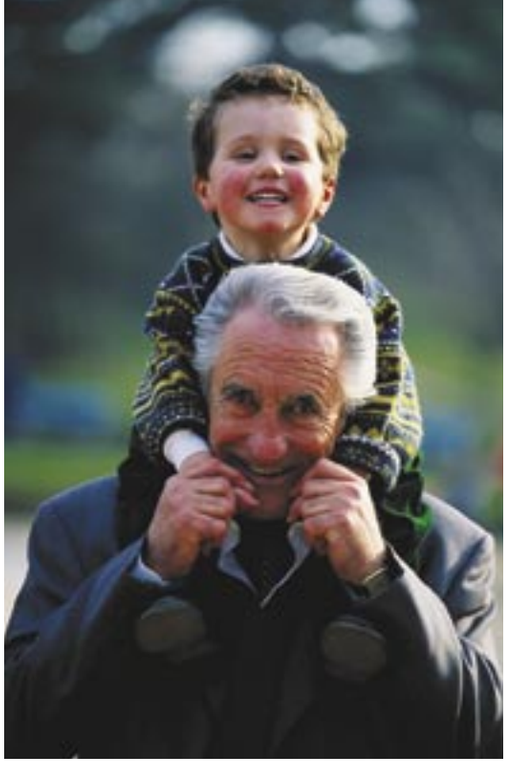
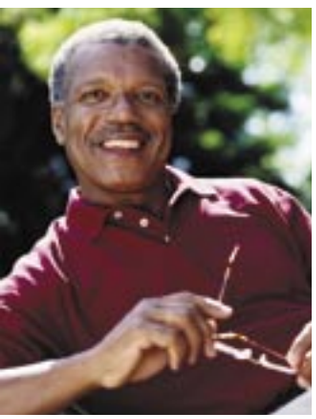




Choosing a Medicare Managed Care Plan

A GUIDE FOR MEDICARE BENEFICIARIES

PHC4

Pennsylvania Health Care Cost Containment Council

Comparing Costs and Benefits

To compare the costs and benefits of the Medicare Managed Care Plans available in your county, click on the following link: http://www.phc4.org/medicare. While these costs and benefits were based on summaries submitted by each health plan, PHC4 urges you to call the plans that you are considering to verify their costs and services covered.

Table of Contents

This guide covers the Medicare Advantage options available at the time of publication. Additional plans and products may be offered in 2006. Check with the Pennsylvania APPRISE Health Insurance Counseling Program at 1-800-783-7067 for more information.

Please note that this guide does not include information about the Medicare-approved "stand-alone" drug plans that only offer the new prescription drug benefit. If you need information about the "stand-alone" plans, please contact APPRISE.

About Medicare Managed Care Plans

What is the purpose of this booklet?

If you are a Medicare beneficiary and thinking about joining a Medicare Managed Care Plan (like an HMO) or have already decided to do so, this booklet is for you. This guide:

- provides information about managed care plans and how their coverage differs from Original Medicare,
- discusses the new "Part D" Prescription Drug benefit,
- compares the services offered by different managed care plans, and
- gives you guidance on who can answer any specific questions you have while making your decision.

What is a Medicare Managed Care Plan?

A Medicare Managed Care Plan is offered by a private (non-government) insurance company that manages the health care of the members enrolled in its program. The Federal government pays these companies a fixed amount of money each month for each member. The company then helps pay for medical care by doctors and hospitals that the member needs during the time he or she is enrolled. Managed care plans are required to provide all services covered under Medicare Parts A and B, and many plans offer additional benefits as well. Managed care plans work to keep the cost of health care under control by coordinating care among different doctors, encouraging members to seek preventive services (such as cholesterol tests and flu shots) and helping members to manage ongoing diseases (such as heart problems or diabetes). Managed care plans also provide or support educational programs and guidelines for treatment.

Is a Medicare Managed Care Plan different from a Medigap Plan?

Yes. A Medigap policy is health insurance sold by private insurers to fill in the "gaps" with Original Medicare. There are ten standardized Medigap plans called "A" through "J." Medigap plans only help pay some of the costs of your Original Medicare coverage. You should not buy a Medigap plan if you are in a Medicare Managed Care Plan. For more information about Medigap plans, call the Pennsylvania Insurance Department Consumer Line at 1-877-881-6388.

About Medicare Managed Care Plans

What if I still have questions about Medicare Managed Care?

If you have questions after reading this booklet, contact the Pennsylvania APPRISE Health Insurance Counseling Program. APPRISE is a free health insurance counseling service designed by the Pennsylvania Department of Aging to help Pennsylvanians with questions or concerns about Medicare. APPRISE counselors are specially trained volunteers who can answer questions about Original Medicare, Medicare Supplemental Insurance (Medigap), Medicare Managed Care Plans, Part D prescription drug coverage and other health insurance issues. APPRISE can also assist you in completing health insurance paperwork and forms or in resolving problems you encounter with billing and other issues. APPRISE provides objective, easy-to-understand information about your health insurance options. All services are free, and your information is kept confidential. Services are provided through 52 local Area Agencies on Aging, serving all 67 counties in Pennsylvania. Call 1-800-783-7067 to locate your nearest APPRISE counseling site.

Is a managed care plan right for me?

Only you and your family can determine if a managed care plan is your best Medicare option.

Remember, if you decide to join a Medicare Managed Care Plan, you are still in the Medicare program and maintain the same rights as someone in Original Medicare. Here are some things to consider:

Your costs in a Medicare Managed Care Plan

You will pay the monthly Medicare Part B premium, which is $88.50 in 2006. Some plans may charge an additional premium to belong to their plan. You may also be responsible for out-of-pocket costs, such as a copayment or coinsurance each time you visit a doctor or go to the hospital. These costs will vary from plan to plan. You will maximize your coverage by using doctors that accept the plan you choose and by following the rules and procedures the plan has established. On January 1 of each year, the managed care plan can change the benefits offered or the amount you pay to receive these benefits.

There may be additional benefits

Managed care plans may offer extra benefits like vision, dental and/or hearing benefits. The plan may have special rules you need to follow. You may also have to pay an extra monthly premium for the extra benefits.

Need for a referral

In a managed care plan, you will receive most of your care from

About Medicare Managed Care Plans

a primary care doctor that you select from a list of providers who accept your plan (known as a "provider network"). If you need to see a specialist, require lab work or need to go to the hospital, you may need a referral from your primary care doctor. If you do not get a referral, the managed care plan may not pay for the cost of the service. Check with each plan regarding its referral requirements.

Possible loss of managed care plan coverage

Each fall, managed care plans decide whether to offer policies to Medicare beneficiaries for the following year. Plans may stop offering coverage in certain counties or stop participating in the Medicare Managed Care Program altogether. If this occurs, you are protected from losing your health care coverage. In most cases, insurance companies are required by law to offer you the right to purchase a Medigap policy, under a situation known as "guaranteed issue rights." Check with an APPRISE counselor for what to do if your plan is ceasing coverage.

How do I enroll in a Medicare Managed Care Plan?

Enrollment is fairly simple and you cannot be turned down because of your health status, although there are exceptions for those people who have end-stage renal disease. Medicare requires that you be enrolled in Medicare Parts A and B before you can join a Medicare Managed Care Plan. To join a plan, request an enrollment form from the managed care plan you choose, then complete and return the form to the plan. The toll-free telephone phone number for each plan is listed on page 28.

When can I join one of these plans?

Generally, you can join a managed care plan at any time. However, managed care plans must accept new members from November 15 through December 31 of each year, a time known as "Open Enrollment." If you join a managed care plan during this time, your coverage will begin on January 1. If you join after Open Enrollment, your coverage will begin the first day of the month following your application. Some managed care plans may be limited in the number of new members they can enroll. Check with the managed care plan to make sure it is still accepting new members.

What if I change my mind about belonging to a plan?

You may leave your plan at any time for any reason. You can change which managed care plan you belong to by simply enrolling in a new managed care plan. You do not need to tell your old plan or send them anything. You will be automatically disenrolled from your old plan when your new plan coverage begins. You should get a letter from your new plan confirming your enrollment. If you choose to change plans, your coverage under the new plan will begin the first day of the month following your application.

Words to Know

Appeal – A special kind of complaint you file if you disagree with any decision made by your managed care plan about your health care services. Call your managed care plan for information on how to file an appeal or complaint.

Coinsurance – The percent of the total cost of a medical service for which you are responsible.

Copayment – The amount that you pay for each medical service, such as a doctor's office visit, each time you use that service. A copayment is usually a fixed amount (like $15).

Deductible – The amount you must pay for certain health care services before your managed care plan begins to pay.

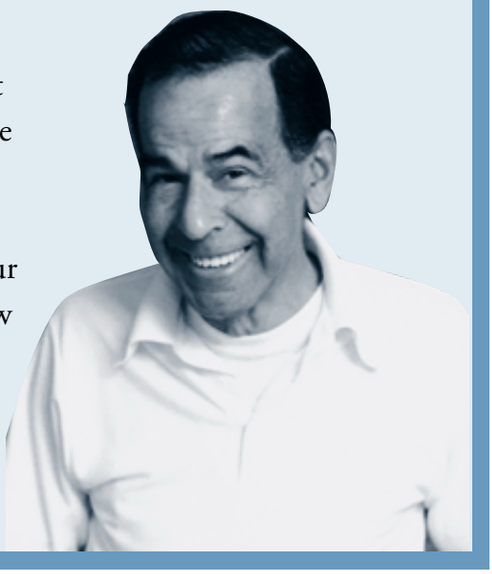
Formulary – A list of prescription drugs covered by the managed care plan. With some Medicare Managed Care Plans, doctors must only prescribe or use drugs listed on the managed care plan's formulary for the plan to pay for the drug. If you use a drug not included on the plan's formulary, you may be responsible for a greater share of the cost of the prescription. Call the plan to request a copy of its formulary.

