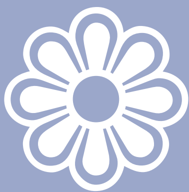

SOUTHEASTERN
PENNSYLVANIA

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:

Bucks

Chester

Delaware

Montgomery

Philadelphia

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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 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:

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

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

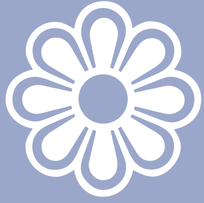
If you are currently getting your Medicare benefits as a member of a Medicare Advantage plan such as a Medicare HMO, you should contact them to find out if they offer a Medicare Prescription Discount Card. In some cases, if you decide that you want a card you may have to select their card even if you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

	Bucks	Chester	Delaware	Montgomery	Philadelphia
Aetna Health Inc. **Golden Choice** (PPO)	✓	pending*	pending*	✓	
Aetna Health Inc. **Golden Medicare**	✓	✓	✓	✓	✓
AmeriChoice **Personal Care Plus**					✓
Elder Health of PA, Inc. **Elder Health** (including Plus and Select)	✓		✓	✓	✓
Health Partners **Senior Partners**					✓
Independence Blue Cross **Personal Choice 65** (PPO)	✓	✓	✓	✓	✓
Keystone Health Plan East **Keystone 65**	✓	✓	✓	✓	✓
United Healthcare **Evercare Choice** (PPO)	✓	✓	✓	✓	✓

* Waiting for final approval from Medicare



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.

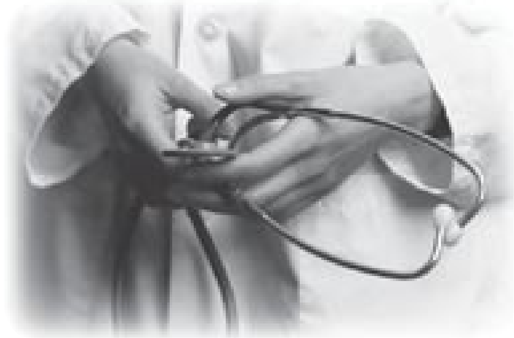
Co-payment – The amount that you pay for each medical service, such as a doctor's office visit, each time you use that service. A co-payment is usually a fixed amount (like $15).

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

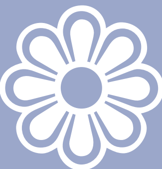
Company	Product	Service Area/Counties	Monthly Premium
Aetna Health Inc.	Golden Choice Option 1 (PPO)[1]	*Suburban Philadelphia* - (Bucks, Montgomery)	$59
	Golden Choice Option 2 (PPO)[1]		$99
	Golden Medicare - Option 1	Philadelphia	$0
	Golden Medicare - Option 2		$35
	Golden Medicare - Option 3		$0
	Golden Medicare – Option 1	*Suburban Philadelphia* - (Bucks, Chester, Delaware, Montgomery)	$0
	Golden Medicare – Option 2		$35
	Golden Medicare – Option 3		$0
AmeriChoice	Personal Care Plus [2]	Philadelphia	$0
Elder Health of PA, Inc.	Elder Health [3]	Bucks, Delaware, Montgomery, Philadelphia	$0
	Elder Health Select		$0
Health Partners	Senior Partners Gold	Philadelphia	$0
	Senior Partners Silver		$0
Independence Blue Cross	Personal Choice 65 Value PPO [1]	*Southeastern PA* - (Bucks, Chester, Delaware, Montgomery, Philadelphia)	$115
	Personal Choice 65 Silver PPO [1]		$140
	Personal Choice 65 Gold PPO [1]		$205
Keystone Health Plan East	Keystone 65 Basic [4]	Philadelphia	$ 0
	Keystone 65 Value [4]		$0
	Keystone 65 Standard [4]		$30
	Keystone 65 Generic [4]		$55
	Keystone 65 Brand [4]		$145
	Keystone 65 Basic [4]	Bucks, Chester, Delaware, Montgomery	$0
	Keystone 65 Value [4]		$0
	Keystone 65 Standard [4]		$45
	Keystone 65 Generic [4]		$70
	Keystone 65 Brand [4]		$160
United Healthcare	Evercare Choice (PPO) [1]	Bucks, Chester, Delaware, Montgomery, Philadelphia	$0

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.

2 AmeriChoice is a Special Needs Plan serving dual eligible members. To join the plan, a member must have Medicare Parts A and B and be receiving Medicaid. Contact the plan for more information.

3 For an additional $49.50 monthly premium, you may add additional coverage for prescription drugs through "Elder Health Plus."

4 For an additional $25 monthly premium, you may add point-of-service coverage for certain services performed by providers outside the Keystone Health Plan East Network.

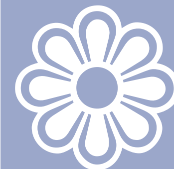


COMPARING COSTS & BENEFITS

Costs for Provider Services

Medicare Managed Care Plan	Counties	Costs to Member for: A Visit to Your Primary Care Doctor[1]	A Routine Physical Exam[2]	A Visit to a Specialist[3]
Aetna Health Inc. **Golden Choice –Option 1**	Suburban Philadelphia	$15 to $20	No copayment	$30
Aetna Health Inc. **Golden Choice –Option 2**	Suburban Philadelphia	$10 to $15	No copayment	$20
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Philadelphia, Suburban Philadelphia	$15 to $20	No copayment	$30
Aetna Health Inc. • **Golden Medicare Plan – Option 2** • **Golden Medicare Plan – Option 3**	Philadelphia, Suburban Philadelphia	$10 to $15	No copayment	$20
AmeriChoice **Personal Care Plus**[4]	Philadelphia	$20	No copayment	$25
Elder Health **Elder Health**	Philadelphia, Delaware, Montgomery, Bucks	No copayment	No copayment. You are covered for an unlimited number of visits.	$25
Elder Health **Elder Health Select**	Philadelphia, Delaware, Montgomery, Bucks	20% of the cost of the visit	No copayment. You are covered for an unlimited number of visits.	20% of the cost of the visit
Health Partners **Senior Partners Gold**	Philadelphia	No copayment	No copayment	$40
Health Partners **Senior Partners Silver**	Philadelphia	20% of the cost of the visit	No copayment	20% of the cost of the visit.

