CENTRAL PENNSYLVANIA

Choosing a Medicare Managed Care Plan

A GUIDE FOR MEDICARE BENEFICIARIES

Including information on Medicare-approved Drug Discount Cards

This guide is a joint project of the
Pennsylvania Health Care Cost Containment Council
and the Pennsylvania Department of Aging.

NOVEMBER 2004

Counties included in this guide:

Berks
Carbon
Centre
Clearfield
Clinton
Columbia
Cumberland
Dauphin
Huntingdon
Juniata
Lackawanna
Lancaster
Lebanon
Lehigh
Luzerne
Lycoming
Mifflin
Monroe
Montour
Northampton
Northumberland
Perry
Schuylkill
Snyder
Union
Wyoming

Medicare Managed Care Plans are not currently available in the following Central Pennsylvania counties:

Adams
Bradford
Franklin
Fulton
Pike
Potter
Sullivan
Susquehanna
Tioga
Wayne
York

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During 2005, Medicare is planning to expand the Medicare Managed Care options available in Pennsylvania. Please check with your APPRISE coordinator for new plans offering coverage and/or new counties that will be served by a Medicare Managed Care Plan.

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,
- 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 both 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 manage on-going 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.

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, 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

In addition to a monthly premium, you may 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 prescription drug coverage or dental and 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 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 the back cover.

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.

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.

Help paying for prescription drugs

With the Medicare Modernization Act of 2003, the government began offering help to offset the high prescription drug costs that burden many Medicare recipients. Leading up to the new Medicare Part "D" program, which begins on January 1, 2006, the government has developed Drug Discount Cards, offered by private companies and approved by Medicare. These cards became available in May 2004 and are a voluntary, temporary way to provide immediate assistance by lowering the retail cost of prescription drugs at the pharmacy counter.

If you have Medicare and do not have outpatient prescription drug coverage through Medicaid, you can get a Medicare-approved drug discount card. You can recognize these cards by looking for the Medicare seal of approval:

SM
MEDICARE Rx
APPROVED

Companies who are allowed to use this symbol on their cards have met Medicare's standards (such as quality customer service, being a reputable business, having a process for handling complaints and being familiar with offering prescription drug discounts.) Keep in mind that some companies may offer drug discount cards that are **not** Medicare approved. If the seal above is not on the company's card, that discount card is not Medicare-approved.

How do I obtain a Drug Discount Card?

You can compare the drug discount cards available in your area and the prices each company charges for specific drugs by visiting www.medicare.gov and clicking on "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE and a representative will help you make your selection. It is helpful to have a list of the medications you are currently taking when you start comparing different drug cards and the discounts they offer.

May I switch to a different Discount Card?

Once you have enrolled in a particular company's discount card program, you may NOT change cards for the rest of that calendar year. The only exceptions to this policy are if:

1) You move to a state in which your discount card is not offered;
2) You join or leave a Medicare Managed Care Plan;
3) You enter or leave a long-term care facility (such as a nursing home); or
4) The company you are enrolled in stops offering its card.

You may only be enrolled in ONE discount card at a time.

Are there any costs to joining a Discount Card?

Companies are allowed to charge drug card enrollees an annual enrollment fee. The most they are allowed to charge is $30 and some companies charge a lesser fee. This fee must be paid each year and if you change discount cards, you must pay the new card's enrollment fee (i.e., the fee is non-transferable).

Other important facts to remember about Drug Discount Cards

- Companies may change their list of discounted drugs and the amount of their discounts at anytime. The company will give you information about, and changes to, its discount drug list if you ask for them. It will also put these changes on its Web site (if it has one). Each company will have a toll-free telephone number for you to call with questions.
- If you take a drug currently covered by Medicare (such as some cancer drugs), the discounts offered by your card will NOT apply.
- Not every card offers discounts on every drug. Be sure to check and make sure that a particular card covers the medications you are taking BEFORE you join that card.
- If you have a preferred pharmacy that you like to use to fill your prescriptions, make sure that pharmacy accepts a particular discount card. You may ask either your pharmacy or each discount drug card you are considering if it includes your pharmacy in its program.
- If you have outpatient prescription drug coverage through Medicaid, you are NOT eligible to join a drug discount card.
- You are the only one that can use your card. If you are married, both you and your spouse must enroll separately. You each may join different discount cards if you find better discounts on particular medications.
- If you run into questions or concerns about the discount card program, you can always contact your local APPRISE office for help.