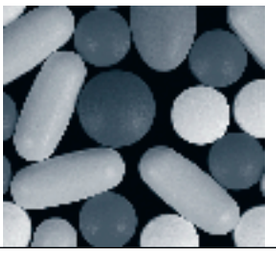
Point of Service (POS) – A managed care plan option that allows you to go to other doctors and hospitals that are not a part of the plan (out-of-network). This option may cost extra.

Preferred Provider Organization (PPO) – A PPO works with many of the same rules as a Medicare Managed Care Plan. However, you do not need a referral to see a specialist provider. If you go to doctors, hospitals or other providers that are not a part of the plan (out-of-network), it may cost extra.

Appeal Rights

If your managed care plan denies payment for a particular service or refuses to provide you with a Medicare-covered service you believe you need, you should make an appeal to the managed care plan. Call your managed care plan for information on how to file an appeal or complaint, or speak with an APPRISE counselor.





Medicare Prescription Drug Coverage

Medicare will begin offering insurance coverage to help people pay for prescription drugs on January 1, 2006. The new program is called Medicare Part D. Based on individual life circumstances, people will have to make different choices about participating in the program. But there are some things that everyone should know:

- Anyone who has Medicare Part A and/or Part B can get drug coverage. No one can be denied based on income level, health reasons or current prescription drug costs.
- The program is voluntary. If you already have good coverage through another program, you do not need to enroll.
- There is additional help for people with limited incomes (less than $14,355 a year for a single person or $19,245 for a married couple in 2005).
- There is no single Medicare drug plan. You must enroll in one of the Medicare-approved private drug plans. These plans vary by what drugs are covered and how much you will have to pay.
- Most people who enroll now will pay lower monthly premiums than if they wait to enroll.
- Medicare Part D drug coverage is not the same as the temporary Medicare-approved drug discount cards. Medicare Part D is a permanent program; the discount cards will be eliminated in May 2006.

How does the program work?

Medicare Part D is a voluntary program that is available to anyone enrolled in Medicare Part A and/or Part B. If you do not enroll in the program when you first can, you can enroll later – but you may have to pay more due to a late penalty.

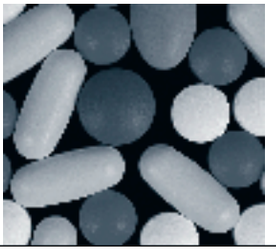
To participate, you must enroll in one of the Medicare-approved private drug plans. These plans vary in terms of drugs covered and monthly premiums paid. However, each plan must meet a minimum standard set by law.

Generally, people on Medicare can get the Part D drug benefit through two types of plans:

- A "stand-alone" plan that only covers prescription drugs. Joining this type of plan enables people to get their other Medicare benefits through the traditional Medicare fee-for-service program (Original Medicare) or a Medigap plan.
- A comprehensive Medicare Health Plan (also known as a Medicare Advantage plan) that covers both prescription drugs and other medical care. (While "stand-alone" plans are available to all eligible Pennsylvanians throughout the state, Medicare Advantage plans vary in availability by geographic location.)

Among the different types of Medicare Health Plans offered are:

- Health Maintenance Organizations (HMOs),



Medicare Prescription Drug Coverage

- Preferred Provider Organizations (PPOs),
- Point of Service (POS) plans, and
- private fee-for-service (PFFS) plans.

Starting January 1, 2006, all Medicare Health Plans (except PFFSs) must offer at least one option that includes prescription drug coverage. If you select a PFFS Plan that does not include drug coverage, you can get drug coverage separately from a stand-alone Medicare drug plan. The plans will vary greatly in the drug coverage they offer but, by law, must be at least as good as the standard Medicare coverage in overall value. Still, you will have to carefully compare your options.

What are the costs and benefits of the program?

If you are currently taking prescription drugs or you may need to in the future, Medicare Part D will protect you from very high costs. While expenses vary by plan, the standard plan includes the following components:

Monthly Premium

The premium is the amount you pay each month to receive drug coverage. While some plans will charge more and others less, an average premium of about $32 a month is expected for standard coverage in 2006. This premium will be in addition to the monthly premium for Medicare Part B. Each person must pay an individual premium as there are no discounts for married couples.

Annual Deductible

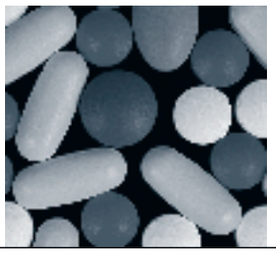
The amount you pay in out-of-pocket costs before your drug coverage kicks in to pay for your expenses is called the deductible. In 2006, deductibles are capped at $250. You will not have to pay more than this amount in a deductible, and some plans may set lower deductibles or not require one at all.

Initial Coverage

After you meet your annual deductible, most plans will cover 75% of the next $2,000 of your drug costs, and you will pay for 25%. With this type of initial coverage, the plan would pay for $1,500, and you would pay $500 in copayments. However, some plans will offer a different copayment formula, instead of the 75-25 split for initial coverage.

Coverage Gap

After the initial level of benefits, there is a gap in coverage, known as the *donut hole*. This gap begins once you have met your $250 deductible and reached the $2,000 threshold (of which your plan paid for 75% of your drug costs). This gap means that your plan will pay nothing toward your next $2,850 in drug costs. Unless you have extra coverage from another program, you will be responsible for 100% of the drug costs during this gap. Still, it is important to point out that people with limited income may qualify for additional help, and a few plans may eliminate the coverage gap for generic drugs, or in limited cases, some brand name drugs.



Medicare Prescription Drug Coverage

Catastrophic Coverage

Once your drug costs go above the coverage gap, your "catastrophic" coverage begins, and your drug plan will pay 95 percent of your drug costs for the rest of the calendar year. Under the standard drug benefit for 2006, catastrophic coverage begins after you have spent $3,600 in out-of-pocket drug costs throughout a calendar year. This $3,600 does not include the amount you have spent on premiums, but it does include your deductible ($250), copayments ($500), and your expenses during the coverage gap ($2,850).

At this level, you will pay 5% of your prescription drug costs, or a $2 copay for generic drugs and a $5 copay for brand name drugs—whichever is higher. There is no limit to this catastrophic coverage in one year. However, it is important to remember that you must reach this catastrophic limit each year.

It is important to note that the program's basic benefit may change from year to year.

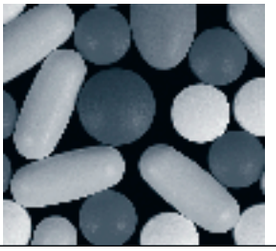
The deductible, the initial amount of drug charges the plan covers (after which the plan stops helping with drug costs), and the amount that you pay to qualify for catastrophic coverage could all increase.

2006 Payments Under Medicare Part D

The following chart shows what the average person can expect under a standard Medicare plan. Please note that it does not include the amount you will pay in monthly premiums or take into account additional drug coverage that you may have. **Remember, out-of-pocket costs may vary by Medicare drug plan**.