See footnotes on page 11.



Costs for Provider Services

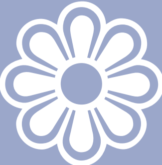
Medicare Managed Care Plan	Counties	Costs to Member for: A Visit to Your Primary Care Doctor[1]	A Routine Physical Exam[2]	A Visit to a Specialist[3]
Independence Blue Cross **Personal Choice 65 Value PPO**	Southeastern PA	$10	$10	$20
Independence Blue Cross • **Personal Choice 65 Silver PPO** • **Personal Choice 65 Gold PPO**		$20	$20	$35
Keystone Health Plan East • **Keystone 65 Basic** • **Keystone 65 Value**	Bucks, Chester, Delaware, Montgomery, Philadelphia	$10	$10	$20
Keystone Health Plan East **Keystone 65 Standard**				$25
Keystone Health Plan East **Keystone 65 Generic**		$15	$15	$35
Keystone Health Plan East **Keystone 65 Brand**		$10	$10	$35
United Healthcare **Evercare Choice**	Bucks, Chester, Delaware, Montgomery, Philadelphia	$0 to 25	No copayment	$0 to 25

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.

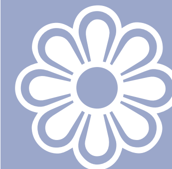
4 If you have both Medicare and Medicaid, your member costs for AmeriChoice will be paid for you through your State Medicaid coverage.



Costs for Provider Services

Medicare Managed Care Plan	Counties	Costs to Member for:	
		In-Hospital Stay[1]	**Outpatient Surgery[2]**
Aetna Health Inc. **Golden Choice – Option 1**	Suburban Philadelphia	$750 copayment	$100 copayment
Aetna Health Inc. **Golden Choice – Option 2**		$250 copayment	
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Philadelphia	$750 copayment	$100 copayment
Aetna Health Inc. **Golden Medicare Plan – Option 2**		$250 copayment	
Aetna Health Inc. **Golden Medicare Plan – Option 3**		15% of the cost of the stay	15% of the cost of the visit
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Suburban Philadelphia	$750 copayment	$100 copayment
Aetna Health Inc. **Golden Medicare Plan – Option 2**		$250 copayment	
Aetna Health Inc. **Golden Medicare Plan – Option 3**		15% of the cost of the stay	15% of the cost for each visit
AmeriChoice **Personal Care Plus**	Philadelphia	$880 deductible	$50 copayment
Elder Health **Elder Health**	Philadelphia, Delaware, Montgomery, Bucks	$275 copayment for each Medicare-covered stay. You are covered for 90-days each benefit period.	No copayment for each visit to an ambulatory surgical center. 20% for each Medicare-covered visit to an outpatient hospital facility.
Elder Health **Elder Health Select**		$912 deductible. You pay $0 each day for days 1-60; $228 each day for days 61-90. You are covered for 90-days each benefit period.	20% for each visit to an ambulatory surgical center. 20% for each Medicare-covered visit to an outpatient hospital facility.

See footnotes on page 13.



Costs for Provider Services

Medicare Managed Care Plan	Counties	Costs to Member for: In-Hospital Stay[1]	Costs to Member for: Outpatient Surgery[2]
Health Partners **Senior Partners Gold**	Philadelphia	$800 copayment	$150 for each visit to an ambulatory surgical center. No copayment for each visit to an outpatient hospital facility.
Health Partners **Senior Partners Silver**	Philadelphia	$912 deductible	20% of the cost for each visit.
Independence Blue Cross **Personal Choice 65 Value PPO**	Southeastern PA	10% of the cost for each stay.	10% of the cost for each visit.
Independence Blue Cross • **Personal Choice 65 Silver PPO** • **Personal Choice 65 Gold PPO**	Southeastern PA	$100 each day for days 1-8. No copayment for days 9-90. $800 annual out-of-pocket maximum.	$200 of the cost for each visit.
Keystone Health Plan East **Keystone 65 Basic**	Philadelphia	$876 deductible. No copayment for days 1-60; $219 each day for days 61-90. $438 each day for days 91-150. Covered for 150 days each benefit period.	20% of the cost for each visit.
Keystone Health Plan East **Keystone 65 Value**	Philadelphia	10% of the cost for each stay in a network hospital.	10% of the cost for each visit.
Keystone Health Plan East • **Keystone 65 Standard** • **Keystone 65 Brand**	Philadelphia	$100 each day for days 1-8; No copayment for days 9-90. $800 annual out-of-pocket maximum.	$100 for each visit.
Keystone Health Plan East **Keystone 65 Generic**	Philadelphia	$150 each day for days 1-8; No copayment for days 9-90. $1,200 annual out-of-pocket maximum.	$150 for each visit.

Continued on next page

[1] 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.

