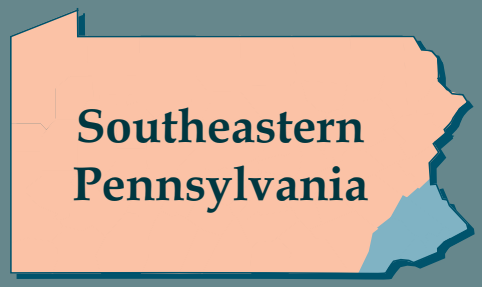


Choosing a Medicare HMO

A Guide for Older Pennsylvanians

Bucks • Chester • Delaware • Montgomery • Philadelphia

This guide is a joint effort of
the Pennsylvania Health Care Cost Containment Council
and the Pennsylvania Department of Aging
November 2001

Table of Contents

The information presented in this report was verified at the time of publication. However, pending legislation and/or future changes by HMOs could alter this information.

What is the purpose of this booklet?

If you are 65 or over, and thinking about joining a Medicare HMO or have already decided to do so, this booklet is for you! This guide:

- provides information about HMOs and how they differ from your traditional Medicare coverage,
- compares the quality of services provided by different HMOs, and
- gives you guidance on who can answer any specific questions you have while making your decision.

What is a Medicare HMO?

A Medicare HMO is a private (non-government) insurance company that manages the health care of the members enrolled in their program. The United States pays these companies a fixed amount of money each month for each member. The company then helps pay for the medical care, both by doctors and hospitals, that the member needs during the time he or she is enrolled.

HMOs work to keep the cost of health care under control by coordinating care among different doctors, encouraging members to seek preventive services (such as tests and flu shots) and helping members manage on-going diseases (such as heart problems or diabetes). HMOs also provide or support educational programs and guidelines for treatment.

Is an HMO right for me?

Only you and your family can determine if an HMO is your best Medicare option. Here are some things to consider:

Your costs may be lower

A monthly premium and charge each time you visit a doctor and, in some cases, the hospital, are all you typically pay if you use doctors that belong to the plan and follow the HMO's rules.

There may be additional benefits

Enrollment is fairly simple and you cannot be turned down because of your health status. The exceptions are those people who have end stage renal disease kidney failure. Full coverage begins on the date of your enrollment in a Medicare HMO.

Need for a referral

In an HMO, you will receive most of your care from a primary care doctor. If you need to see a specialist, require lab work or go to the hospital, your primary care doctor will give you a referral. If you do not get this referral, the HMO may not pay for the cost of the service. You may consider purchasing an additional benefit known as a "point-of-service option" from those plans that offer one. For an additional monthly premium, this option gives you more freedom to see specialists without the need for a referral.

Possible loss of HMO coverage

Each year, the HMO decides whether to offer policies to Medicare beneficiaries for the following year. They may stop offering coverage in certain counties or stop participating in the Medicare HMO program altogether. The HMO can change which benefits are offered or the amount you pay to receive these benefits.

How do I enroll in a Medicare HMO?

Medicare requires that you be enrolled in Medicare Parts A and B before you can enroll in a Medicare HMO. Enrollment is simple: request an enrollment form from the HMO you choose, then complete and return the form.

With a few exceptions, HMOs are required to accept new members regardless of their health status. However, some HMOs may be limited in the number of new members they can enroll. Check with the HMO to see if it is still accepting new members, then enroll as soon as possible.

What is different for 2002?

Beginning this year, enrollees must choose an HMO during the annual enrollment period, which is November and December of 2001. *You may change plans only one time during 2002, and that change must take place during the first six months of the year*. To leave an HMO you may either notify the HMO in writing or complete a form at your local Social Security Office.

Which HMOs are available where I live?

HMOs offer their services to residents of specific counties. This list shows the plans currently available in your county, as well as the name of that company's Medicare HMO.

It should be noted that Personal Choice 65 is a Preferred Provider Organization (PPO), which differs in some ways from an HMO. See the information on Benefits and Co-payments (on pages 16-21) to see how this PPO differs from the HMOs.

County	HMO	Company
Bucks	Personal Choice 65 (PPO)	Independence Blue Cross
	Keystone 65 Standard Medical Plan	Keystone Health Plan East
	Keystone 65 Basic Medical Plan	Keystone Health Plan East
Chester	Golden Medicare	Aetna U.S. Healthcare
	Personal Choice 65 (PPO)	Independence Blue Cross
	Keystone 65 Standard Medical Plan	Keystone Health Plan East
	Keystone 65 Basic Medical Plan	Keystone Health Plan East
Delaware	Golden Medicare	Aetna U.S. Healthcare
	Personal Choice 65 (PPO)	Independence Blue Cross
	Keystone 65 Standard Medical Plan	Keystone Health Plan East
	Keystone 65 Basic Medical Plan	Keystone Health Plan East
Montgomery	Personal Care Plus	AmeriChoice
	Personal Choice 65 (PPO)	Independence Blue Cross
	Keystone 65 Standard Medical Plan	Keystone Health Plan East
	Keystone 65 Basic Medical Plan	Keystone Health Plan East
Philadelphia	Golden Medicare	Aetna U.S. Healthcare
	Personal Care Plus	AmeriChoice
	WiseChoice for Philadelphia	Health Net of PA
	Senior Partners	Senior Partners
	Personal Choice 65 (PPO)	Independence Blue Cross
	Keystone 65 Standard Medical Plan	Keystone Health Plan East
	Keystone 65 Basic Medical Plan	Keystone Health Plan East