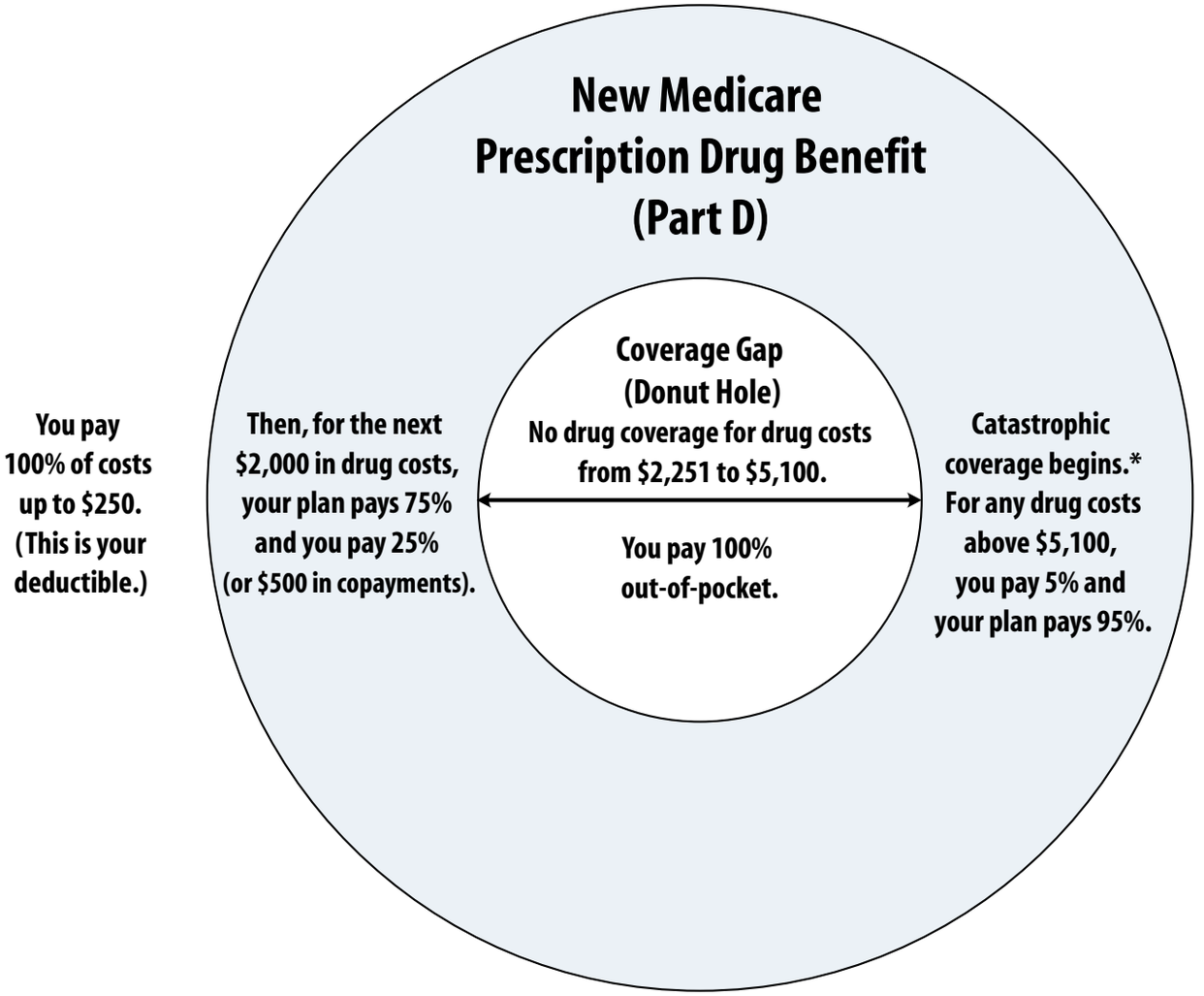
Prescription Drug Spending *	Medicare-Approved Plan Pays	You Pay *
$0-$250	$0	Up to $250 Deductible
$251-$2,250	75% of drug costs – Up to $1,500	25% of drug costs – Up to $500
$2,251-$5,100 Coverage Gap/Donut Hole	0% of drug costs – $0	100% of drug costs – Up to $2,850
Subtotal:	Up to $1,500	Up to $3,600 out-of-pocket
Over $5,100 (Catastrophic Benefit)	95%	5% or $2 copay/generic $5 copay/brand name

* if you have no drug coverage other than Medicare



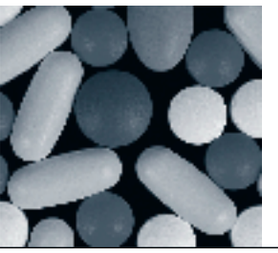
Medicare Prescription Drug Coverage

In addition to an average annual premium of $384, you will have other out-of-pocket costs.



This chart identifies out-of-pocket costs for the "basic benefit" in 2006. Out-of-pocket costs may vary by Medicare drug plan.

* Catastrophic coverage begins after you have spent $3,600 out-of-pocket, including:
  - Deductible ($250)
  - Copayments ($500)
  - Expenses during coverage gap ($2,850)



Medicare Prescription Drug Coverage

When can I enroll?

If you are already on Medicare, you can sign up for the drug benefit beginning November 15, 2005. In general, coverage should begin at the start of the month after you enrolled in an approved plan. However, the earliest you can receive coverage is January 1, 2006.

The open enrollment period for Medicare Part D runs until May 15, 2006. This means that, to avoid penalties, you must sign up before May 15, 2006. People not yet on Medicare will be able to sign up for drug coverage when they first join the program.

If you are currently eligible for Medicare, you can sign up for drug coverage after the open enrollment period. But most people will not get a second chance to do so until the end of 2006. It is also important to note that, with some exceptions, there is a penalty for signing up late. The penalty is a higher premium—an extra 1% of the national average premium for each month (or 12% for each year) that you delay in enrolling. Medicare recipients will not incur a penalty for delayed enrollment if they currently have comparable coverage – also known as creditable coverage – from another source.

There are very specific enrollment guidelines. If you have questions, contact APPRISE at 1-800-783-7067 for help. APPRISE is a program sponsored by the Pennsylvania Department of Aging that provides assistance in understanding Medicare benefits and helping you select the best plan for your situation.

How do I enroll in a plan?

You can enroll with a plan over the phone, on the plan's Web site or by filling out and mailing in an application. You will also be able to enroll in most plans through Medicare's enrollment center at www.medicare.gov or by calling 1-800-MEDICARE.

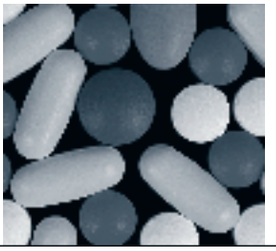
Once you enroll in a plan, you will receive its drug card, which you will need to get prescriptions filled at the pharmacy accepted by your plan or by mail order. The pharmacist will use the card to access your information electronically and to determine what your prescriptions will cost.

You can only change Medicare drug plans once a year during the annual plan enrollment period – unless you meet special circumstances, such as your plan leaves the Medicare program or you move out of the plan's service area.

How do I pick a plan?

Depending on where you live, you should have at least two different Medicare-approved plans from which to choose. To pick the plan that best meets your needs, you will need to:

- Compare the monthly premiums.
- Check to see if the drugs you take are covered by the plans offered in your area.



Medicare Prescription Drug Coverage

- Compare the price for each of your prescriptions.
- Check to see if your local pharmacy is in the plan's network.

Medicare's Web site (www.medicare.gov) will allow you to compare the plans point by point. Remember, that a plan may not cover all of the drugs you take. If the plan you are considering does not cover all of your medications, talk to your doctor and find out if it is possible to switch to a drug that is covered. If switching is not an option, talk to a plan representative about whether you are eligible for an exception.

It is important to know that drug prices are not the same for every plan. Each participating plan negotiates directly with the drug manufacturers to get discounts on the drugs they purchase. Also remember that plans can change their lists of covered drugs and can impose other restrictions, such as changing the drugs that require prior-authorization.

What if I already have drug coverage from another source?

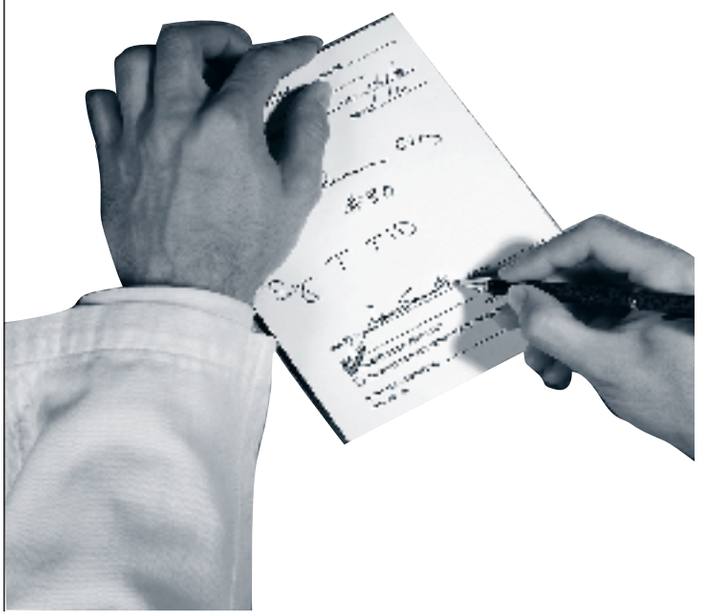
Many people have unique personal situations that will affect their choices under the new program. If you have drug coverage from one of the following sources, there are special considerations you will have to make. The following summaries shed light on only a few scenarios and do not reflect the full range of decisions people will have to make. If you currently have drug coverage from another source and have questions, call 1-800-MEDICARE to speak with a Medicare customer service representative or APPRISE at 1-800-783-7067.

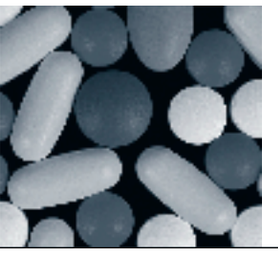
Current Job or Retiree Benefit

Your current/former employer or union may change its drug coverage because of the new Medicare program. Employers and unions can offer coverage that takes the place of the Medicare prescription drug coverage or adds to it. Before you enroll in a Medicare drug plan, you should get information from your employer or union about how your drug coverage through them may change.

Medigap Plan

If you currently have a Medigap policy that includes drug coverage, you cannot keep this plan





Medicare Prescription Drug Coverage

and participate in the Medicare prescription drug plan. For prescription drug coverage, you can:

- Enroll in a Medicare prescription drug plan and keep your Medigap policy *without* the drug coverage.
- Enroll in a Medicare prescription drug plan and switch to a new Medigap policy *without* the drug coverage.
- Enroll in a Medicare Advantage Health Plan that includes drug coverage. With this option, you will not need a Medigap policy.
- Keep your current Medigap policy with the prescription drug coverage included and not participate in the Medicare prescription drug plan.

It is important for you to think about how your current Medigap drug coverage compares to the new Part D benefit. Also note that, beginning in 2006, Medigap insurers cannot issue new policies that include drug coverage.

Discount Drug Card

The Medicare discount drug card program is being eliminated. If you have a Medicare-approved drug discount card, you will not be able to use it after May 15, 2006 or after you sign up for the new Medicare drug benefit, whichever comes first.