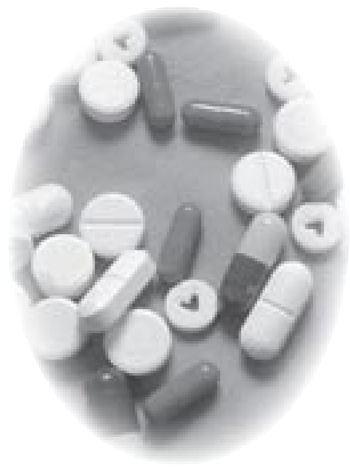
[2] Unless otherwise noted, a visit is defined as a Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility.

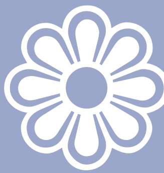
Costs for Provider Services

Medicare Managed Care Plan	Counties	Costs to Member for: In-Hospital Stay[1]	Costs to Member for: Outpatient Surgery[2]
Keystone Health Plan East **Keystone 65 Basic**	Bucks, Chester, Delaware, Montgomery	$876 deductible. No copayment for days 1-60; $219 each day for days 61-90. $438 each day for days 91-150. Covered for 150 days each benefit period.	20% of the cost for each visit.
Keystone Health Plan East **Keystone 65 Value**		10% of the cost for each stay in a network hospital.	10% of the cost for each visit.
Keystone Health Plan East • **Keystone 65 Standard** • **Keystone 65 Brand**		$100 each day for days 1-8; No copayment for days 9-90. $800 annual out-of-pocket maximum.	$100 for each visit.
Keystone Health Plan East **Keystone 65 Generic**		$150 each day for days 1-8; No copayment for days 9-90. $1,200 annual out-of-pocket maximum.	$150 for each visit.
United Healthcare **Evercare Choice**	Bucks, Chester, Delaware, Montgomery, Philadelphia	$125 each day for days 1-10; $0 for days 11-90.	$25 for each visit.

1 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.

2 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**	Suburban Philadelphia	No pharmacy benefit under basic plan. *For an additional premium of $30/ month, you may add supplemental prescription drug coverage.*	Call the plan for more details.
Aetna Health Inc. **Golden Choice – Option 2**	Suburban Philadelphia	No pharmacy benefit under basic package. *For an additional premium of $50/ month, you may add supplemental prescription drug benefit.*	Call the plan for more details.
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Philadelphia	No pharmacy benefit under basic package. *For an additional premium of $29/ month, you may add a supplemental prescription drug benefit.*	Call the plan for more details.
Aetna Health Inc. **Golden Medicare Plan – Option 2**	Philadelphia	No pharmacy benefit under basic package. *For an additional premium of $50/ month, you may add a supplemental prescription drug benefit.*	Call the plan for more details.
Aetna Health Inc. **Golden Medicare Plan – Option 3**	Philadelphia	From a pharmacy (30-day supply) $15 Generic Mail order (90-day supply) $30 Generic You pay 100% of the cost for Brand drugs at Aetna's contracted rate.	No individual limit for Generic or Brand drugs. Call the plan for more details.

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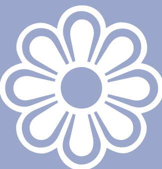
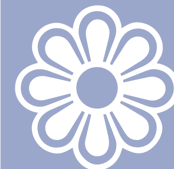


Prescription Drug Benefits

Medicare Managed Care Plan	Counties	Costs to Member	Formulary Drugs and Limits on Coverage
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Suburban Philadelphia	No pharmacy benefit under basic package. *For an additional premium of $29/ month, you may add a supplemental prescription drug benefit.*	Call the plan for more details.
Aetna Health Inc. **Golden Medicare Plan – Option 2**	Suburban Philadelphia	No pharmacy benefit under basic package. *For an additional premium of $50/ month, you may add a supplemental prescription drug benefit.*	Call the plan for more details.
Aetna Health Inc. **Golden Medicare Plan – Option 3**	Suburban Philadelphia	From a pharmacy (30-day supply) $15 Generic Mail order (90-day supply) $30 Generic You pay 100% of the cost for Brand drugs at Aetna's contracted rate.	No individual limit for Generic or Brand drugs. Call the plan for more details.
AmeriChoice **Personal Care Plus**		No coverage	No coverage
Elder Health **Elder Health**	Philadelphia, Delaware, Montgomery, Bucks	No pharmacy benefit *For an additional $49.50 per month premium (Elder Health Plus) you have the option to purchase prescription drug coverage as follows:* *From a pharmacy (30-day supply)* *$10 Generic* *Mail order (90-day supply)* *$20 Generic*	Call the plan for details. If you purchase the optional benefit, there is an overall limit of $250 quarterly for Generic drugs. Any unused amount CAN be carried over to the next period.



Prescription Drug Benefits

Medicare Managed Care Plan	Counties	Costs to Member	Formulary Drugs and Limits on Coverage
Elder Health **Elder Health Select**		No coverage	No coverage
Health Partners • **Senior Partners Gold** • **Senior Partners Silver**		No coverage	No coverage
Independence Blue Cross **Personal Choice 65 Value PPO**		No coverage	No coverage
Independence Blue Cross **Personal Choice 65 Silver PPO**	Southeastern PA	From a pharmacy (30-day supply) $15 Generic Mail order (90-day supply) $30 Generic	No individual limit on Generic drugs. Call for details.
Independence Blue Cross **Personal Choice 65 Gold PPO**	Southeastern PA	From a pharmacy (30-day supply) $15 Generic $20 Brand (Formulary) $30 Brand (non-Formulary) Mail order (90-day supply) $30 Generic $40 Brand (Formulary) $60 Brand (non-Formulary)	No individual limit on Generic drugs. $500 annual limit for combined Formulary Brand and non-Formulary prescription drugs. Call for details.
Keystone Health Plan East • **Keystone 65 Basic** • **Keystone 65 Value** • **Keystone 65 Standard**		No coverage	No coverage
Keystone Health Plan East **Keystone 65 Generic**	Philadelphia	From a pharmacy (30-day supply) $15 Generic Mail order (90-day supply) $30 Generic	No individual limit on Generic drugs.