Help for low-income enrollees to pay for prescriptions

Certain lower-income enrollees may also qualify for up to a $600 credit per year to help pay for prescription drugs that may be applied directly to the cost of prescription drugs. Eligibility for this assistance is based on a person's income and whether he or she already has any other drug coverage.

To be eligible for the $600 credit, you have to get a Medicare-approved drug discount card and:

- You must be entitled to or enrolled in Part A and/or Part B.
- You don't have any other health insurance

Continued on next page

Help paying for prescription drugs continued

with any outpatient prescription drug coverage. However, you can get the credit if your other health insurance is a Medicare Advantage plan or a Medigap policy.

- Your annual income is not more than $12,569 if you are single or no more than $16,862 if you are married.

Please contact your local APPRISE office for help in determining if you qualify for this $600 credit and to obtain help in applying for the aid.

NOTE: If you apply and are accepted before the end of 2004, any of the $600 you do not spend will be carried over into 2005. This is in addition to the $600 you will receive for the 2005 calendar year. If you believe you qualify for this assistance, make sure to apply before December 31, 2004!

Also, if you are enrolled in the state pharmacy assistance program (PACE), you can get a Medicare-approved drug discount card and may be eligible for the $600 credit. For more information, please contact PACE at 1-800-225-7223.

The information on pages 4 – 6 is taken from the Medicare publication "Guide to Choosing a Medicare-Approved Drug Discount Card." If you would like to receive a free copy of this publication, please contact 1-800-MEDICARE or visit www.medicare.gov and request one.

PACE Cardholders and the Medicare Prescription Discount Card

If you are enrolled in the PACE Program and are eligible for the $600 transitional assistance credit, the PACE Program will offer you the opportunity to enroll in the First Health Discount Card. By using the $600 credit, you will save PACE money because Medicare will pay for your prescriptions. During that time, you will not have to pay your PACE co-payments.

When the $600 credit is used up, the PACE Program will begin to pay your drugs and you will be charged the $6.00 co-payment for generic drugs and the $9.00 co-payment for brand name drugs. For more information about PACE/PACENET please contact 1-800-225-7223.

Medicare Prescription Discount Cards and Medicare Advantage Plans

If you are currently getting your Medicare benefits as a member of a Medicare Advantage plan such as a Medicare HMO, you should contact them to find out if they offer a Medicare Prescription Discount Card. In some cases, if you decide that you want a card you may have to select their card even if you are currently enrolled in the PACE Program.

Which managed care plans are available where I live?

The chart lists the counties where one or more Medicare Managed Care Plans are available. Medicare Managed Care Plans are not currently available in some counties (see inside front cover). This guide covers all Medicare managed care options available at the time of publication. However, some companies may offer additional managed care options during 2005. Call the plans for more information. Their telephone numbers are listed on the back cover.

	Aetna Health Inc. **Golden Choice (PPO)**	AmeriHealth **AmeriHealth 65**	Geisinger Health Plan **Geisinger Gold**	HealthAmerica **Advantra**	Keystone Health Plan Central **SeniorBlue**
Berks		✓			✓
Carbon			✓		
Centre				✓	✓
Clearfield			✓		
Clinton			✓		
Columbia			✓		✓
Cumberland					✓ (partial)
Dauphin			✓		✓
Huntingdon			✓		
Juniata			✓		✓
Lackawanna			✓		
Lancaster		✓	✓		
Lebanon			✓		
Lehigh	✓	✓			✓
Luzerne			✓		
Lycoming			✓		
Mifflin			✓		✓
Monroe	✓		✓		
Montour			✓		✓
Northampton	✓	✓			✓
Northumberland					✓
Perry					✓
Schuylkill	✓		✓		✓
Snyder			✓		✓
Union			✓		✓
Wyoming			✓		

COMPARING COSTS & BENEFITS

This section provides a comparison of the costs charged by each Medicare Managed Care Plan, including additional monthly premiums, copayments and coinsurance amounts. It also provides a summary of several additional benefits, including prescription drug coverage, home health care, durable medical equipment, skilled nursing facilities, ambulance services, and vision coverage.