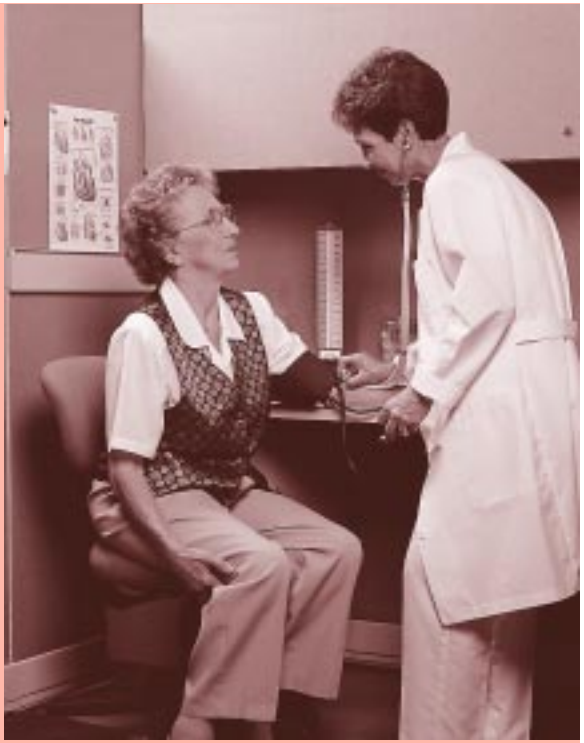
Comparing the Quality of Medicare HMOs

This section of the report provides information to help you choose between those plans available where you live. It will help you evaluate how well the HMOs:

- help their members stay well,
- help their members control diseases such as diabetes or heart problems, and
- ensure that members are provided care to deal with injuries and illness.

This section also includes responses to a survey of HMO members that indicates how satisfied the members are with their HMOs.

Preventing Illness



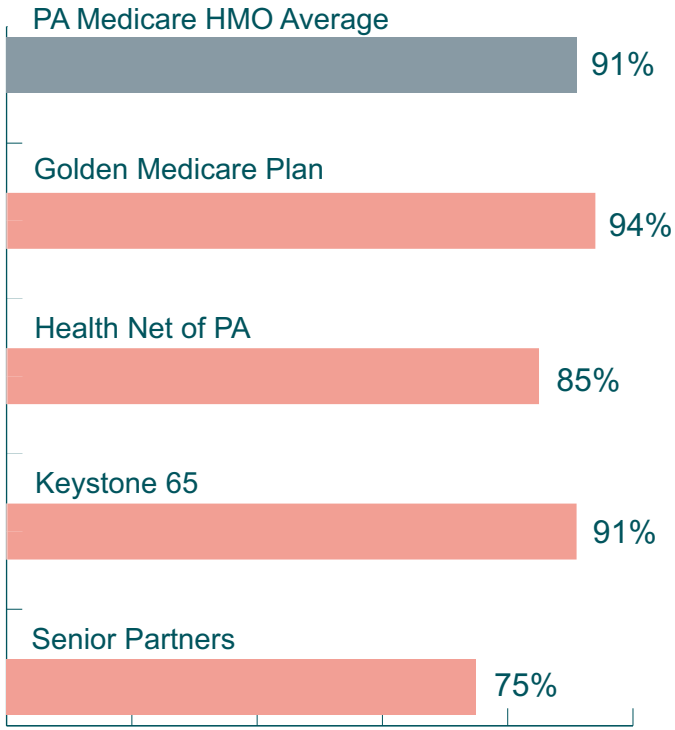
Information reported on pages 6 through 21 was provided by the Federal government. All information in this report is for calendar year 2000, with one footnoted exception.

No information is included in this section for AmeriChoice because that HMO was new in 2000. Personal Choice 65, Independence Blue Cross's Preferred Provider Organization (PPO), was also relatively new. For this reason, not all measures are available for this PPO.

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. The graph below shows the percentage of HMO members who were seen by a health care provider within the last year.

Percent of members seen by a health care provider within the past year *



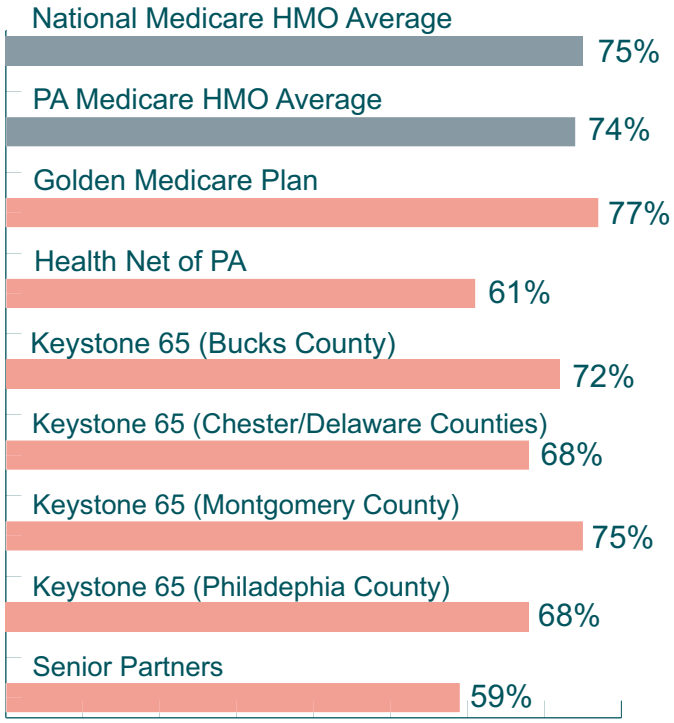
** These data are for calendar year 1999.*

Generally speaking, the higher the percentage, the better the result.

Flu Shots

The flu is a highly contagious respiratory infection. Nationwide, over 40,000 people die from the flu every year. People over 65 are at higher risk of having medical problems from the flu and should get a flu shot.