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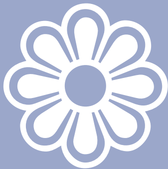
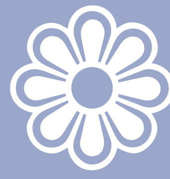


Prescription Drug Benefits

Medicare Managed Care Plan	Counties	Costs to Member	Formulary Drugs and Limits on Coverage
Keystone Health Plan East **Keystone 65 Brand**	Philadelphia	From a pharmacy (30-day supply) $15 Generic $25 Brand (Formulary) $50 Brand (Non-Formulary) Mail order (90-day supply) $30 Generic $50 Brand (Formulary) $100 Brand (non-Formulary)	No individual limit for Generic drugs. There is a $250 quarterly limit for combined Formulary Brand and Non-formulary Brand drugs. Call for details.
Keystone Health Plan East • **Keystone 65 Basic** • **Keystone 65 Value** • **Keystone 65 Standard**		No coverage	No coverage
Keystone Health Plan East **Keystone 65 Generic**	Bucks, Chester, Delaware, Montgomery	From a pharmacy (30-day supply) $15 Generic Mail order (90-day supply) $30 Generic	No individual limit for Generic drugs. Call for details.
Keystone Health Plan East **Keystone 65 Brand**	Bucks, Chester, Delaware, Montgomery	From a pharmacy (30-day supply) $15 Generic $25 Brand (Formulary) $50 Brand (Non-Formulary) Mail order (90-day supply) $30 Generic $50 Brand (Formulary) $100 Brand (non-Formulary)	No individual limit for Generic drugs. There is a $250 quarterly limit for combined Formulary Brand and Non-formulary Brand drugs. Call for details.
United Healthcare **Evercare Choice**		No coverage	No coverage



Home Health Care & Durable Medical Equipment

Medicare Managed Care Plan	Counties	Costs to Member for: Home Health Care[1]	Costs to Member for: Durable Medical Equipment [2]
Aetna Health Inc. **Golden Choice – Option 1** **Golden Choice – Option 2**	Suburban Philadelphia	$20 copayment for Medicare-covered home health visits	20% of the cost for each Medicare-covered item.
Aetna Health Inc. **Golden Medicare Plan – Option 1** **Golden Medicare Plan – Option 2** **Golden Medicare Plan – Option 3**	Philadelphia, Suburban Philadelphia	$20 copayment for Medicare-covered home health visits.	20% of the cost for each Medicare-covered item.
AmeriChoice **Personal Care Plus**	Philadelphia	No copayment	$25 copayment for each Medicare covered item.
Elder Health **Elder Health**	Philadelphia, Delaware, Montgomery, Bucks	No copayment	No copayment
Elder Health **Elder Health Select**			20% of the cost for each Medicare-covered item.
Health Partners **Senior Partners Gold**	Philadelphia	No copayment	No copayment
Health Partners **Senior Partners Silver**			20% of the cost for each Medicare-covered item.
Independence Blue Cross • **Personal Choice 65 Value PPO** • **Personal Choice 65 Silver PPO** • **Personal Choice 65 Gold PPO**	Southeastern PA	No copayment for Medicare-covered home health visits.	No copayment for Medicare-covered items.

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

[2] Includes wheelchairs, oxygen, etc.

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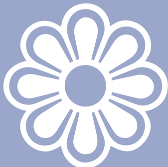
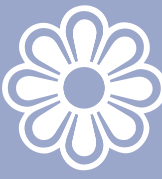


Home Health Care & Durable Medical Equipment

Medicare Managed Care Plan	Counties	Costs to Member for: Home Health Care[1]	Costs to Member for: Durable Medical Equipment [2]
Keystone Health Plan East **• Keystone 65 Basic**	Philadelphia	No copayment.	20% of the cost for each Medicare-covered item.
Keystone Health Plan East **• Keystone 65 Value** **• Keystone 65 Standard** **• Keystone 65 Generic** **• Keystone 65 Brand**			No copayment
Keystone Health Plan East **Keystone 65 Basic**	Bucks, Chester, Delaware, Montgomery	No copayment	20% of the cost for each Medicare-covered item.
Keystone Health Plan East **• Keystone 65 Value** **• Keystone 65 Standard** **• Keystone 65 Generic** **• Keystone 65 Brand**			No copayment
United Healthcare **Evercare Choice**	Bucks, Chester, Delaware, Montgomery, Philadelphia	No copayment	20% of the cost for each Medicare-covered item

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

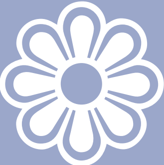
[2] Includes wheelchairs, oxygen, etc.