Medicaid

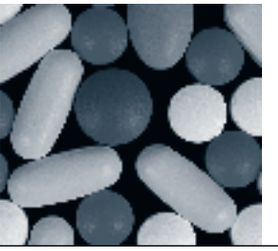
Medicaid currently provides drug coverage to "dual eligible" Medicare beneficiaries. This drug coverage ends December 31, 2005, and dual eligibles will now get their drug coverage through Medicare. However, Medicaid will still cover other health care costs. If you are dual eligible, you will be automatically enrolled in a Medicare drug plan if you do not sign up on your own by December 31, 2005.

State Pharmacy Assistance Program (PACE)

If you are enrolled in the state pharmacy assistance program (PACE) that helps pay for your drug costs, you should check with PACE at 1-800-225-7223 to find out how the two programs will work together before you join a program. Remember, you have until May 15, 2006 to join the new Medicare drug program.

Veterans or Military Retiree Drug Benefits

If you have drug coverage through the Veterans Administration health care system and decide not to sign up for a Medicare drug plan now, you will not have to pay a penalty if you enroll at a later date.



Medicare Prescription Drug Coverage

Manufacturer's Patient Assistance Program

You may be able to receive low-cost prescriptions through a drug manufacturer's patient assistance program and have Medicare drug coverage. You will need to find out if you still qualify for the company's program.

Low-Cost Drugs from Canada or Other Countries

If you enroll in a standard Medicare drug plan, drugs purchased from abroad will not be covered. While you may pay less for drugs purchased abroad during the coverage gap, you would not be able to count these expenses toward the out-of-pocket maximum that qualifies you for catastrophic coverage.

Is there extra help for people with limited incomes?

The new Medicare drug program provides extra financial help for people with limited incomes and assets. A single person with income less than $14,355 a year and assets below $11,500 (or a married couple with income less than $19,245 and assets below $23,000) may qualify for extra help. If you have dependent children or grandchildren living with you, you may be able to earn more and qualify. Assets include bank accounts, stocks, bonds, and life insurance policies. They do not include the house you live in, cars and other personal possessions.

If you are currently eligible for Medicaid, a Medicare Savings Program (that pays Medicare Part B premiums), or Supplemental Security Income, you will automatically be able to get extra help without applying. If you are not in one of these programs, but think you qualify for extra help, you will have to apply for it through the Social Security Administration.

Where do I go for more information?

Contact APPRISE to help you make a decision based on your specific medication needs. There are many other resources available if you need further information and assistance. See page 24 for a list of these resources.

Available Medicare Managed Care Plans by County

	Adams	Allegheny	Armstrong	Beaver	Bedford	Berks	Blair	Bradford	Bucks	Butler	Cambria	Cameron	Carbon	Centre	Chester	Clarion	Clearfield
Aetna Health, Inc. Golden Choice PPO									✓						✓		
Aetna Health, Inc. Golden Medicare									✓						✓		
AmeriHealth AmeriHealth 65						✓											
Capital Advantage Insurance SeniorBlue PPO	✓					✓								✓			
Elder Health of PA Elder Health		✓							✓								
Elder Health of PA Personal Care Plus																	
Gateway Health Plan Medicare Assured	✓	✓	✓	✓		✓	✓			✓	✓						
Geisinger Health Plan Geisinger Gold							✓				✓		✓				✓
Geisinger Health Plan Gold Preferred PPO							✓				✓		✓				✓
HealthAmerica Advantra		✓	✓	✓						✓				✓			
HealthAssurance Advantra PPO		✓															
Health Partners Senior Partners									✓								
Highmark Freedom Blue PPO	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓				✓	✓
Humana Insurance HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO									✓						✓		
Keystone Health Plan Central Senior Blue						✓								✓			
Keystone Health Plan East Keystone 65									✓						✓		
Keystone Health Plan West SecurityBlue		✓	✓	✓	✓		✓			✓	✓						
Unison Health Plan Unison Advantage	✓	✓	✓	✓		✓	✓			✓						✓	
United Healthcare Evercare						✓			✓						✓		
UPMC Health Plan For Life HMO		✓	✓	✓	✓		✓			✓	✓						
UPMC Health Plan For Life PPO		✓	✓	✓	✓		✓			✓	✓						

Available Medicare Managed Care Plans by County

	Clinton	Columbia	Crawford	Cumberland	Dauphin	Delaware	Elk	Erie	Fayette	Forest	Franklin	Fulton	Greene	Huntingdon	Indiana	Jefferson
Aetna Health, Inc. Golden Choice PPO						✓										
Aetna Health, Inc. Golden Medicare						✓										
AmeriHealth AmeriHealth 65																
Capital Advantage Insurance SeniorBlue PPO		✓		✓	✓						✓	✓				
Elder Health of PA Elder Health						✓										
Elder Health of PA Personal Care Plus																
Gateway Health Plan Medicare Assured				✓	✓			✓	✓						✓	
Geisinger Health Plan Geisinger Gold	✓	✓			✓									✓		
Geisinger Health Plan Gold Preferred PPO	✓	✓			✓									✓		
HealthAmerica Advantra					✓				✓				✓			
HealthAssurance Advantra PPO					✓				✓				✓			
Health Partners Senior Partners																
Highmark Freedom Blue PPO			✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓
Humana Insurance HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO						✓										
Keystone Health Plan Central Senior Blue		✓		✓	✓											
Keystone Health Plan East Keystone 65						✓										
Keystone Health Plan West SecurityBlue			✓					✓	✓				✓		✓	
Unison Health Plan Unison Advantage					✓			✓	✓				✓		✓	✓
United Healthcare Evercare						✓										
UPMC Health Plan For Life HMO								✓	✓						✓	✓
UPMC Health Plan For Life PPO			✓					✓	✓						✓	✓

Available Medicare Managed Care Plans by County

	Juniata	Lackawanna	Lancaster	Lawrence	Lebanon	Lehigh	Luzerne	Lycoming	McKean	Mercer	Mifflin	Monroe	Montgomery	Montour	Northampton	Northumberland	Perry
Aetna Health, Inc. Golden Choice PPO						✓						✓	✓		✓		
Aetna Health, Inc. Golden Medicare													✓				
AmeriHealth AmeriHealth 65			✓			✓									✓		
Capital Advantage Insurance SeniorBlue PPO	✓		✓		✓	✓					✓			✓	✓	✓	✓
Elder Health of PA Elder Health													✓				
Elder Health of PA Personal Care Plus																	
Gateway Health Plan Medicare Assured			✓	✓	✓	✓									✓		✓
Geisinger Health Plan Geisinger Gold	✓	✓	✓		✓		✓	✓			✓	✓		✓		✓	
Geisinger Health Plan Gold Preferred PPO	✓	✓	✓		✓		✓	✓			✓	✓		✓			
HealthAmerica Advantra			✓	✓	✓												
HealthAssurance Advantra PPO			✓	✓	✓												
Health Partners Senior Partners													✓				
Highmark Freedom Blue PPO		✓	✓	✓	✓	✓	✓		✓	✓					✓		✓
Humana Insurance HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO													✓				
Keystone Health Plan Central Senior Blue	✓					✓					✓			✓	✓	✓	✓
Keystone Health Plan East Keystone 65													✓				
Keystone Health Plan West SecurityBlue				✓						✓							
Unison Health Plan Unison Advantage		✓	✓	✓			✓			✓							✓
United Healthcare Evercare			✓										✓				
UPMC Health Plan For Life HMO				✓						✓							
UPMC Health Plan For Life PPO				✓						✓							

Available Medicare Managed Care Plans by County

	Philadelphia	Pike	Potter	Schuylkill	Snyder	Somerset	Sullivan	Susquehanna	Tioga	Union	Venango	Warren	Washington	Wayne	Westmoreland	Wyoming	York
Aetna Health, Inc. Golden Choice PPO	✓			✓													
Aetna Health, Inc. Golden Medicare	✓																
AmeriHealth AmeriHealth 65																	✓
Capital Advantage Insurance SeniorBlue PPO				✓	✓					✓							✓
Elder Health of PA Elder Health	✓																
Elder Health of PA Personal Care Plus	✓																
Gateway Health Plan Medicare Assured						✓							✓		✓		✓
Geisinger Health Plan Geisinger Gold				✓	✓					✓						✓	
Geisinger Health Plan Gold Preferred PPO				✓	✓					✓						✓	
HealthAmerica Advantra													✓		✓		
HealthAssurance Advantra PPO															✓		
Health Partners Senior Partners	✓																
Highmark Freedom Blue PPO			✓			✓					✓	✓	✓		✓		✓
Humana Insurance HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO	✓																
Keystone Health Plan Central Senior Blue				✓	✓					✓							
Keystone Health Plan East Keystone 65	✓																
Keystone Health Plan West SecurityBlue						✓							✓		✓		
Unison Health Plan Unison Advantage				✓		✓							✓		✓		✓
United Healthcare Evercare	✓																✓
UPMC Health Plan For Life HMO						✓					✓		✓		✓		
UPMC Health Plan For Life PPO						✓					✓		✓		✓		

Comparing Quality

Key Quality Measures

Staying Healthy

A managed care plan (such as an HMO) covers services for prevention or early detection of health problems, usually at little or no cost to the members. The graphs on pages 18 and 19 can help you evaluate how well the managed care plans are providing preventive care to help their members stay healthy. Generally, managed care plans with a **higher** percentage score are doing a better job of providing preventive care.