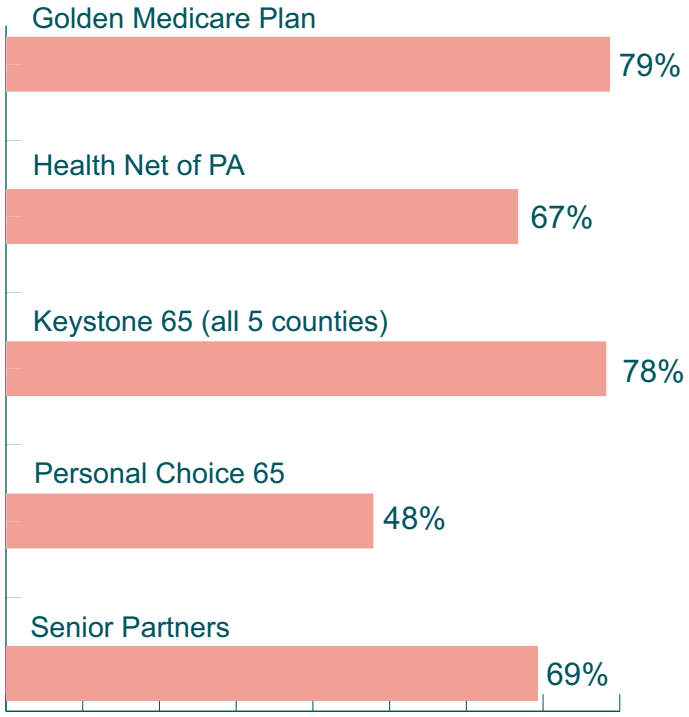
Percent of members over age 65 who received a flu shot last year



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

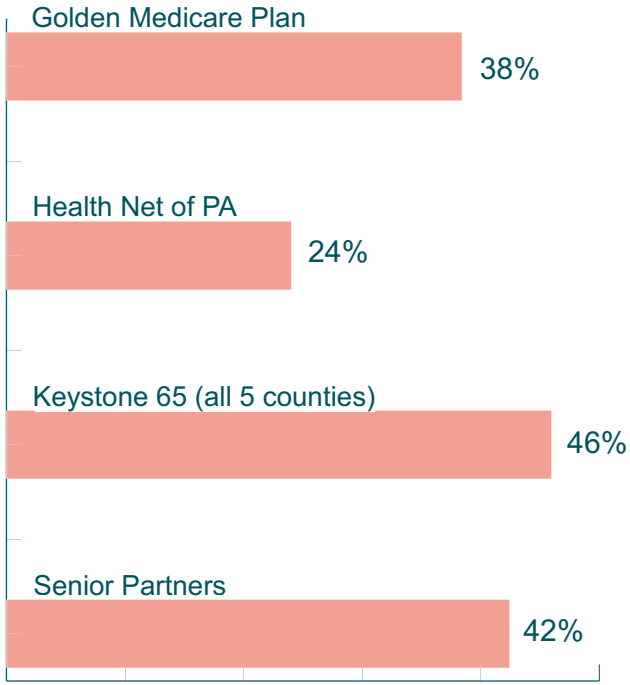


Managing On-going Illnesses

Control of High Blood Pressure

HMO members who have been diagnosed with hypertension (high blood pressure) should work with their doctor to control this problem. Controlled high blood pressure means a reading no higher than 140 over 90.

Percent of members diagnosed with high blood pressure whose blood pressure is controlled



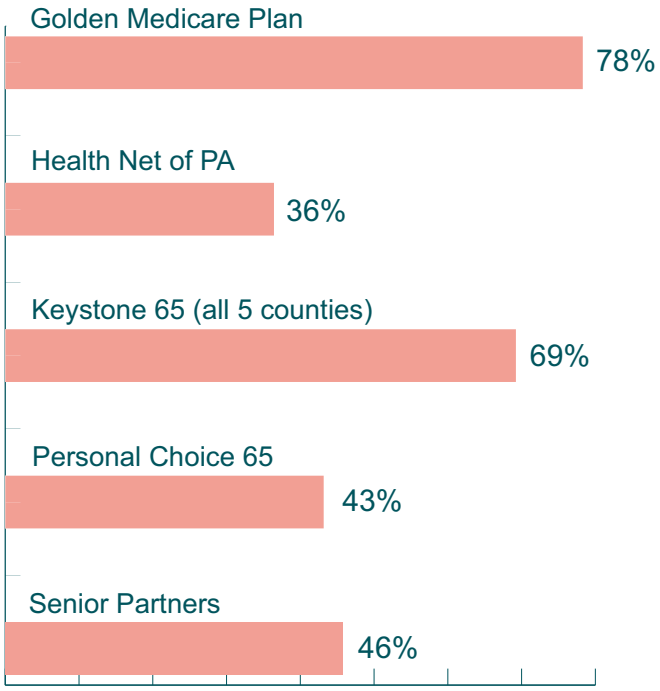
Generally speaking, the higher the percentage, the better the result.

DIABETES

Annual Eye Exams

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

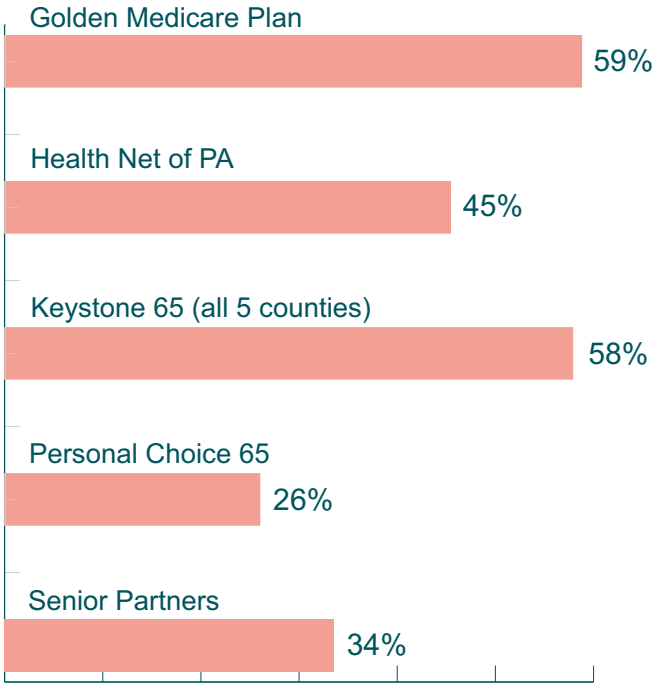
Percent of members with diabetes who received an eye exam within the past year



Monitoring Kidney Disease

Kidney disease is another concern of HMO members with diabetes. Careful monitoring for the presence of kidney disease helps avoid several serious complications that may accompany diabetes.