Skilled Nursing Facilities & Ambulance Services

Medicare Managed Care Plan	Counties	Costs to Member for: A Stay in a Skilled Nursing Facility[1]	Costs to Member for: Ambulance Service
Aetna Health Inc. • **Golden Choice – Option 1** • **Golden Choice – Option 2**	Suburban Philadelphia	$25 copayment each day for days 1-100.	$100 copayment
Aetna Health Inc. • **Golden Medicare Plan - Option 1** • **Golden Medicare Plan - Option 2** • **Golden Medicare Plan - Option 3**	Philadelphia, Suburban Philadelphia	$25 copayment each day for days 1-100.	$100 copayment
AmeriChoice **Personal Care Plus**	Philadelphia	No copayment	No copayment
Elder Health **Elder Health**	Philadelphia, Delaware, Montgomery, Bucks	No copayment for days 1-30; $114 copayment each day for days 31-100.	20% of the cost.
Elder Health **Elder Health Select**		No copayment for days 1-20; $114 copayment each day for days 21-100.	
Health Partners **Senior Partners Gold**	Philadelphia	No copayment	No copayment
Health Partners **Senior Partners Silver**			20% of the cost.
Independence Blue Cross **Personal Choice 65 Value PPO**	Southeastern Pennsylvania	10% of the cost.	10% of the cost.
Independence Blue Cross • **Personal Choice 65 Silver PPO** • **Personal Choice 65 Gold PPO**		$25 copayment each day for days 1-100.	$100 copayment

[1] No prior hospital stay is required.



Skilled Nursing Facilities & Ambulance Services

Medicare Managed Care Plan	Counties	Costs to Member for: A Stay in a Skilled Nursing Facility[1]	Ambulance Service
Keystone Health Plan East **Keystone 65 Basic**	Philadelphia	No copayment for days 1-20; $109.50 each day for days 21-100.	20% of the cost.
Keystone Health Plan East **Keystone 65 Value**	Philadelphia	10% of the cost for each stay.	10% of the cost.
Keystone Health Plan East • **Keystone 65 Standard** • **Keystone 65 Generic** • **Keystone 65 Brand**	Philadelphia	$25 copayment each day for days 1-100.	$50
Keystone Health Plan East **Keystone 65 Basic**	Bucks, Chester, Delaware, Montgomery	No copayment for days 1-20; $109.50 each day for days 21-100.	20% of the cost.
Keystone Health Plan East **Keystone 65 Value**	Bucks, Chester, Delaware, Montgomery	10% of the cost for each stay.	10% of the cost.
Keystone Health Plan East • **Keystone 65 Standard** • **Keystone 65 Generic** • **Keystone 65 Brand**	Bucks, Chester, Delaware, Montgomery	$25 copayment each day for days 1-100.	$50
United Healthcare **Evercare Choice**	Bucks, Chester, Delaware, Montgomery, Philadelphia	No copayment	$100

[1] No prior hospital stay is required.

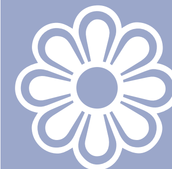
Vision Services

Medicare Managed Care Plan	Counties	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**	Suburban Philadelphia	No copayment	$30	No copayment for glasses, contacts, lenses and frames. $100 allowance for eyewear every two years.
Aetna Health Inc. **Golden Choice – Option 2**			$20	
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Philadelphia	No copayment	$30	
Aetna Health Inc. **• Golden Medicare Plan – Option 2** **• Golden Medicare Plan – Option 3**			$20	
Aetna Health Inc. **Golden Medicare Plan – Option 1**	Suburban Philadelphia	No copayment	$30	
Aetna Health Inc. **• Golden Medicare Plan – Option 2** **• Golden Medicare Plan – Option 3**			$20	
AmeriChoice **Personal Care Plus**	Philadelphia	No copayment	No copayment	No copayment for one pair glasses/contacts after each cataract surgery. $250 allowance for eyewear each year. Additional benefits are available.
Elder Health **Elder Health**	Philadelphia, Delaware, Montgomery, Bucks	$25	$25	No copayment for glasses (one pair every two years).
Elder Health **Elder Health Select**		20% of the cost	20% of the cost	

[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.

Vision Services

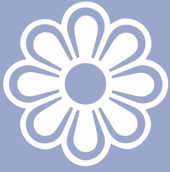
Medicare Managed Care Plan	Counties	Costs to Member: Routine Eye Exam[1]	Costs to Member: Medicare-Covered Exams[2]	Coverage for Glasses/Contacts[3]
Health Partners **Senior Partners Gold**	Philadelphia	No copayment (one visit every two years)	No copayment	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years.
Health Partners **Senior Partners Silver**	Philadelphia	No copayment	No copayment	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every year.
Independence Blue Cross **Personal Choice 65 Value PPO**	Southeastern PA	No coverage for routine eye exams.	$20	See footnote.
Independence Blue Cross **Personal Choice 65 Silver PPO**	Southeastern PA	No coverage for routine eye exams.	$35	See footnote.
Independence Blue Cross **Personal Choice 65 Gold PPO**	Southeastern PA	No coverage for routine eye exams.	$35	See footnote.
Keystone Health Plan East **Keystone 65 Basic**	Philadelphia	$20 (one exam every two years)	$20	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years. $150 allowance for eyewear every two years.
Keystone Health Plan East **Keystone 65 Value**	Philadelphia	$20 (one exam every two years)	$20	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years. $100 allowance for eyewear every two years.
Keystone Health Plan East **Keystone 65 Standard**	Philadelphia	$25 (one exam every two years)	$25	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years. $100 allowance for eyewear every two years.
Keystone Health Plan East **• Keystone 65 Generic** **• Keystone 65 Brand**	Philadelphia	$35 (one exam every two years)	$35	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years. $100 allowance for eyewear every two years.