Plans may offer other benefits such as mental health coverage, dental and hearing services, podiatry, and diabetic supplies. Contact each managed care plan or visit the Medicare Web site (www.medicare.gov) for information on additional benefits, your costs, and any limits or restrictions on coverage.

In addition to any premium charged by the Medicare Managed Care plan, you will also pay the monthly Medicare Part B premium, which is $78.20 in 2005.

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.

Co-payment – The amount that you pay for each medical service, such as a doctor's office visit, each time you use that service. A co-payment 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.

Additional Monthly Premiums

Company	Product	Service Area/Counties	Monthly Premium
Aetna Health Inc.	**Golden Choice Option 1 (PPO)**[1]	Lehigh, Monroe, Northampton, Schuylkill	$25
	Golden Choice Option 2 (PPO)[1]	Lehigh, Monroe, Northampton, Schuylkill	$65
AmeriHealth	**AmeriHealth 65**	Berks, Lancaster, Lehigh, Northampton	$0
Geisinger Health Plan	**Gold Select**	Carbon, Monroe	$ 53
		Clearfield, Mifflin	$ 21
		Clinton, Columbia, Lycoming, Montour, Schuylkill, Snyder, Union	$ 36
		Dauphin, Lancaster, Lebanon	$ 30
		Huntingdon, Juniata	$31
		Lackawanna	$ 33
		Luzerne	$ 88
		Wyoming	$43
	Gold Classic	Clearfield, Mifflin	$ 72
		Clinton, Columbia, Lycoming, Montour, Schuylkill, Snyder, Union	$ 82
		Dauphin, Lancaster, Lebanon	$ 78
		Lackawanna	$ 84
		Luzerne	$133
		Wyoming	$99
HealthAmerica	**Advantra**	Centre	$142
Keystone Health Plan Central	**SeniorBlue**	Berks, Cumberland (partial), Schuylkill	$ 104
		Centre, Columbia, Juniata, Mifflin, Montour, Northumberland, Perry, Snyder, Union	$ 106
		Dauphin, Lehigh, Northampton	$167

[1] This plan allows you to go to out-of-network doctors and hospitals. Higher costs apply to out-of-network services. Contact the plan for more details.

Costs for Provider Services

Medicare Managed Care Plan	Costs to Member for: A Visit to Your Primary Care Doctor[1]	A Routine Physical Exam[2]	A Visit to a Specialist[3]	In-Hospital Care[4]	Outpatient Surgery[5]
Aetna Health Inc. **Golden Choice Option 1 (PPO)**	$20 to $25	No copayment	$35	$750	$100
Aetna Health Inc. **Golden Choice Option 2 (PPO)**	$10 to $15	No copayment	$20	$250	$100
AmeriHealth **AmeriHealth 65**	$10	$10	$20	$876 deductible. $0 for days 1-60; $219 each day for days 61-90; $438 each day for days 91-150.	20%
Geisinger **Gold Select**	$10	$10	$20	15% of the cost	15%
Geisinger **Gold Classic**	$10	$10	$20	$50 each day for days 1-5; $0 each days for days 6-90.	$50 copayment
HealthAmerica **Advantra**	$25	$25	$35	$250	$50
Keystone Health Plan Central **SeniorBlue**	$10	$10	$10	No copayment	No copayment

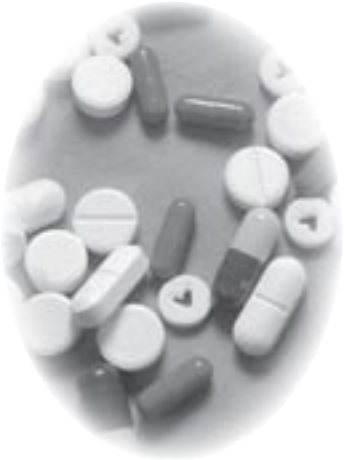
1 For services covered by Medicare.

2 Limit: one exam per year unless otherwise noted.

3 Unless otherwise noted, you must get a referral from your primary care doctor for full benefits.

4 Unless otherwise noted, each stay is defined as a Medicare-covered inpatient stay in a network hospital and you are covered for unlimited days each benefit period.