Managing Ongoing Illnesses

Three graphs on pages 20 and 21 show how well the managed care plans are helping their members with diabetes to manage their condition. Generally, managed care plans with a **higher** percentage score are doing a better job of providing services to manage these ongoing illnesses.

Preventing Heart Disease

Heart disease is the greatest health risk for people over age 65. The graph on page 21 shows how well plans encourage the use of medication to prevent future heart attacks.

Member Satisfaction

The graphs on pages 22 and 23 show several member satisfaction measures from the annual Consumer Assessment of Health Plans Survey®.

The graph information on pages 18 to 23 is the most current available data from the Medicare Web site at the time of publication.

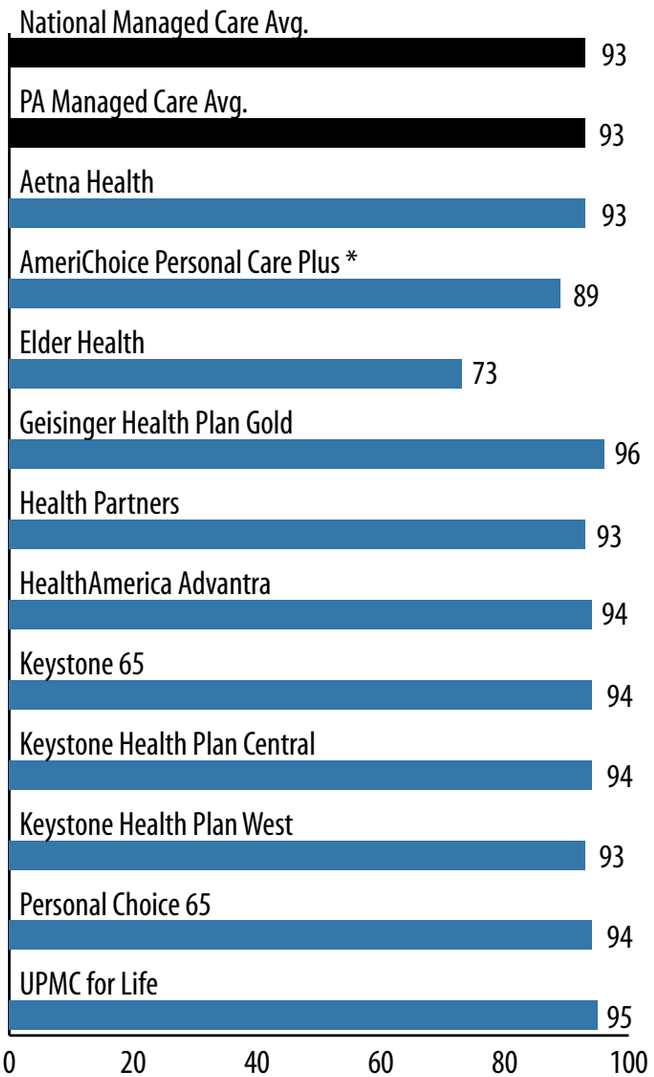
Some plans offering coverage in 2006 are not included in this section because they were too new to provide data.

The way data is collected for PPOs is different from the way data is collected for other Medicare managed care plans. Therefore, the quality rates of these plans should not be compared with those of the other plans.

Visits to the Doctor

It is important to see your health care provider on a regular basis so that health problems can be detected early.

Percent of members seen by a health care provider in a year



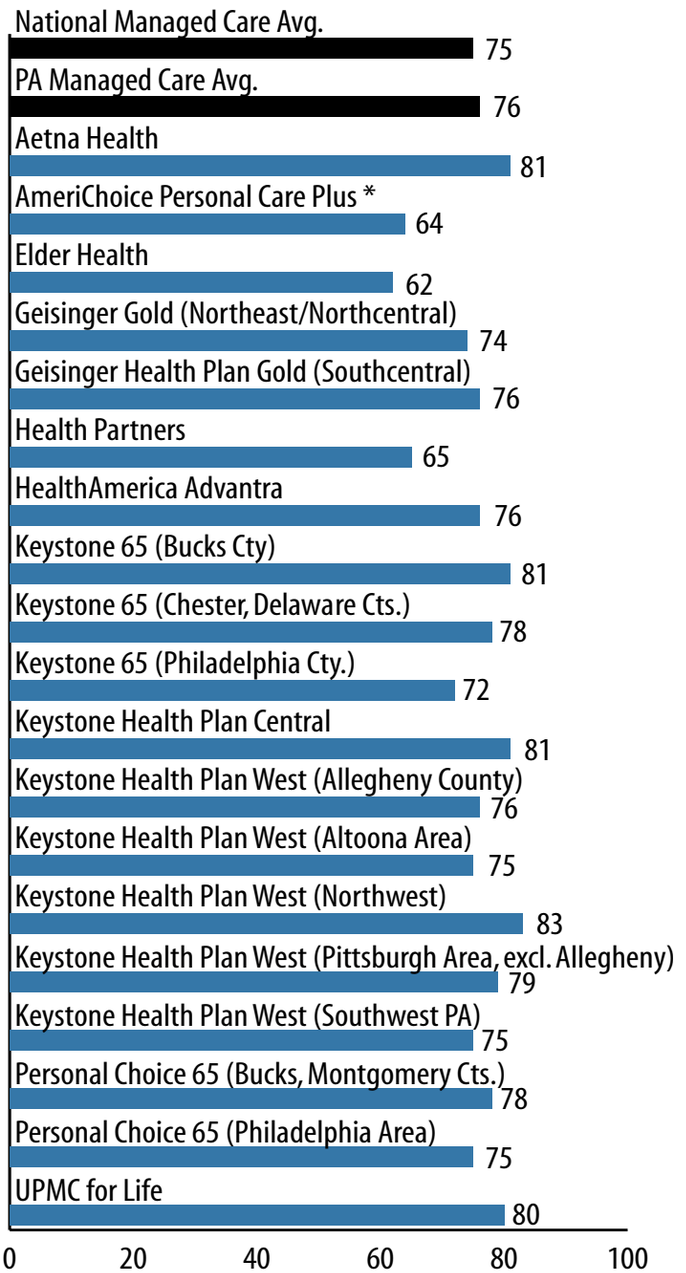
* Now owned by Elder Health of PA. No longer offered as AmeriChoice.

Comparing Quality

Flu Shots

Every year over 40,000 people in the nation die from the flu, a highly contagious respiratory infection. People over 65 are at a higher risk of having medical problems from the flu and should receive a flu shot annually.

Percent of members over age 65 who received flu shots in a year



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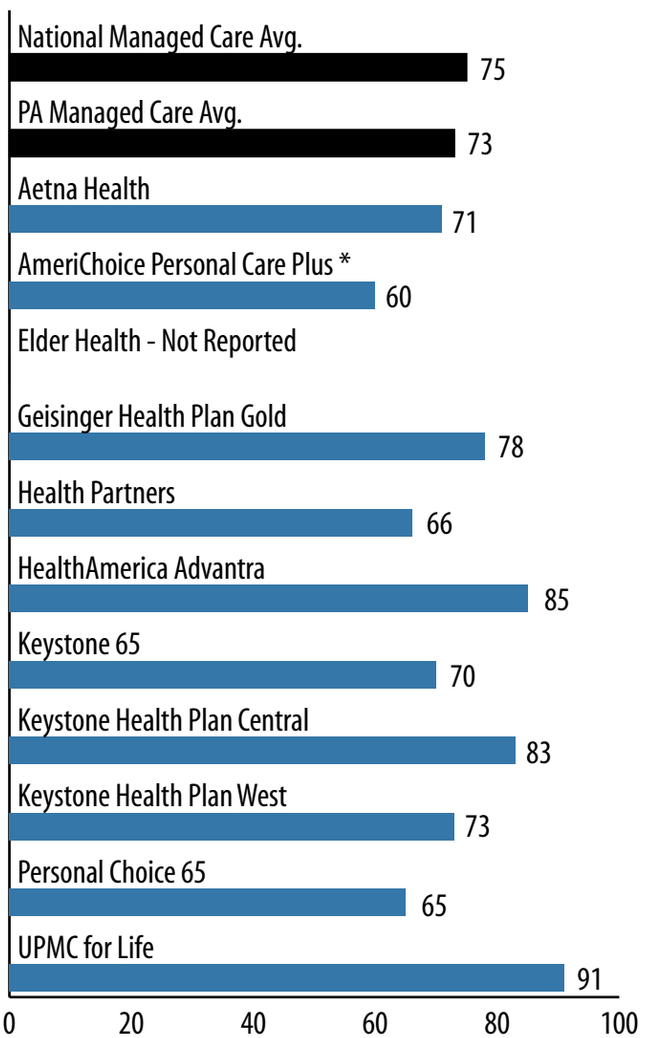
Breast Cancer Screening

An X-ray, known as a mammogram, can help find cancer in the breast when the tumor is too small to be felt. When breast cancer is found early, it is more likely to be treated successfully. There is less chance that the cancer will spread to other parts of the body.