Percent of members with diabetes who were checked for the beginnings of kidney disease within the past year



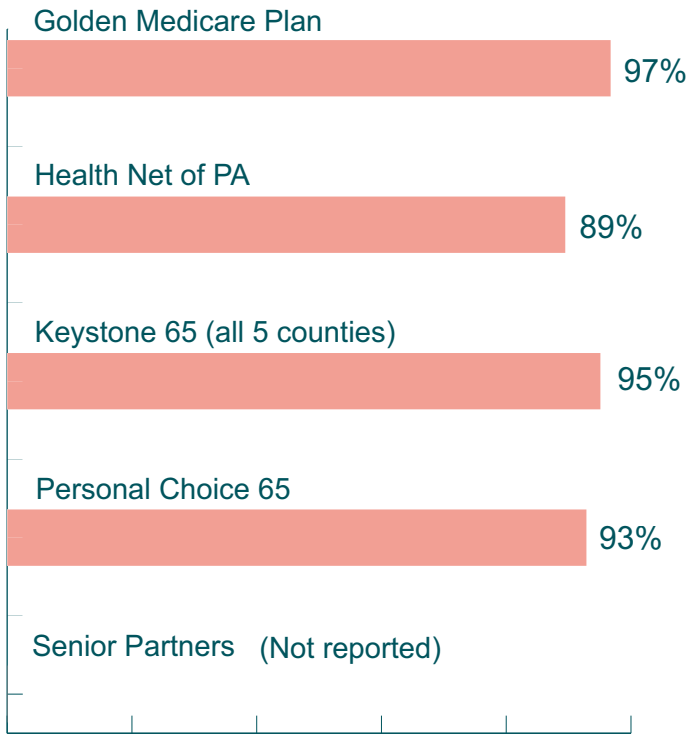
Acute Care

HEART ATTACK

Use of Beta Blockers

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

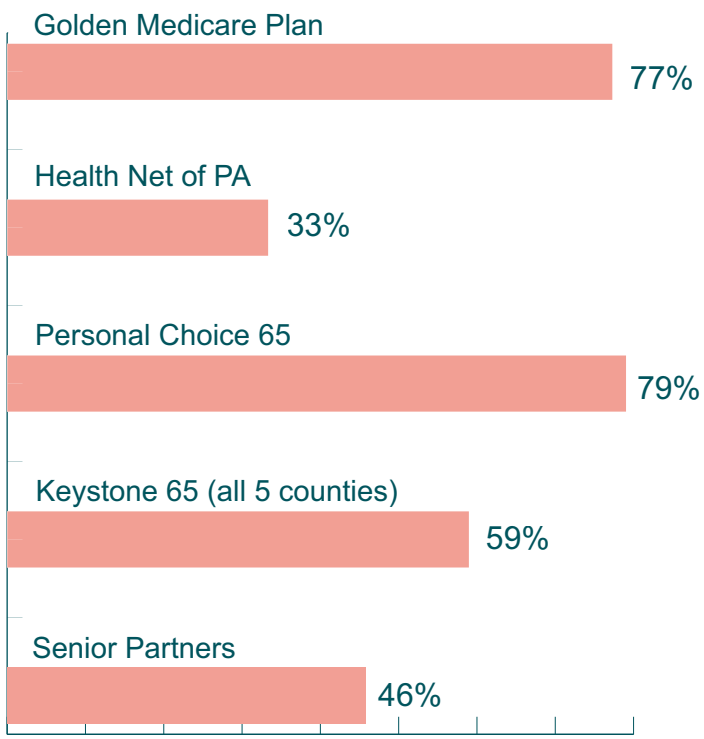


Generally speaking, the higher the percentage, the better the result.

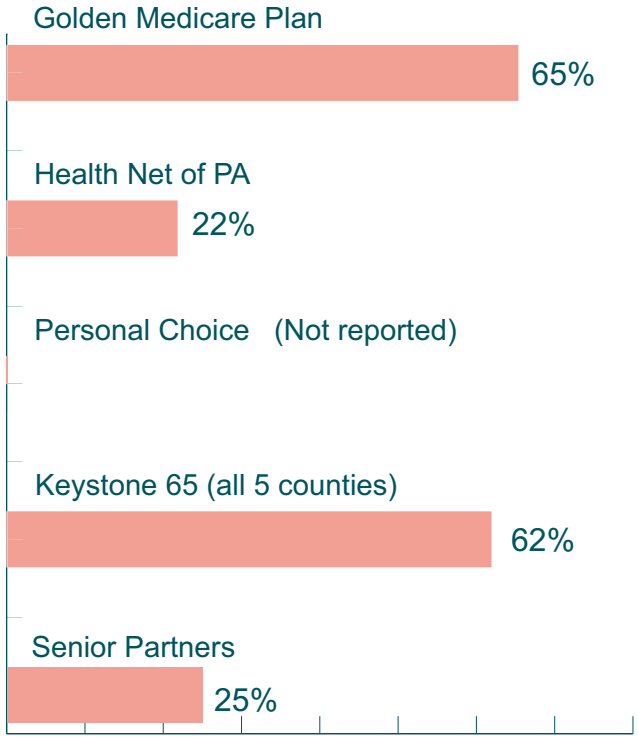
Testing for "Bad" Cholesterol

The level of cholesterol in the blood is directly related to developing heart disease and blocked arteries, which can lead to a heart attack. "Bad" cholesterol is the main cause of this clogging. The first graph shows the percentage of an HMO's members who received a test to measure the level of bad cholesterol during the year 2000. The second graph shows the percentage of the HMO's members whose test showed a bad cholesterol level of less than 130 mg/dL. Any level less than 130 mg/dL decreases the risk to the person, so a higher percentage is a better result.