Vision Services

Medicare Managed Care Plan	Counties	Costs to Member: Routine Eye Exam[1]	Costs to Member: Medicare-Covered Exams[2]	Coverage for Glasses/Contacts[3]
Keystone Health Plan East **Keystone 65 Basic**	Bucks, Chester, Delaware, Montgomery	$20 (one exam every two years)	$20	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years. $150 allowance for eye-wear every two years.
Keystone Health Plan East **Keystone 65 Value**	Bucks, Chester, Delaware, Montgomery	$20 (one exam every two years)	$20	No copayment for one pair glasses, one pair contacts, one pair lenses and one pair frames every two years. $100 allowance for eye-wear every two years.
Keystone Health Plan East **Keystone 65 Standard**		$25 (one exam every two years)	$25	
Keystone Health Plan East **• Keystone 65 Generic** **• Keystone 65 Brand**		$35 (one exam every two years)	$35	
United Healthcare **Evercare Choice**	Bucks, Chester, Delaware, Montgomery, Philadelphia	$0 to 25	$0 to 25	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.



COMPARING QUALITY

Staying Healthy

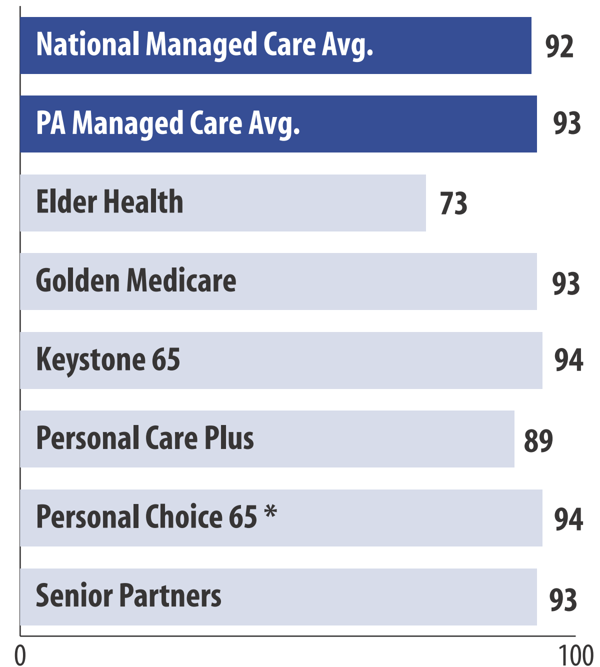
A managed care plan (such as an HMO) covers services for prevention or early detection of health problems, usually at little or no cost to the members. The graphs on pages 26 and 27 can help you evaluate how well the managed care plans are providing preventive care to help their members stay healthy. Generally, managed care plans with a higher percentage score are doing a better job of providing preventive care.

No information in this section is available for Aetna Health "Golden Choice" or United Healthcare "Evercare Choice" because the plans were too new to provide data.

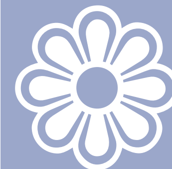
Visits to the Doctor

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



* Data for Personal Choice 65 PPO is collected in a different manner than the other plans and should not be compared to the other scores listed.

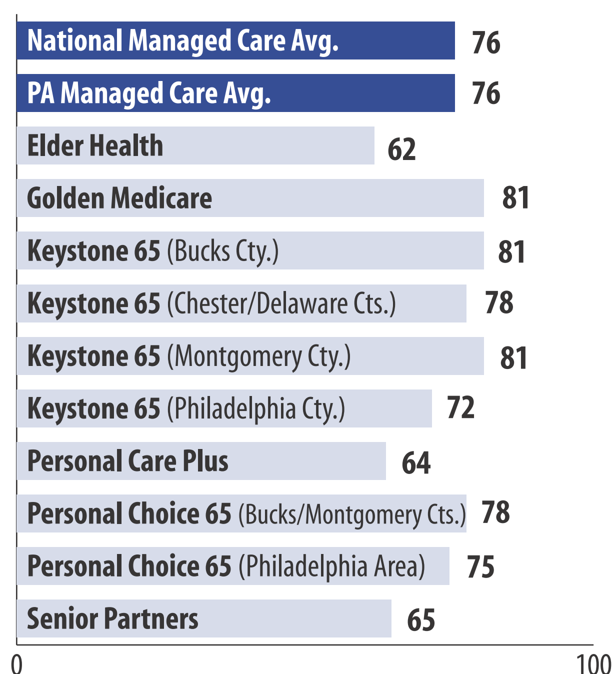


Staying Healthy

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.

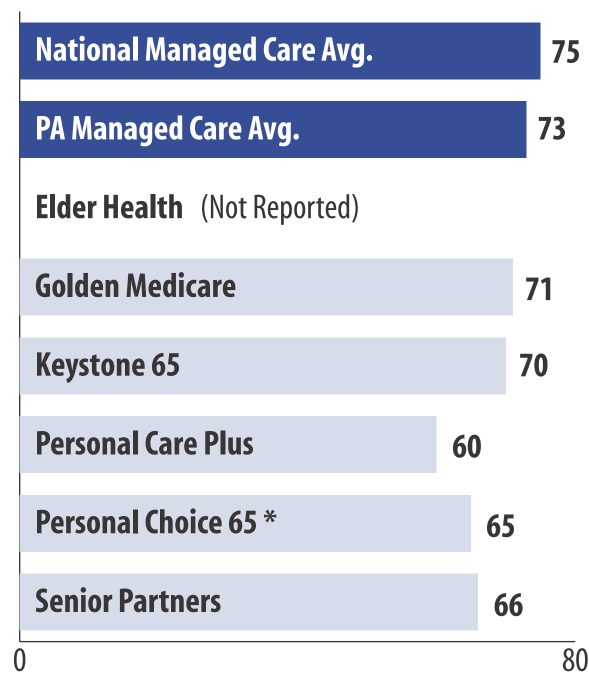
Percent of members over age 65 who received flu shots last year



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[1]



[1] This information is from 2002 and 2003.