Percent of female members (age 52 through 69) who received a mammogram in a two year period

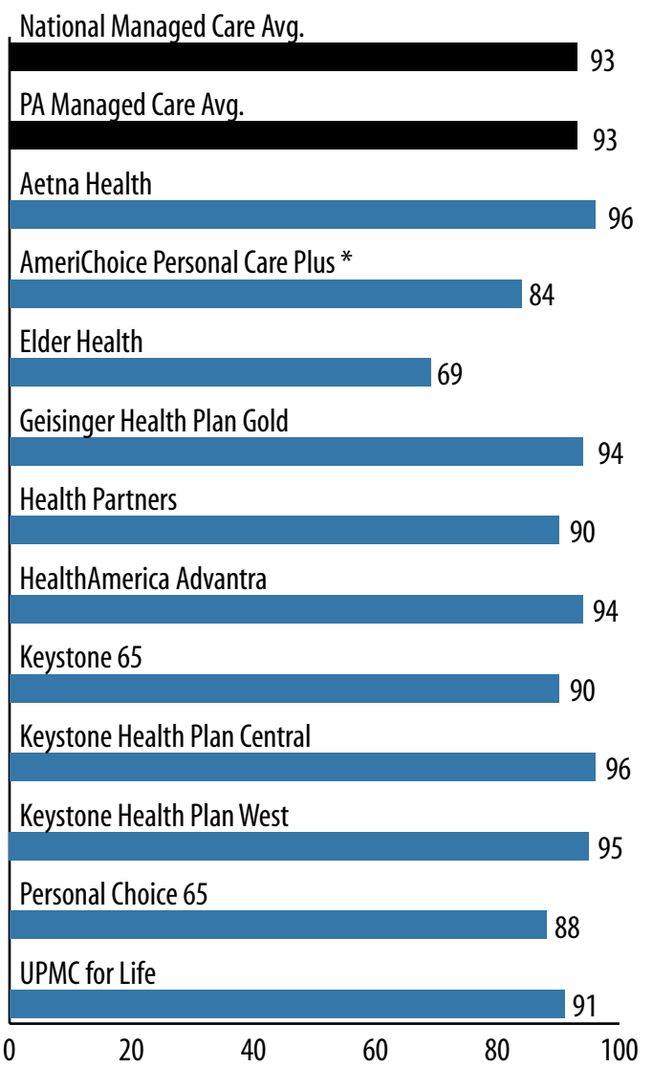


Comparing Quality

Cholesterol testing for members with diabetes

Members with diabetes have a higher risk for heart disease. High lipid (cholesterol) levels can make the risk even higher. Finding that these levels are higher than normal can help you and your doctor take steps to lower your lipid levels.

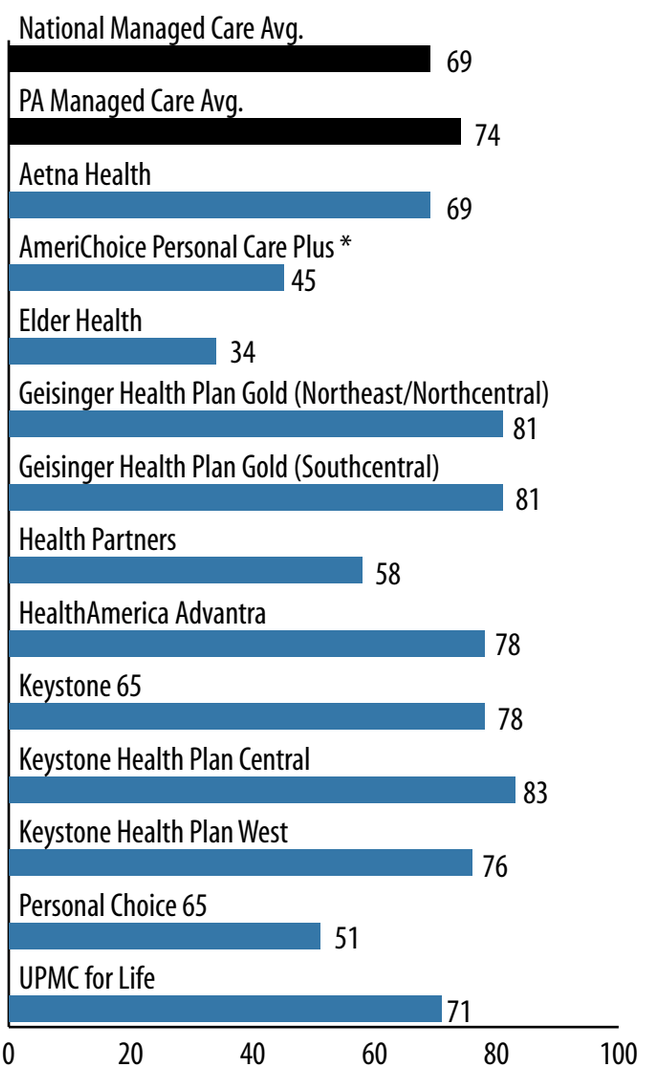
Percent of members with diabetes who received a test for cholesterol levels in a two year period



Annual eye exams for members with diabetes

Members with diabetes have a greater risk of developing serious eye diseases, such as glaucoma. It is important that members with diabetes have an annual eye exam.

Percent of members with diabetes who received an eye exam



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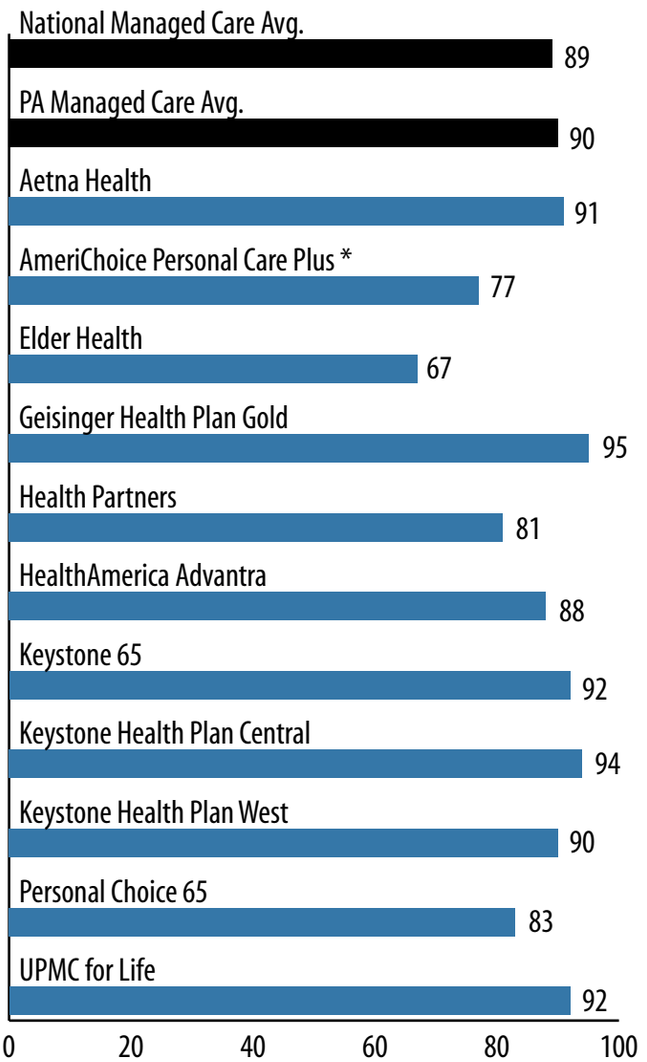
Comparing Quality

Glucose control testing for members with diabetes

Regular testing of blood sugar levels is recommended in order to monitor diabetes. Poor control of blood sugar levels can cause problems with the eyes, feet or kidneys.

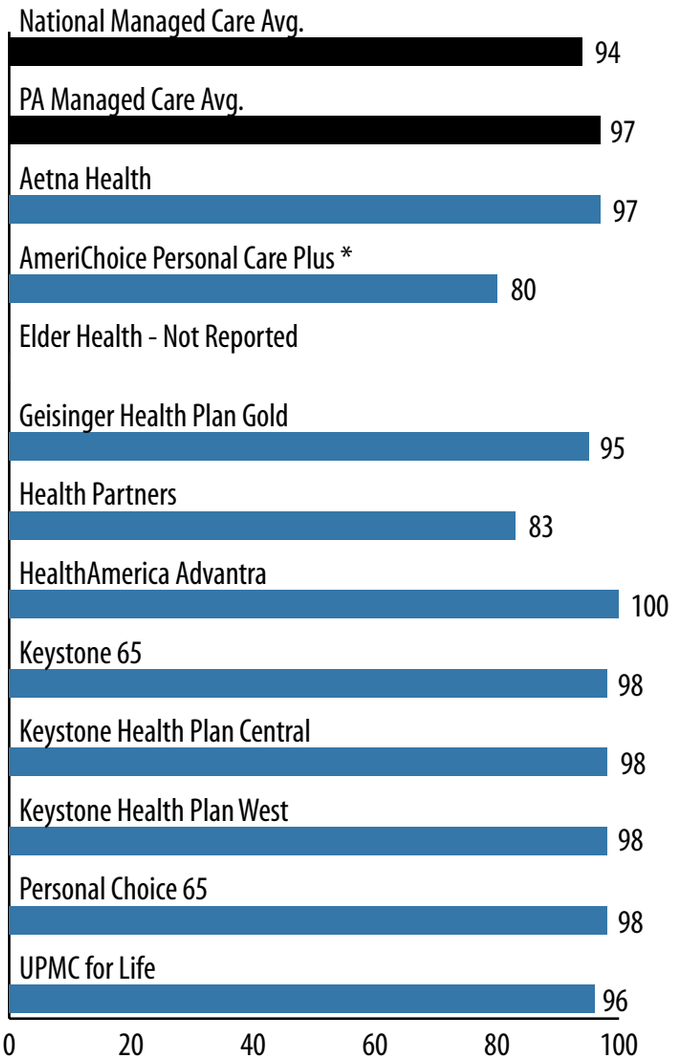
Percent of members with diabetes who received a blood sugar control (Hemoglobin A1c) test



Beta blockers after a heart attack

Research shows that when people who have had a heart attack use a drug called a "beta blocker," future heart attacks may be prevented.