Percent of members tested for "bad" cholesterol



Percent of members who had a "bad" cholesterol score of less than 130 mg/dL

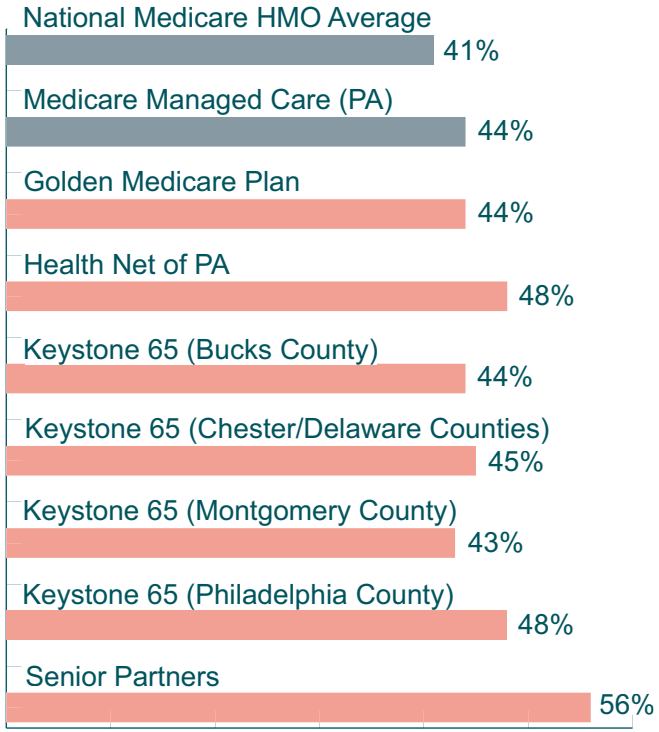


Member Satisfaction

Overall Rating of Plan

The graph below shows the percentage of members who rated their own Medicare HMO as the best possible health plan. Based on all their experiences with their own health plan, they gave their plan a rating of 10 out of 10 (the highest score).

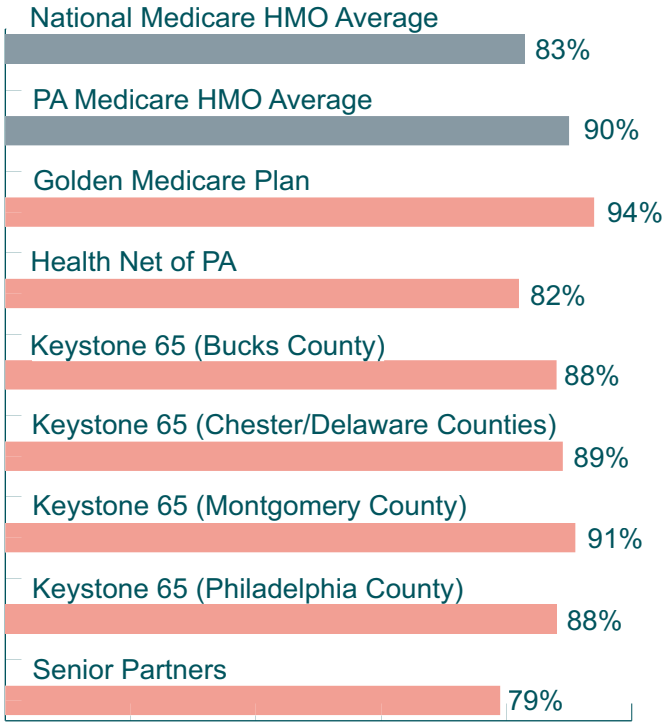
Percent of members who rated their own Medicare HMO as the best possible health plan



Getting a Referral to a Specialist

Most HMOs require you to get a referral from your primary care doctor if you need to see a specialist. The graph below shows how many HMO members said they had no problems getting a referral to a specialist.

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

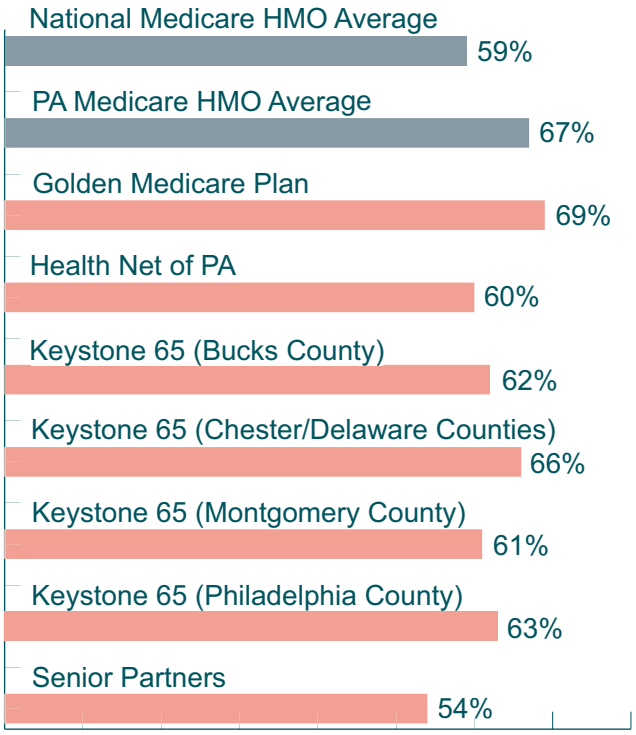


Generally speaking, the higher the percentage, the better the result.

Getting Care Quickly

Members were asked how often, in the past 6 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.