5 Unless otherwise noted, a visit is defined as a Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility.



Prescription Drug Benefits

Medicare Managed Care Plan	Counties	Costs to Member	Formulary Drugs and Limits on Coverage
Aetna Health Inc. **Golden Choice Option 1**	All counties where the plan is available (see page 9).	For an additional $24 monthly premium you can purchase outpatient prescription drug coverage.	Call the plan for details on prescription drug coverage.
Aetna Health Inc. **Golden Choice Option 2**		For an additional $64 monthly premium you can purchase outpatient prescription drug coverage.	
AmeriHealth **AmeriHealth 65**		No coverage	No coverage
Geisinger **Gold Select**	All counties where the plan is available (see page 9).	No coverage	15% of the cost for injectables (Limit $1000 maximum out-of-pocket expense)
Geisinger **Gold Classic**		No coverage	10% of the cost for injectables (Limit $1000 maximum out-of-pocket expense)
HealthAmerica **Advantra**		No coverage	No coverage
Keystone Health Plan Central **SeniorBlue**	Berks, Centre, Columbia, Cumberland (partial), Juniata, Mifflin, Montour, Northumberland, Perry, Schuylkill, Snyder, Union	From a pharmacy (90-day supply) 50% Generic Mail order (90-day supply) 50% Generic	$250 quarterly limit for Generic prescription drugs.
	Dauphin, Lehigh, Northampton	From a pharmacy (90-day supply) 50% Formulary Generic 50% Formulary Brand Mail order (90-day supply) 50% Formulary Generic 50% Formulary Brand	$250 quarterly limit for Formulary Generic and Formulary Brand prescription drugs. Call the plan for details on prescription drug coverage.

Home Health Care & Durable Medical Equipment

Medicare Managed Care Plan	Costs to Member: Home Health Care[1]	Costs to Member: Durable Medical Equipment[2]
Aetna Health Inc. **Golden Choice Options 1 and 2**	$20 copayment	20% coinsurance
AmeriHealth **AmeriHealth 65**	No copayment	20% coinsurance
Geisinger **Gold Select**	$10/day	15% coinsurance
Geisinger **Gold Classic**	$10/day	10% coinsurance
HealthAmerica **Advantra**	No copayment	No copayment
Keystone Health Plan Central **SeniorBlue**	No copayment	No copayment

[1] Includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services.

[2] Includes wheelchairs, oxygen, etc.

Skilled Nursing Facilities & Ambulance Services

Medicare Managed Care Plan	Costs to Member for: A Stay in a Medicare-Certified Skilled Nursing Facility [1]	Costs to Member for: Ambulance Service
Aetna Health Inc. **Golden Choice Options 1 and 2**	$25 each day for days 1–100	$100 copayment
AmeriHealth **AmeriHealth 65**	No copayment for days 1–20; $109.50 each day for days 21–100.	20% coinsurance
Geisinger **Gold Select**	15% coinsurance	$50 copayment. You do not pay this amount if you are admitted to the hospital.
Geisinger **Gold Classic**	No copayment for days 1–10; $25 each day for days 11–100.	
HealthAmerica **Advantra**	No copayment for days 1–5; $40 each day for days 6–100.	$25 copayment
Keystone Health Plan Central **SeniorBlue**	No copayment	No copayment

[1] No prior hospital stay is required.

Vision Services

Medicare Managed Care Plan	Costs to Member: Routine Eye Exam[1]	Costs to Member: Medicare-Covered Exams[2]	Coverage for Glasses/Contacts[3]
Aetna Health Inc. **Golden Choice Option 1**	No copayment	$35	No copayment for glasses, contacts, lenses and frames. $100 allowance for eyewear every two years.
Aetna Health Inc. **Golden Choice Option 2**		$20	
AmeriHealth **AmeriHealth 65**	$20 (one exam every two years)	$20	No copayment for glasses (one pair) or contacts (one pair) every two years. $150 allowance for eyewear every two years.
Geisinger • **Gold Select** • **Gold Classic**	$20	$20	No copayment for glasses (one pair) or contacts (one pair). $150 allowance for eyewear once every two years from the date of last purchase.
HealthAmerica **Advantra**	$35	$35	No copayment for glasses (one pair) or contacts (one pair). $150 allowance for eyewear every two years.
Keystone Health Plan Central **SeniorBlue**	No coverage for routine eye exams.	$10	See footnote.