* Data for Personal Choice 65 PPO is collected in a different manner than the other plans and should not be compared to the other scores listed.

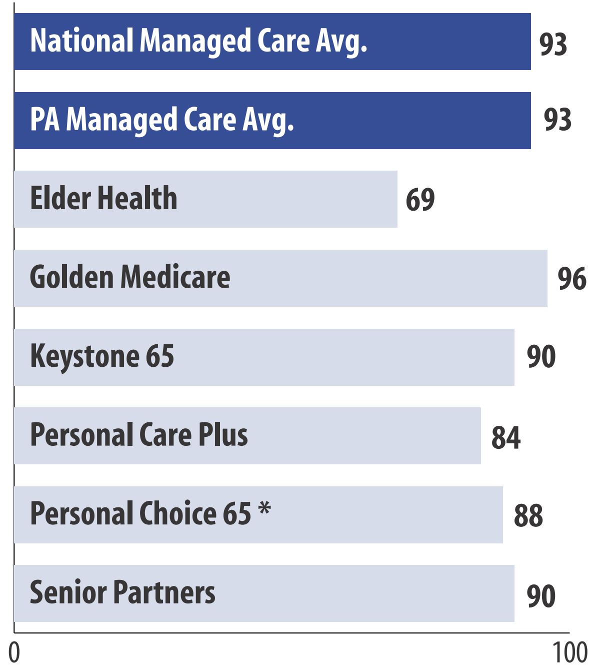
Managing On-Going Illnesses

The graphs on pages 28 and 29 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.

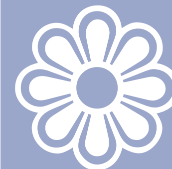
"Bad" cholesterol testing for members with diabetes

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



* Data for Personal Choice 65 PPO is collected in a different manner than the other plans and should not be compared to the other scores listed.

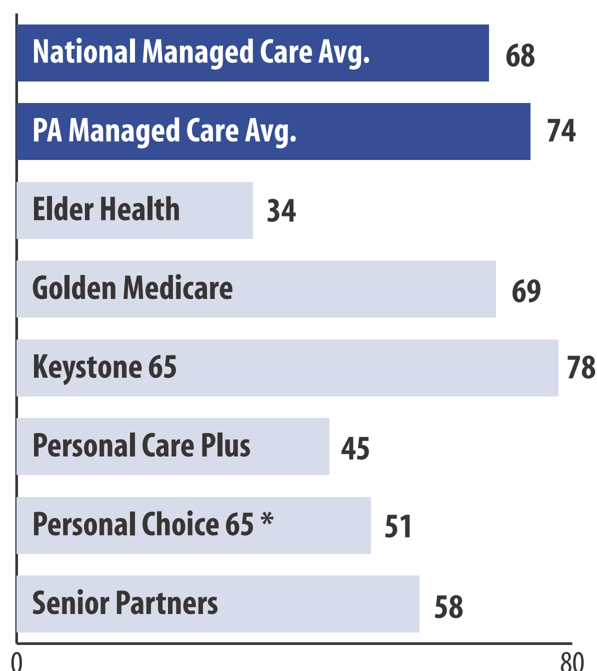


Managing On-Going Illnesses

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.

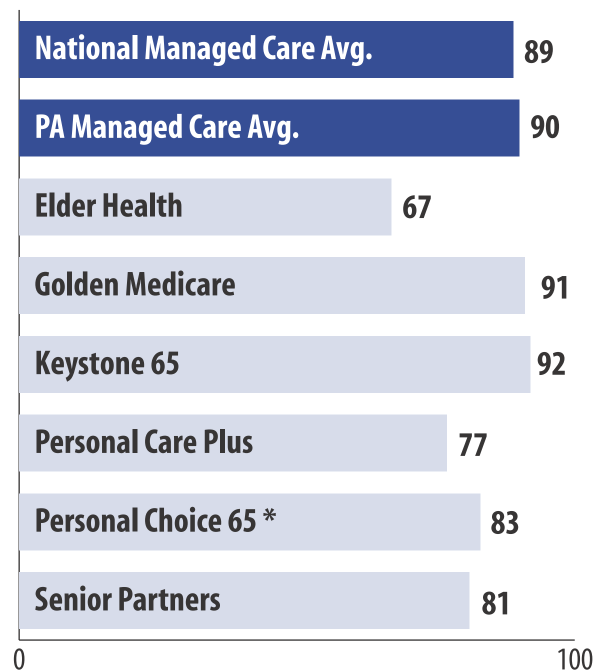
Percent of members with diabetes who received an eye exam within the past year



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



* Data for Personal Choice 65 PPO is collected in a different manner than the other plans and should not be compared to the other scores listed.

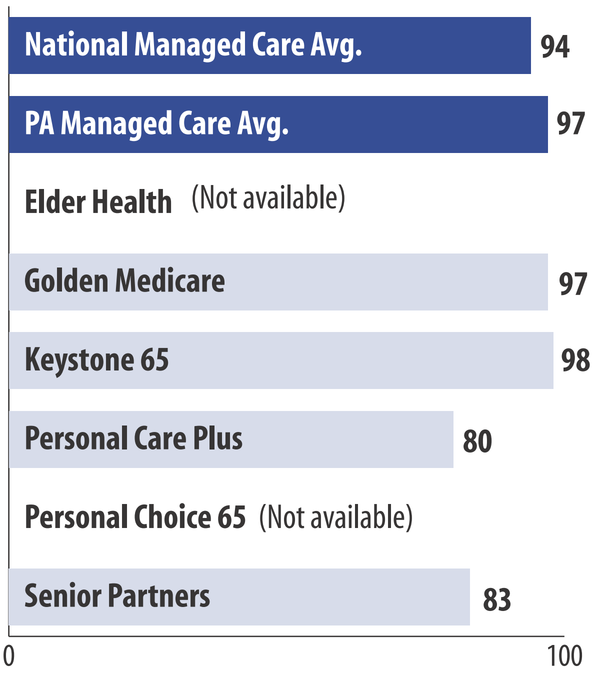
Preventing Heart Disease

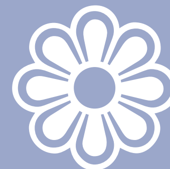
Heart disease is the greatest health risk for people over age 65. The graph on this page shows how well plans encourage the use of medication to prevent future heart attacks. Generally, managed care plans with the higher percentage scores are doing a better job of preventing illness and helping their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

