan’s annual enrollment period as long as the State retiree is living and still covered by the State Health Plan.

What does Medicare pay? What does the State Health Plan pay?

It is important to remember that the State Health Plan is a secondary plan of coverage to Medicare and not supplemental coverage. North Carolina law requires State Health Plan benefits to coordinate with Medicare benefits. This means that charges left unpaid by Medicare are paid by the State Health Plan after the yearly deductible or coinsurance are applied, up to the total allowed charge for the procedure or after the copayment is paid for those services on the PPO plans that require only a copayment.

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Services	Medicare Benefit	Medicare Pays ⁽¹⁾	State Health Plan (SHP) Standard PPO Benefit (In-Network)	You Pay ⁽¹⁾
HOSPITALIZATION Semi-private room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days 61 st to 90 th day 91 st to 150 th day ⁽²⁾ Beyond 150 days	All but \$1,156 All but \$289 a day All but \$578 a day Nothing	Costs remaining after Medicare pays – up to the State Health Plan allowable amount less SHP annual deductible, copayment and coinsurance	\$1,156 Medicare deductible which is applied to the \$233 SHP copayment and toward the SHP \$700 annual deductible if not met and any 20% coinsurance owed
POST-HOSPITAL SKILLED NURSING FACILITY CARE You must have been 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. ⁽³⁾	First 20 days 21 st to 100 th day Beyond 100 days	100% of approved amount All but \$144.50 a day Nothing	20% after annual deductible Maximum benefit period of 100 days	Starting with the 21 st day the lesser amount between Medicare and SHP
HOME HEALTH CARE (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	20% after annual deductible (including durable medical equipment)	The lesser amount between Medicare and SHP pay, i.e., the lesser of the deductibles
HOSPICE CARE 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 drugs and inpatient respite care.	20% after annual deductible	The lesser amount between Medicare and SHP
BLOOD⁽⁴⁾	Whole Blood and Packed Red Cells	Inpatient – All but first 3 pints per calendar year Outpatient – 80% of approved amount after Part B deductible (\$140) ⁽⁵⁾ is met and starting with 4 th pint)	100% cost except for charges related to a blood donor including member in case of autologous blood donation	Nothing if member receives transfusion of blood, plasma, blood plasma expanders or other fluids injected into bloodstream

1) These figures are for 2012 and are subject to change each year.

2) Lifetime reserve days may be used only once.

3) Neither Medicare nor Medigap insurance will pay for most nursing home care.

4) 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.

5) Once you have paid \$140 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.

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PHYSICIAN OFFICE VISITS	Medicare pay for medical visits	80% of approved amount after Part B deductible (\$140) ⁽⁵⁾ is met	\$30 copay for primary care physician \$70 copay for specialist	Will pay no more than the SHP copay
OUTPATIENT MEDICAL SERVICES MRI's, MRA's, PET Scans, Ultrasounds, EEGs, EKGs and other diagnostic testing	Medicare pays for medical services in or out of the hospital	80% of approved amount after Part B deductible (\$140) ⁽⁵⁾ is met	20% after annual deductible has been met	The lesser amount between Medicare and SHP – pay the lesser of the deductibles
CLINICAL LABORATORY SERVICES	Blood tests, urinalysis, etc.	Generally 100% of approved amount	Covered at 100%	Nothing
AMBULANCE	Medicare typically pays for transportation to closest appropriate facility	80% of approved amount after Part B deductible (\$140) ⁽⁵⁾ is met	20% after annual deductible has been met	The lesser amount between Medicare and SHP – pay the lesser of the deductibles
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary	80% of approved amount after Part B deductible (\$140) ⁽⁵⁾ is met	20% after annual deductible has been met	The lesser amount between Medicare and SHP – pay the lesser of the deductibles
EMERGENCY ROOM VISIT	Medicare pay for medical visits	80% of approved amount after Part B deductible (\$140) ⁽⁵⁾ is met	\$233 copayment, then 20% after annual deductible has been met	The lesser amount between Medicare and SHP – pay the lesser of the deductibles