[1] One per year unless otherwise noted.
[2] For diagnosis and treatment of diseases/conditions of the eye.
[3] No copayment for one pair glasses/contacts after each cataract surgery.

Staying Healthy

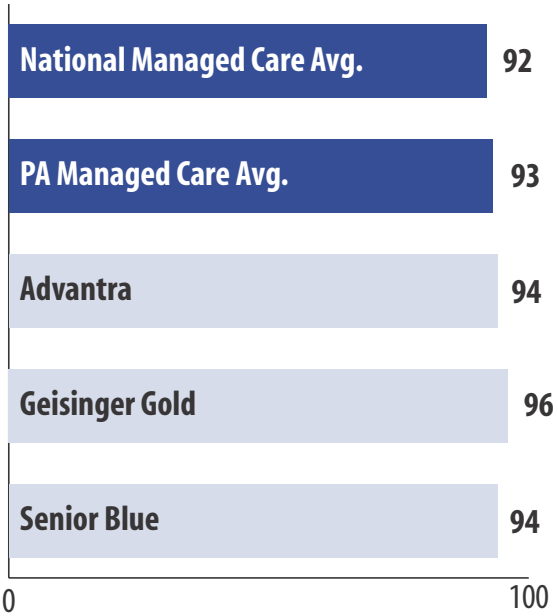
A managed care plan (such as an HMO) covers services for prevention or early detection of health problems, usually at little or no cost to the members. The graphs on pages 15 and 16 can help you evaluate how well the managed care plans are providing preventive care to help their members stay healthy. Generally, managed care plans with a higher percentage score are doing a better job of providing preventive care.

No information is available in this section for Aetna Health "Golden Choice", AmeriHealth 65 or Health Assurance because the plans were too new to provide data.

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 within the past year

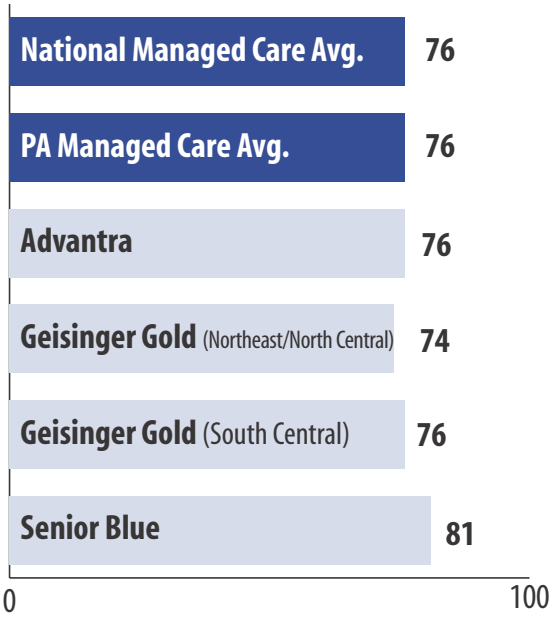


Staying Healthy

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.

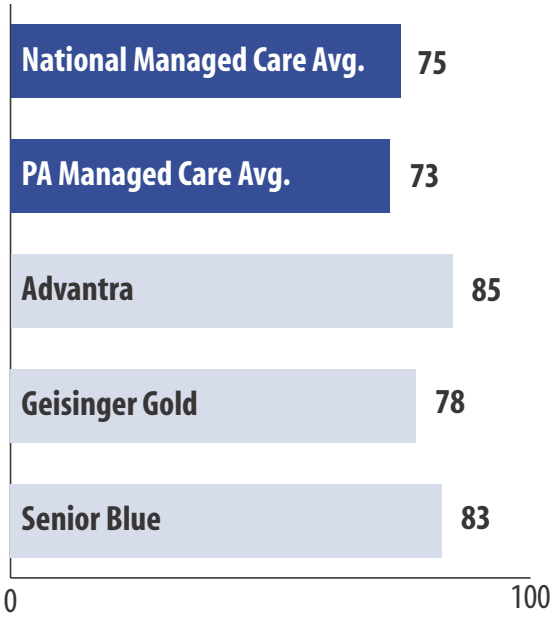
Percent of members over age 65 who received flu shots last year



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 during self-examination. Finding a tumor early increases the chance that it can be treated successfully and can prevent the cancer from spreading to other parts of the body.