Percent of members who were prescribed beta blockers after a hospital stay for a heart attack



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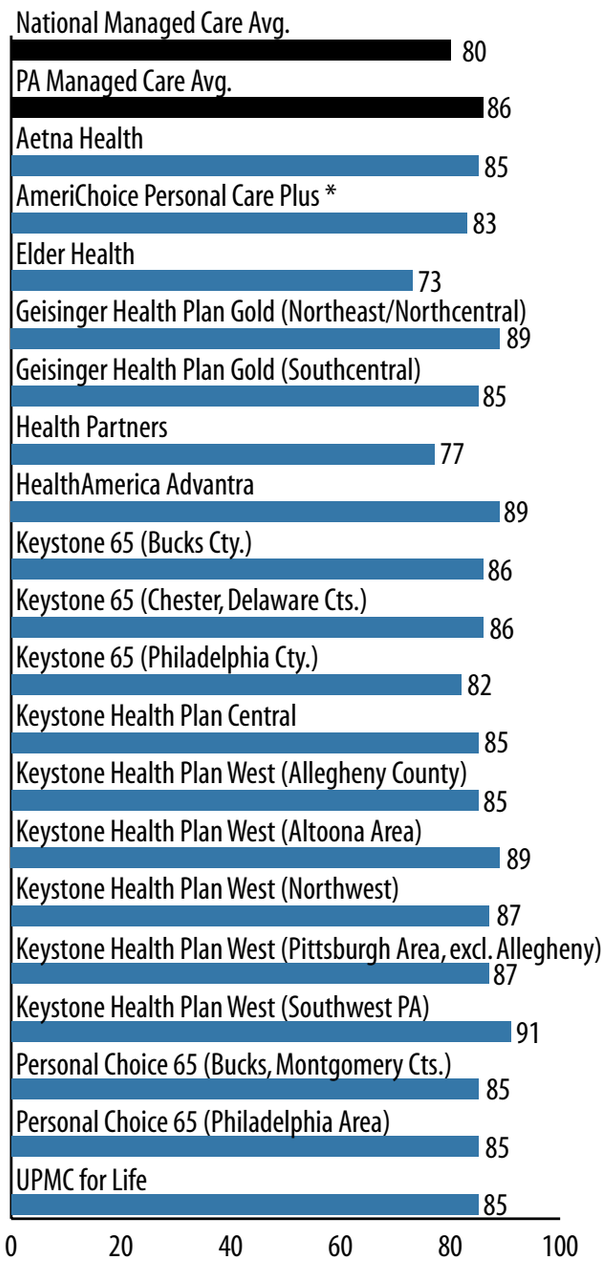
Comparing Quality

No problems getting care

Plan members were asked if they had any problems in the past six months finding a personal doctor or nurse, getting a referral to a specialist, getting the care they and their doctor believed necessary, and getting care approved by the health plan without delays.

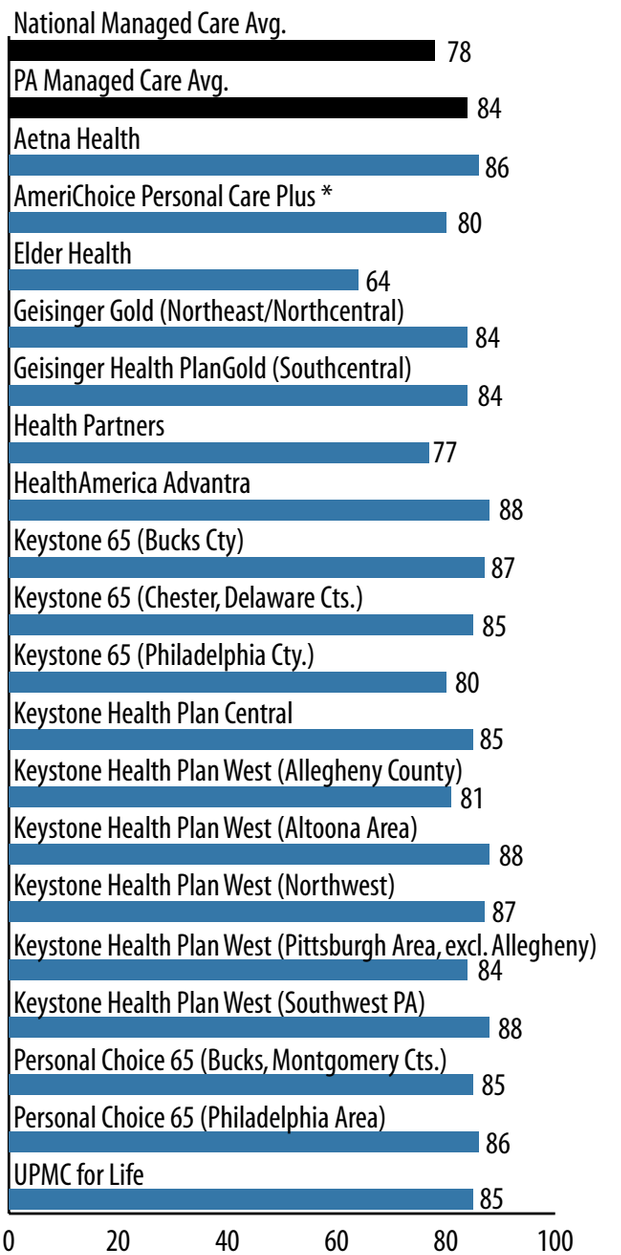
Percent of members who said they had no problems getting the care they needed



No problem seeing a specialist

Most managed care plans require you to get a referral from your primary care doctor if you need to see a specialist.

Percent of members who said it was not a problem to see a specialist



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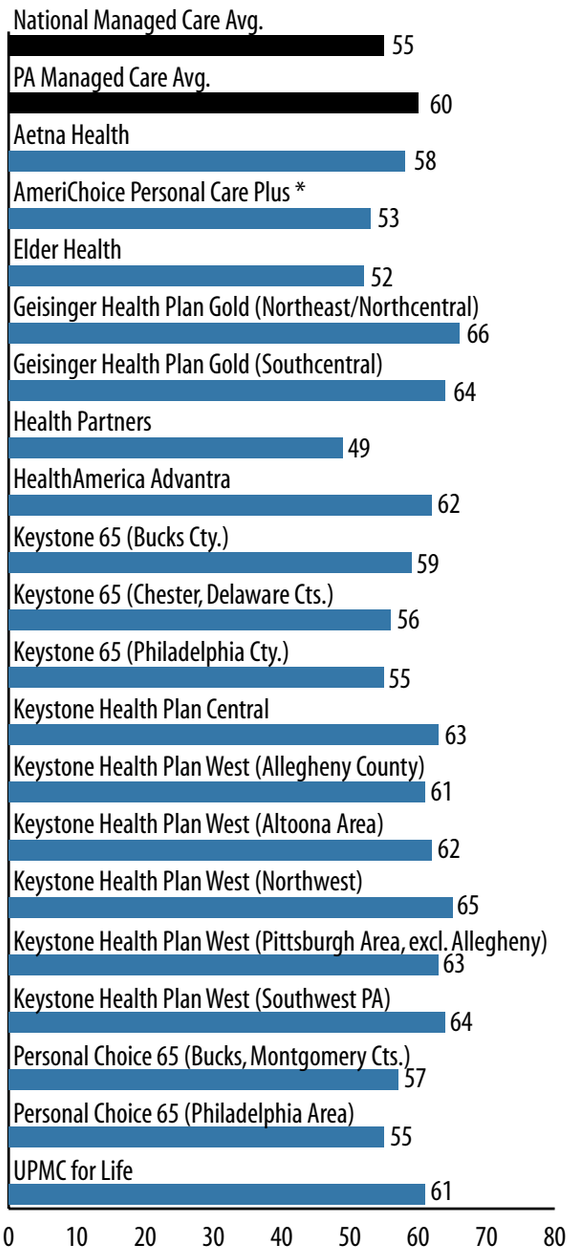
Comparing Quality

Getting care quickly

Members were asked how often, in the past six months, they got help or advice when they called the doctor's office during regular office hours, got an appointment for routine care or for an injury or illness as soon as they wanted it, and waited no more than 15 minutes past their appointment time.