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- 3) Neither Medicare nor Medigap insurance will pay for most nursing home care.
- 4) 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.
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The North Carolina State Health Plan Benefits for Plan Year 2012-2013

Plan Design Feature	70/30 Basic Plan (Premium Free)		80/20 Standard Plan (\$10.52/month)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$933 Individual \$2,799 Family	\$1,866 Individual \$5,598 Family	\$700 Individual \$2,100 Family	\$1,400 Individual \$4,200 Family
Plan Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses after deductible and difference between allowable and actual charges	20% of eligible expenses after deductible	40% of eligible expenses after deductible and difference between allowable and actual charges
Coinsurance Maximum (does not include deductible)	\$3,793 Individual \$11,379 Family	\$7,586 Individual \$22,758 Family	\$3,210 Individual \$9,630 Family	\$6,420 Individual \$19,260 Family
Primary Care	\$35 copayment	50% of eligible expenses after deductible and difference between allowable and actual charges	\$30 copayment	40% of eligible expenses after deductible and difference between allowable and actual charges
Specialist	\$81 copayment	50% of eligible expenses after deductible and difference between allowable and actual charges	\$70 copayment	40% of eligible expenses after deductible and difference between allowable and actual charges
Inpatient Copayment	\$291 then 30% coinsurance after deductible	\$291 then 50% coinsurance after deductible and difference between allowable and actual charges	\$233 then 20% coinsurance after deductible	\$233 then 40% coinsurance after deductible and difference between allowable and actual charges
Preventive Benefits	\$35–Primary Care \$81 – Specialist	Not covered	\$30–Primary Care \$70 – Specialist	Not covered

What is the State Health Plan's Prescription Drug Benefit?

The prescription drug benefit is managed by Medco. You may contact them by calling **1-800-336-5933**. The following is only a summary of how the prescription drug management will be administered. For detailed information regarding your prescription benefit, visit the "Pharmacy Page" on the State Health Plan Web site at www.shpnc.org/pharmacy.html or refer to your Benefits Booklet available online at www.shpnc.org/sc-benefits-booklet.html. Prescription drugs are covered if they are FDA approved with several exceptions:

- Prescription drug copayments are limited to \$2,500 per person per benefit year. After the \$2,500 maximum is reached, the plan pays 100% of allowed prescription drug charges.
- Some prescription drugs may have limitations or restrictions such as prior approval, step therapy or quantity limits in order to be covered. It is very important to make sure that prior approval is received before going to the pharmacy. Ask your physician to contact Medco to initiate prior approval. To get a list of prescription drugs that might require prior approval to be covered or to exceed the quantity limit, please contact Medco Customer Services at **1-800-336-5933**.
- To receive coverage you must use a pharmacy participating with Medco and show your State Health Plan ID card to the pharmacist. For delivery to your home, mail order is also an available option.

Copayments for a 30-day supply are:

Generic – \$12 ~~ Preferred Brand – no generic available – \$40 ~~ Non-Preferred Brand – no generic equivalent – \$64

For brand name drugs with an available generic members will be required to pay the generic copayment, plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug, not to exceed \$100 per 30-day supply of the brand medication.

Preferred Diabetic Supplies – \$10 ~~ Non-Preferred Diabetic Supplies – \$25 ~~ Specialty Drugs – 25% up to \$100

Are There Any Discounts or Other Resources Available Through the State Health Plan?

As a State Health Plan member, you have access to discounts on certain services that are not covered by the health plan. Discounts may be available for eye exams, eye wear, hearing aids and Lasik eye surgery. You may also be able to obtain vitamins and herbal supplements at discounted prices. Additional discounts may be available for travel, fitness and weight management. Visit the State Health Plan web site and click on "Member Services."