Percent of female members (age 52 through 69) who received a mammogram within the past two years *



* This information is from 2002 and 2003.

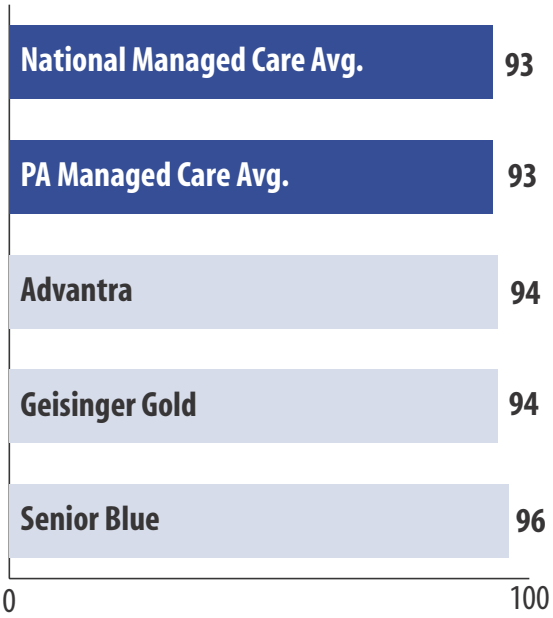
Managing On-Going Illnesses

The graphs on pages 17 and 18 show how well the managed care plans are helping their members with diabetes manage their condition. Generally, managed care plans with a higher percentage score are doing a better job of providing services to manage these on-going illnesses.

"Bad" cholesterol testing for members with diabetes

A high level of "bad" cholesterol (LDL-C) in the blood is the main cause of blocked arteries, which can lead to heart disease. Persons with diabetes are at a higher risk for heart disease, making it especially important to maintain a low "bad" cholesterol level.

Percent of members with diabetes who received a test to measure the level of "bad" cholesterol during 2003

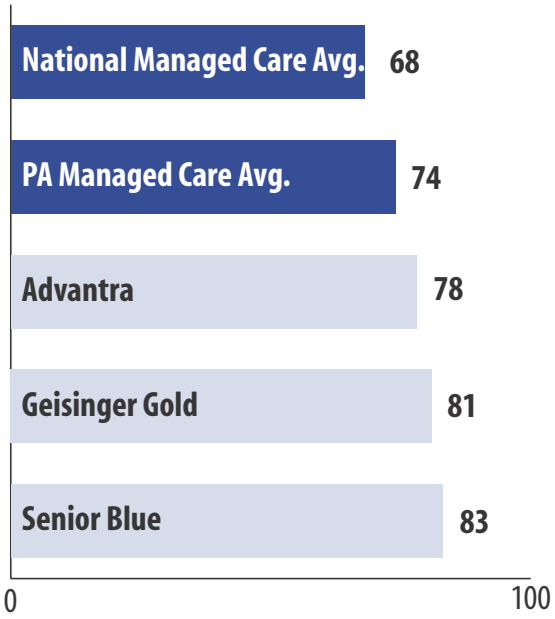


Managing On-Going Illnesses

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.

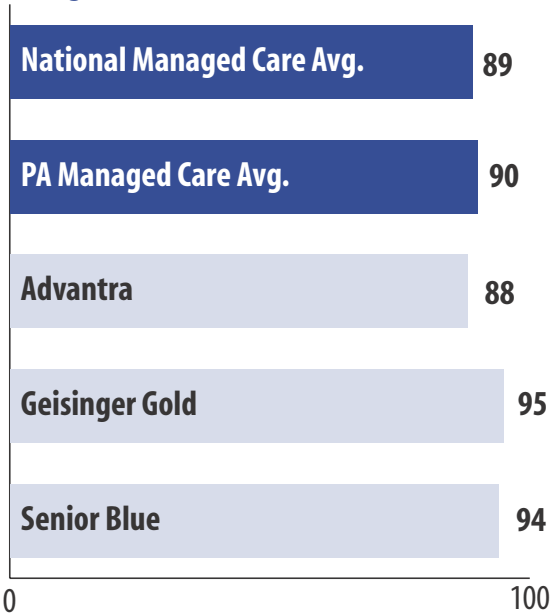
Percent of members with diabetes who received an eye exam within the past year