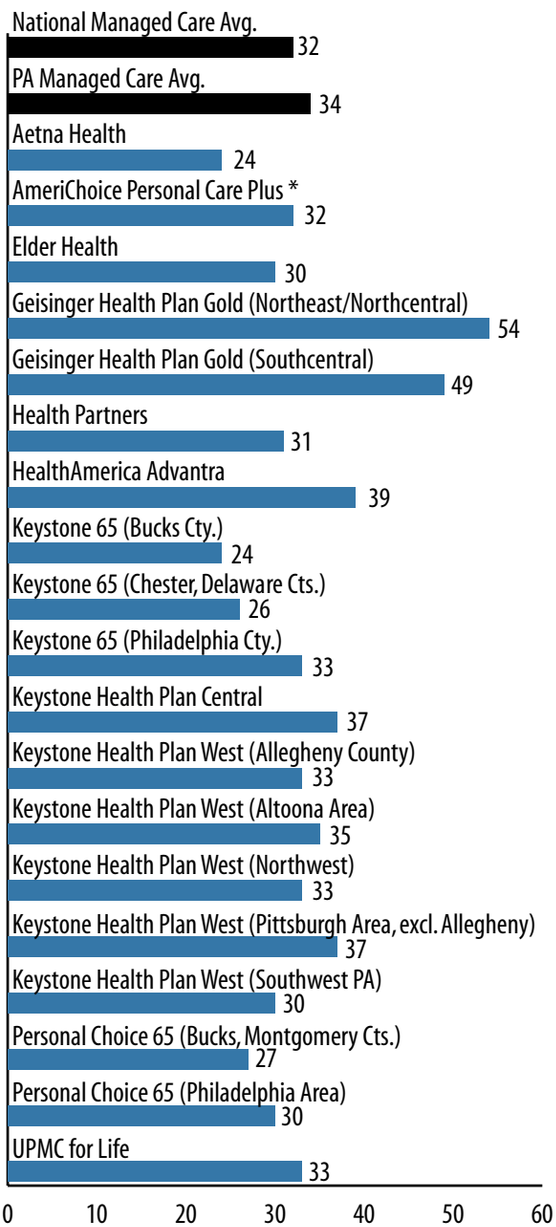
Percent of members who said they always got care when they needed it, without a long wait



Overall rating of plan

Members were asked to rate all of their experiences with their own health plan, using a scale from 0 (worst possible plan) to 10 (best possible plan).

Percent of members who rated their own Medicare Managed Care Plan as the best possible health plan



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Agencies Providing Information to Seniors

Agency	Telephone Number	Web Site
APPRISE		
A program sponsored by the Pennsylvania Department of Aging that provides assistance in understanding Medicare benefits and finding programs that may help with the costs of prescription drugs or Medicare Part B premiums, help in comparing and selecting Medicare supplemental insurance or a Medicare Managed Care Plan, assistance with filing a Medicare appeal and help in selecting long-term care insurance. Language translation is available for most languages.	1-800-783-7067 Monday-Friday 9 a.m. to 4 p.m.	www.aging.state.pa.us
Medicare		
U.S. government hotline for information about the Medicare program, Medicare bills and services, Medicare fraud, and to obtain Medicare publications. English and Spanish speaking operators are available.	1-800-MEDICARE (1-800-633-4227) 24 hours, 7 days a week	www.medicare.gov
Medicare Fraud and Abuse Hotline		
Call or email to report cases of abuse of the Medicare billing program.	1-800-HHS-TIPS (1-800-447-8477) Email: hhtips@oig.hhs.gov	
PA Insurance Department		
To file a complaint about a Medicare Managed Care Plan.	1-877-881-6388	www.insurance. state.pa.us
Social Security Administration		
Call to sign up for Medicare Parts A or B, for Medicare eligibility information, to obtain a new Medicare card, to change your address or to obtain information about your Social Security benefits. English and Spanish speaking operators are available.	1-800-772-1213 Monday-Friday 7 a.m. to 7 p.m.	www.ssa.gov
Quality Insights of Pennsylvania		
Organization providing assistance in filing Medicare appeals and help if you believe you have been prematurely discharged from a hospital or Skilled Nursing Facility.	1-800-322-1914 or call 1-800-MEDICARE	www.qipa.org

Agencies Providing Information to Seniors

Agency	Telephone Number	Web Site
AARP Pennsylvania		
Advocacy group for older Americans	1-866-389-5654	www.aarp.org
Alzheimer's Association		
Information about programs and services	1-800-272-3900	www.alz.org
American Diabetes Association		
Support and information for persons with diabetes	1-800-DIABETES (1-800-342-2383)	www.diabetes.org
Pennsylvania Office of Attorney General Health Care		
Provides assistance to consumers on health care practices	1-877-888-4877	www.attorneygeneral.gov
Pennsylvania Dental Association		
Information on programs providing dental care for seniors	717-234-5941	www.padental.org
Pennsylvania Department of Public Welfare Help Line		
Financial assistance programs for low-income seniors	1-800-692-7462	
Veterans Affairs (Benefits Information)		
Provides information and programs to military veterans	1-800-827-1000	www.va.gov

Prescription Drug Assistance

Pharmaceutical Assistance (PACE)		
State program to provide financial assistance for seniors' prescription drugs	1-800-225-7223 Hearing impaired: 1-800-222-9004	
Medical Assistance ACCESS		
Department of Public Welfare program for low-income residents	1-800-543-7633	
PA Patient Assistance Program Clearinghouse (PAP)		
Help in finding low or no cost prescription drug assistance from pharmaceutical companies	1-800-955-0989	

Important Questions

…to ask yourself

- What will my "out of pocket" expenses (such as copayments and deductibles) be when I visit my doctor, enter the hospital, go to an outpatient surgery center, or pick up prescription drugs?
- What routine visits, physical exams, dental work, eye exams, hearing aids, and prescription drugs does each plan cover?
- Are the doctors' offices, labs and other services in the managed care plan's network convenient for me?
- Is my preferred hospital in the managed care plan's network?
- If I travel or spend several months in a second home, will the managed care plan make arrangements with those areas to provide health care services while I'm there?
- If I live in a continuing care retirement community, is it part of the managed care plan's network?
- Do I live in an area where the long-term care facilities are part of the managed care plan's network?

…to ask your doctor or managed care plan

- Is the managed care plan accepting additional members?
- What are the managed care plan's monthly premiums for the different levels of available coverage?
- Is my doctor in the managed care plan's network? If not, am I willing to change doctors?
- Are participating doctors accepting new patients?
- If I need to see a specialist regularly, does the managed care plan's network have the type of doctors I need to see?
- How easy is it for me to see a specialist? What are the rules for getting approval to see a specialist?
- What hours are available for appointments with doctors?
- Where do I go for emergencies during doctor office hours and after hours?
- Can I change doctors if I am not satisfied with the doctor I have?
- What are the requirements for notifying the managed care plan after receiving emergency care?
- Is there a telephone hotline for medical advice?

10 Things to Know about Medicare Prescription Drug Coverage

1. Enrollment is voluntary. If you have good coverage through another program, you do not need to enroll.

2. If you are currently Medicare-eligible, enrollment starts November 15, 2005. If you join by December 31, 2005, you will get coverage beginning January 1, 2006.

3. Remember, you do not have to sign up until **May 16, 2006**. While a late-enrollment penalty may be incurred if you sign up after May 16, 2006, do not feel pressured to sign up right away with a plan.

4. The new Medicare Part D coverage is not the same as the temporary Medicare-approved drug discount card program, which will be eliminated in May 2006.

5. Medicare-approved drug plans vary by what drugs are covered and how much you will have to pay. Make sure that the drugs you take are covered by a plan before you join.

6. In 2006, an average premium of about $32 is expected for standard coverage. In addition, you will pay a deductible, not to exceed $250. After the deductible is met, your plan will cover 75% of your next $2,000 in drug costs…then you will hit a major gap in coverage.

7. Beware of the donut hole! Once you've spent $2,250 in drug costs, you enter into the coverage gap, known as the "donut hole." From $2,251 in drug costs all the way up to $5,100, your Medicare drug plan will not cover your drugs. You will pay 100% of your drug costs during this gap before your catastrophic coverage kicks in.

8. If you have limited income, you may qualify for extra help in paying for a Medicare drug plan.

9. For general information or to research plans offered in your area, you should visit www.medicare.gov or call 1-800-MEDICARE.

10. For free, unbiased counseling about the Medicare drug benefit, contact Pennsylvania's APPRISE program at 1-800-783-7067.

Plans included in this Guide

Plan Name	Product Name	Toll-Free Number
Aetna Health	Golden Choice PPO Golden Medicare	1-800-832-2640
AmeriHealth	AmeriHealth 65	1-800-898-3492
Capital Advantage Insurance Co.	SeniorBlue PPO	1-800-990-4201
Elder Health of PA	Elder Health Personal Care Choice	1-215-606-6382
Gateway Health Plan	Medicare Assured	1-800-392-1147
Geisinger Health Plan	Geisinger Gold Geisinger Gold Preferred	1-800-631-1656
HealthAmerica	Advantra Advantra PPO	1-800-470-4272
Health Partners	Senior Partners	1-800-233-9645
Highmark, Inc.	Freedom Blue PPO	1-800-511-0589
Humana Insurance Company	HumanaChoice PPO	1-800-833-6578
Independence Blue Cross	Personal Choice 65 PPO	1-877-393-6733
Keystone Health Plan Central	SeniorBlue	1-800-990-4201
Keystone Health Plan East	Keystone 65	1-877-393-6733
Keystone Health Plan West	SecurityBlue	1-800-576-6343
Unison Health Plan	Unison Advantage	1-800-290-4009
United Healthcare	Evercare	1-800-393-0993
UPMC Health Plan	UPMC For Life UPMC For Life PPO	1-877-381-3765

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency responsible for addressing the problem of escalating health costs and ensuring the quality of health care in Pennsylvania. PHC4 fosters competition in the health care market through the collection, analysis, and dissemination of quality health care information.

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Harrisburg, PA 17101
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Fax: 717-232-3821
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