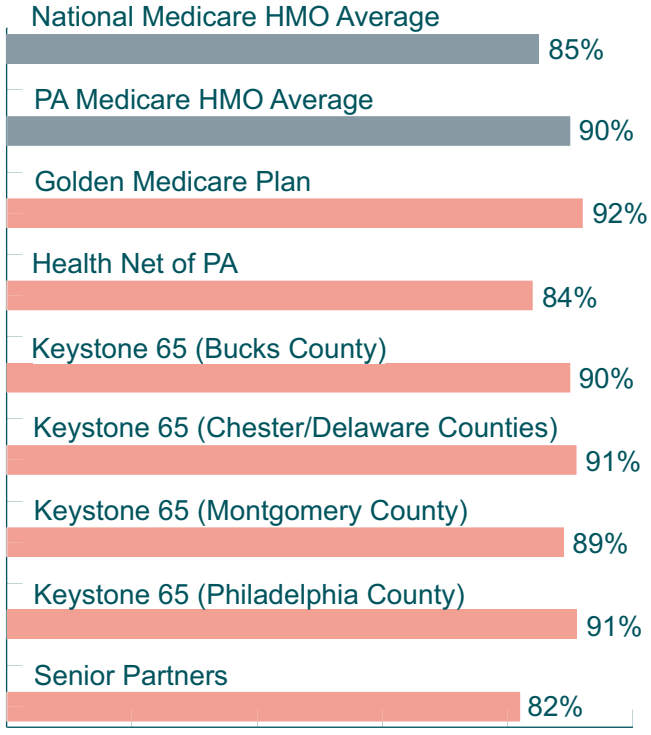
Percent of members who said they always got care when they needed it, without long waits



No Problems Getting Care

Plan members were asked if they had any problems in the past 6 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



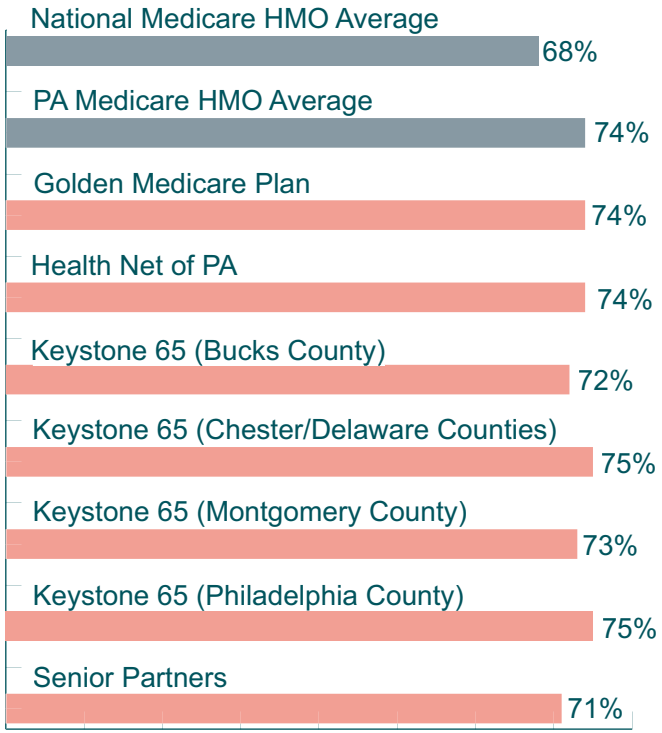
Member Satisfaction

Generally speaking, the higher the percentage, the better the result.

Communication with Doctors

Members answered survey questions that asked them how often, in the last 6 months, doctors in their HMO listened carefully, explained things in a way they could understand, showed respect for what they had to say, and spent enough time with them.

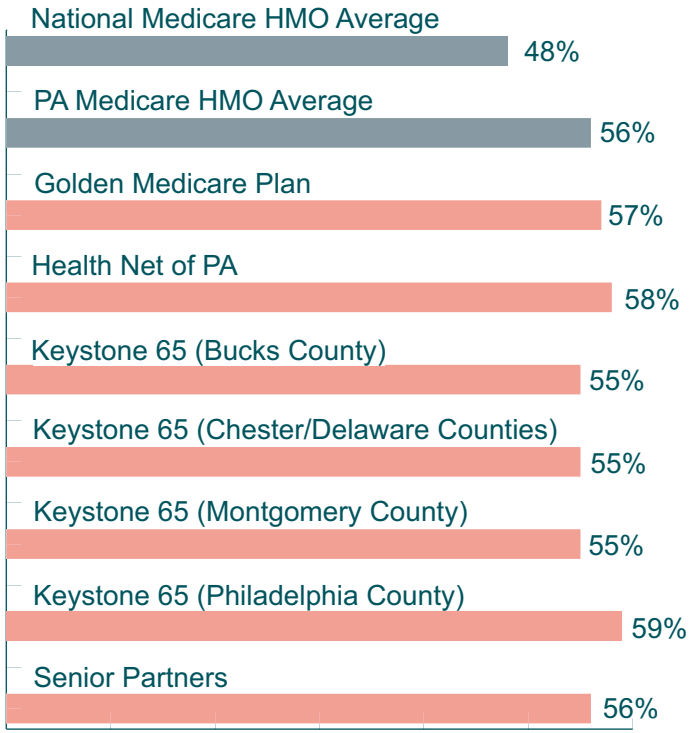
Percent of members who said their doctors in their Medicare HMO always communicated well



Receiving the Best Possible Care

HMO members rated the health care they received in the past 6 months. The graph below shows the percentage of members who gave their personal health care a score of 10 on a scale of 0 (the worst care) to 10 (the best possible care).

Percent of members who rated their own care as the best possible care



Comparing Costs and Benefits of Medicare HMOs

This section provides an overview of Medicare HMO costs and benefits. Contact the HMOs for more detail about the information contained in this section.