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 test (Hemoglobin A1c test) during 2003



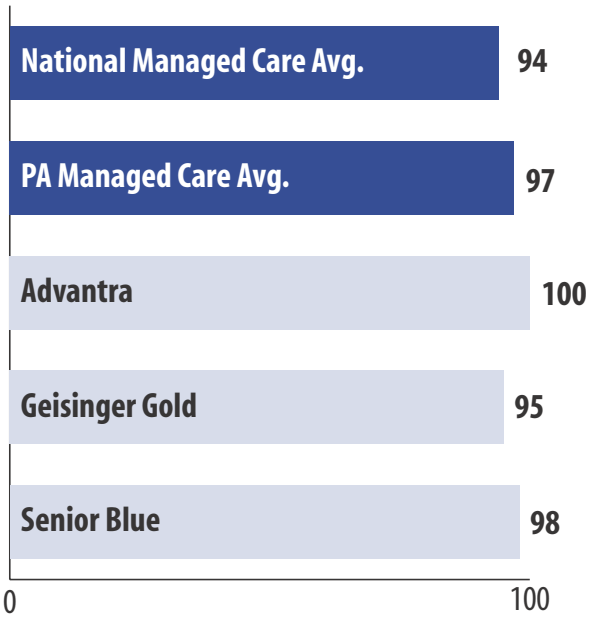
Preventing Heart Disease

Heart disease is the greatest health risk for people over age 65. The graph on this page shows how well plans encourage the use of medication to prevent future heart attacks. Generally, managed care plans with the higher percentage scores are doing a better job of preventing illness and helping their members stay healthy.

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 heart attack



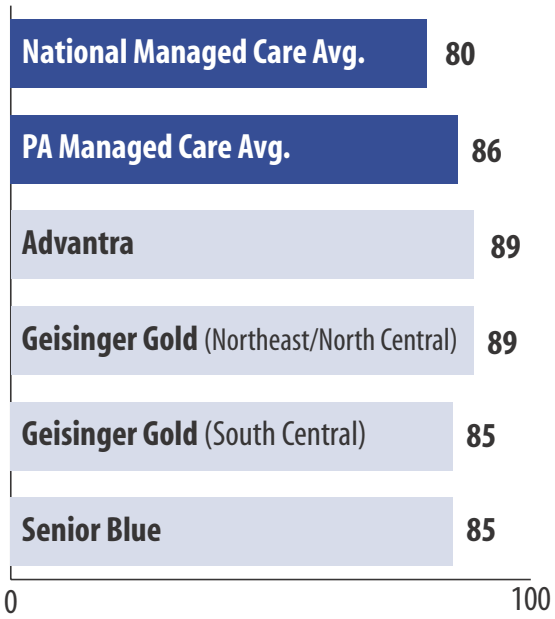
Member Satisfaction

Satisfaction surveys offer members' opinions and ratings on quality and service. These member satisfaction measures were taken from the annual Consumer Assessment of Health Plans Survey® for Calendar Year 2003. Independent research companies conduct the survey for each managed care plan.

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.

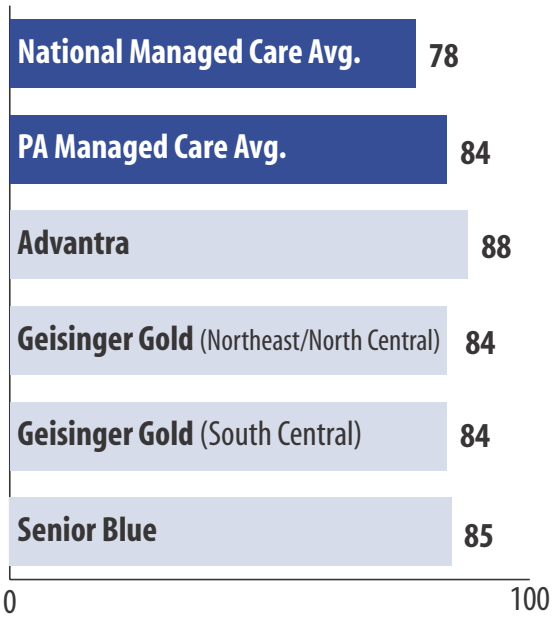
Percent of members who said they had no problems getting the care they needed