Plan	Percent
National Managed Care Avg.	80
PA Managed Care Avg.	86
Elder Health	73
Golden Medicare	85
Keystone 65 (Bucks Cty)	86
Keystone 65 (Chester/Delaware Cts.)	86
Keystone 65 (Montgomery Cty)	83
Keystone 65 (Philadelphia Cty)	82
Personal Care Plus	83
Personal Choice 65 (Bucks/Montgomery Cts.)	85
Personal Choice 65 (Philadelphia Area)	85
Senior Partners	77

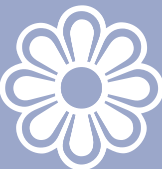
No problem seeing a specialist

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

Plan	Percent
National Managed Care Avg.	78
PA Managed Care Avg.	84
Elder Health	64
Golden Medicare	86
Keystone 65 (Bucks Cty.)	87
Keystone 65 (Chester/Delaware Cts.)	85
Keystone 65 (Montgomery Cty.)	81
Keystone 65 (Philadelphia Cty.)	80
Personal Care Plus	80
Personal Choice 65 (Bucks/Montgomery Cts.)	85
Personal Choice 65 (Philadelphia Area)	86
Senior Partners	77

No information in this section is available for Aetna Health "Golden Choice" or United Healthcare "Evercare Choice" because the plans were too new to provide data.



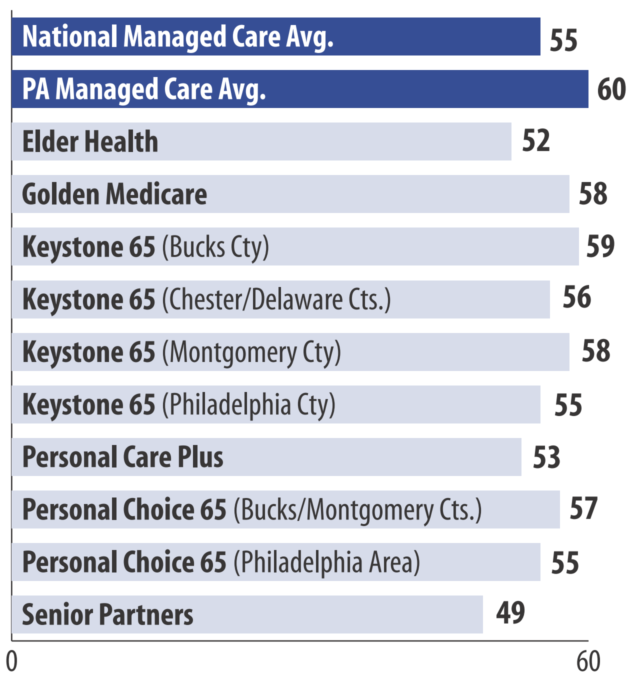
COMPARING QUALITY

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.

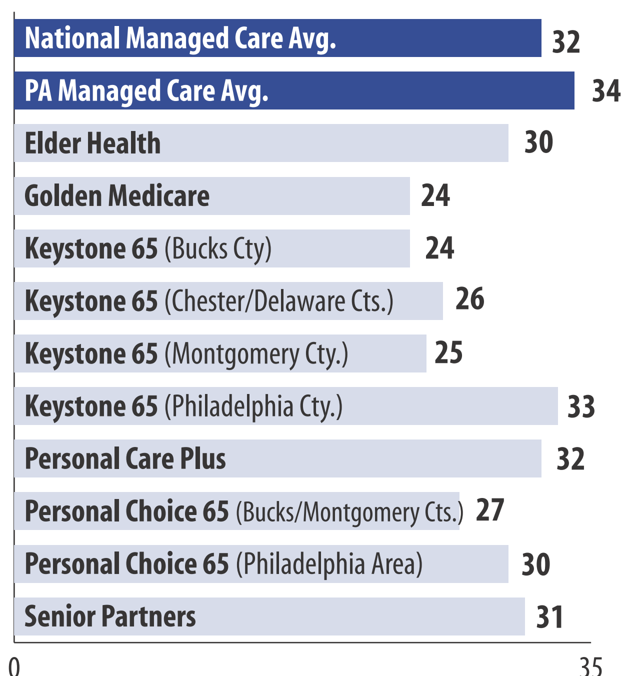
Percent of members who said they always got care when they needed it, without long wait



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

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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

Agency	Telephone Number
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

Aetna Health **Golden Choice and Golden Medicare** 1-800-832-2640

AmeriChoice **Personal Care Plus** 1-877-289-1917

Elder Health of PA **Elder Health** 1-215-606-6393

Health Partners **Senior Partners** 1-888-776-9466

Independence Blue Cross **Personal Choice 65** 1-877-393-6733

Keystone Health Plan East **Keystone 65** 1-877-393-6733

United Healthcare **Evercare** 1-800-393-0993

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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