For each of the HMOs listed, you still pay the Medicare Part B premium in addition to any premium charged by the plan. For the Year 2002, the Medicare Part B premium will be $54.

What is the cost to you?

	Golden Medicare (Aetna U.S. Healthcare)		Personal Care Plus (AmeriChoice)	WiseChoice of Philadelphia (Health Net of PA)
	Philadelphia City	Philadelphia Suburbs		
Additional Monthly Premium	$80	$62	$0	$0
Primary Care Doctor Co-Payment	You pay $10 to $15 for each office visit for Medicare-covered services.	You pay $20 to $25 for each office visit for Medicare-covered services.	You pay $5 for each office visit for Medicare-covered services.	You pay 20% of the cost of the office visit for Medicare-covered services.
Specialist Visit Co-Payment	You pay $20 for a visit to a specialist for Medicare-covered services IF your primary care doctor referred you.	You pay $25 for a visit to a specialist for Medicare-covered services IF your primary care doctor referred you.	You pay $5 for a visit to a specialist for Medicare-covered services IF your primary care doctor referred you.	You pay 20% of the cost of the visit to a specialist for Medicare-covered services IF your primary care doctor referred you.
Routine Physical Exam	You pay $10 for each exam with one allowed per year.	You pay $20 for each exam with one allowed per year.	You pay $5 per exam with one allowed per year. A doctor's office visit co-payment may also apply.	There is no co-payment for routine physical exams and no limit on the number of exams you may have.
In Hospital Care	There is no co-payment for Inpatient Hospital services at a network hospital. You are covered for unlimited days each benefit period.	You pay $850 for each Medicare-covered stay in a network hospital. You are covered for unlimited days each benefit period.	You are covered for unlimited days each benefit period.	You pay a deductible of $792. You pay $0/day for days 1-60 and $198/day for days 61-90 of a Medicare-covered stay in a network hospital. You are covered for 90-days each benefit period.
Outpatient Surgery	No co-payment for each Medicare-covered visit to an ambulatory surgery center. You pay $20 for each Medicare-covered visit to an outpatient hospital facility.	No co-payment for each Medicare-covered visit to an ambulatory surgery center. You pay $25 for each Medicare-covered visit to an outpatient hospital facility.	No co-payment for each Medicare-covered visit to an ambulatory surgical center or to an outpatient hospital facility.	You pay 20% of the cost for each Medicare-covered visit to an ambulatory surgery center or to an outpatient hospital facility.

	Personal Choice 65 (Independence Blue Cross)	Keystone 65 (Keystone Health Plan East)				Senior Partners
		Standard Plan		Basic Plan		
		Philadelphia City	Philadelphia Suburbs	Philadelphia City	Philadelphia Suburbs	
Additional Monthly Premium	$135	$35	$94	$0	$59	$0
Primary Care Doctor Co-Payment	You pay $10 for each primary care doctor office visit for Medicare-covered services.	You pay $10 for each office visit for Medicare-covered services.		You pay $15 for each office visit for Medicare-covered services.		No co-payment for Medicare-covered services.
Specialist Visit Co-Payment	You pay $25 for a visit to a specialist for Medicare-covered services. You DO NOT need a referral to see a specialist in the network.	You pay $15 for a visit to a specialist for Medicare-covered services IF your primary care doctor referred you.		You pay $20 for a visit to a specialist for Medicare-covered services IF your primary care doctor referred you.		You pay $15 for a visit to a specialist for Medicare-covered services IF your primary care doctor referred you.
Routine Physical Exam	You pay $10 for each exam with one allowed per year.	You pay $10 per exam with one allowed per year.		You pay $15 per exam with one allowed each year.		No co-payment. You are allowed unlimited exams each year.
In Hospital Care	There is no co-payment for Inpatient Hospital services at a network hospital. You are covered for unlimited days each benefit period	No co-payment for services in a network hospital. You are covered for unlimited days each benefit period.		You pay a deductible of $750 with no co-payment for services in a network hospital. You are covered for unlimited days each benefit period.		No co-payment with coverage for 90 days each benefit period.
Outpatient Surgery	You pay $0 for each Medicare-covered visit to an ambulatory surgical center or to an outpatient hospital facility.	You pay $0 for each Medicare-covered visit to an ambulatory surgical center or to an outpatient hospital facility.		You pay $250 for each Medicare-covered visit to an ambulatory surgical center or to an outpatient hospital facility.		There is no co-payment for each Medicare-covered visit to an ambulatory surgical center or to an outpatient hospital facility.

Comparing Benefits

Golden Medicare (Aetna U.S. Healthcare)		Personal Care Plus (AmeriChoice)	WiseChoice for Philadelphia (Health Net of PA)
Philadelphia City	**Philadelphia Suburbs**		
PHARMACY BENEFITS			
No limit on generic drugs. $300 per year limit on brand drugs (on formulary or not).	No pharmacy benefit.	$375 per six months limit on all formulary drugs (generic or brand). NO coverage for drugs not on formulary.	No pharmacy benefit.
Drug Co-Payments		**Drug Co-Payments**	
30-day supply: Generic (formulary OR non-formulary): You pay $15. Formulary brand: You pay $30. Non-formulary brand: You pay $50. ***90-day mail order supply:*** Generic (formulary OR non-formulary): You pay $30. Formulary brand: You pay $60. Non-formulary brand: You pay $100. Check with the HMO for more details and to get a copy of the drugs on the formulary.		***30-day supply:*** Generic: You pay $10. Brand: You pay $20. ***90-day mail order supply***: Generic: You pay $20. Brand: You pay $40. Check with the HMO for more details and to get a copy of the drugs on the formulary.	

Note: This section includes several major benefits offered by the HMOs. All HMOs offer additional benefits such as chiropractic, podiatry, mental health, skilled nursing facility and home health care services. Check with each HMO or the Medicare Web site (www.medicare.gov) for a complete list of benefits and what your costs will be.