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

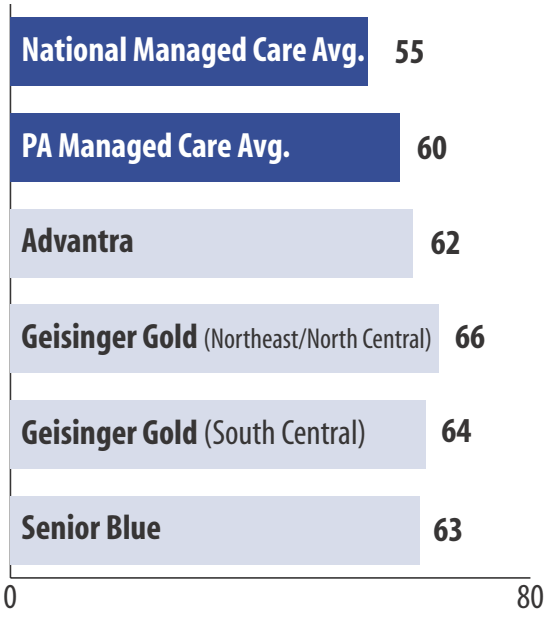


Member Satisfaction

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 treatment for injury or illness as soon as they wanted it, got an appointment for routine care as soon as they wanted, and waited no more than 15 minutes past their appointment time.

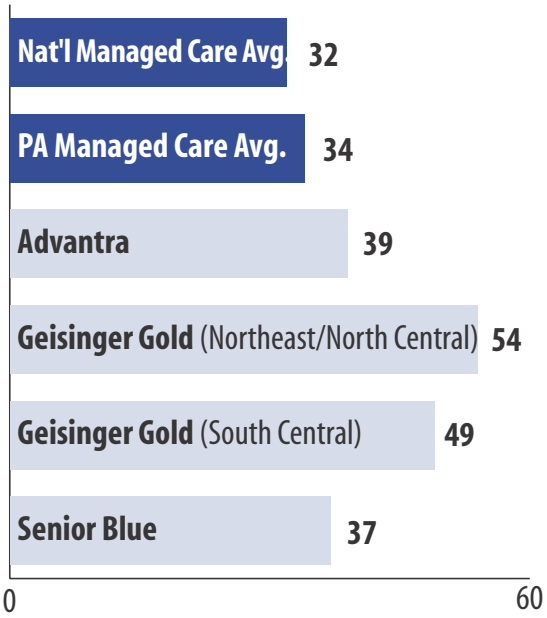
Percent of members who said they always got care when they needed it, without long wait



Overall rating of plan

The graph shows the percent of members who gave their own Medicare Managed Care Plan a rating of 10 out of 10 (the highest score).

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



Agencies Providing Information for 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 for 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 Unit 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	1-800-269-0173	
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, or go to an outpatient surgery center?
- What routine visits, physical exams, dental work, eye exams and hearing exams does each plan cover?
- What is the annual or quarterly dollar limit on prescription drug coverage?
- 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 other plans in 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?
- Are mail order pharmacies available?

Plans included in this Guide

Medicare Managed Care Plan	Toll-Free Telephone Number to Enroll
Aetna Health, Inc. **Golden Choice**	1-800-832-2640
AmeriHealth **AmeriHealth 65**	1-877-393-6733
Geisinger Health Plan **Geisinger Gold**	1-800-631-1656
HealthAmerica **Advantra**	1-800-470-4272
Keystone Health Plan Central **Senior Blue**	1-800-990-4201

This guide covers all Medicare Managed Care options available at the time of publication. However, some companies may offer additional managed care options during 2005. Call the plans listed above for more information.

Edward G. Rendell, Governor

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