Personal Choice 65 (Independence Blue Cross)	Keystone 65 (Keystone Health Plan East)				Senior Partners
	Standard Plan		Basic Plan		
	Philadelphia City	Philadelphia Suburbs	Philadelphia City	Philadelphia Suburbs	
PHARMACY BENEFITS					
No limit on generic drugs, either formulary or non-formulary. No coverage for brand drugs.	You may add prescription drug coverage for an additional premium by selecting one of the following options: **Option 1: You pay $35/month.** Unlimited generic drugs with $10 co-payment and no annual coverage limit. **Option 2: You pay $70/month.** Unlimited generic drugs with $10 co-payment and no annual coverage limit. $15 co-payment for brand drugs on formulary and $25 for brand non-formulary. Brand drugs have a $375 coverage limit every 6 months. **Option 3: You pay $80/month.** Unlimited generic drugs with $10 co-payment and no annual coverage limit. $15 co-payment for brand drugs on formulary and $25 for brand non-formulary. Brand drugs have a $500 coverage limit every 6 months. Contact the HMO for more details and a copy of their formulary.				No limit on formulary generic drugs. Authorization may be required for formulary drugs. Contact the HMO for more details and specific co-payment requirements.
Drug Co-payments					
On plan formulary ***30-day supply:*** Generic: You pay $10. ***90-day mail order supply:*** Generic: You pay $20. **Not on plan formulary** ***30-day supply:*** Generic: You pay $15. Must use designated pharmacies. Check with the HMO for more details.					

Comparing Benefits

Golden Medicare (Aetna U.S. Healthcare)		Personal Care Plus (AmeriChoice)	WiseChoice for Philadelphia (Health Net of PA)
Philadelphia City	**Philadelphia Suburbs**		
VISION SERVICES			
Routine eye exam: You pay $20 (1 per year). Medicare-covered exam (for diagnosis and treatment of eye disease): You pay $20. One pair glasses/contacts after cataract surgery: No co-payment.	Routine eye exam: You pay $25 (1 per year). Medicare-covered exam (for diagnosis and treatment of eye disease): You pay $25. One pair glasses/contacts after cataract surgery: No co-payment.	Routine eye exam: You pay $10 (1 per year). Medicare-covered exam (for diagnosis and treatment of eye disease): You pay $10. HMO pays $150 per year for eyewear, with no co-pay (glasses, contacts, lenses and frames). One pair glasses/contacts after cataract surgery: No co-payment.	Routine eye exam/non-Medicare covered glasses: No coverage Medicare-covered exam (diagnosis/treatment of eye disease): You pay 20% of the cost of the exam. Glasses/contacts after cataract surgery: You pay 20%.
DENTAL SERVICES			
No coverage		Oral exam, including cleanings, fluoride treatment and x-rays: No co-payment.	Oral exam: You pay $3. Cleanings, fluoride, x-rays: No co-payment. Additional benefits also available.
HEARING SERVICES			
Medicare-covered hearing exam: You pay $20. Routine hearing exam (with a limit of one per year): You pay $20. Fitting of hearing aid: No co-payment. $500 allowance over three years for hearing aids. No payment for hearing aids.	Medicare-covered hearing exam: You pay $25. Routine hearing exam (with a limit of one per year): You pay $25. Fitting of hearing aid: No co-payment. $500 allowance over three years for hearing aids. No co-payment for hearing aids.	Medicare-covered hearing exam: You pay $5. Routine hearing exam (with a limit of one per year): You pay $5. Fitting of hearing aid: You pay $5. Each hearing aid: No co-payment for up to one aid every 3 years ($300 allowance for hearing aids over 3 years).	Medicare-covered hearing exam: You pay 20% of the cost of the exam. Routine hearing tests and hearing aids: No coverage.

Personal Choice 65 (Independence Blue Cross)	Keystone 65 (Keystone Health Plan East)				Senior Partners
	Standard Plan		Basic Plan		
	Philadelphia City	Philadelphia Suburbs	Philadelphia City	Philadelphia Suburbs	
VISION SERVICES					
Routine eye exam/ non Medicare-covered glasses: No coverage. Medicare-covered exam (for diagnosis/treatment of eye disease): You pay $25. Glasses/contacts after cataract surgery: No co-payment.	Routine eye exam: You pay $20 (1 every 2 years). Medicare-covered exam (for diagnosis and treatment of eye disease): You pay $20. $100 coverage every 2 years for eye wear. No co-payment for one pair glasses, one pair contacts, one pair lenses, and one pair frames every 2 years.		Routine eye exam: You pay $15 (1 every 2 years). Medicare-covered exam (for diagnosis and treatment of eye disease): You pay $15. $100 coverage every 2 years for eye wear. No co-payment for one pair glasses, one pair contacts, one pair lenses, and one pair frames every 2 years.		Routine eye exam: No co-payment (1 every 2 years). Medicare-covered exam (for diagnosis and treatment of eye disease): No co-payment. There is no co-payment for one pair glasses, one pair contacts, one pair lenses, one pair frames every 2 years.
DENTAL SERVICES					
No coverage.	Oral exam (one every 6 months): You pay $10. Cleanings (one every 6 months): No co-payment.				Oral exam (2 per year): No co-payment. Cleanings (2 per year): No co-payment.
HEARING SERVICES					
Medicare-covered hearing exam: You pay $25. Routine hearing tests and hearing aids: No coverage.	Medicare-covered hearing exam: You pay $15. Routine hearing exam (1 allowed every 3 years): You pay $15. Fitting of hearing aid (1 allowed every 3 years):You pay $15. $500 allowance for hearing aids over 3 years.		Medicare-covered hearing exam: You pay $20. Routine hearing exam (1 allowed every 3 years): You pay $20. Fitting of hearing aid (1 every 3 years): You pay $20. $500 allowance for hearing aids over 3 years.		No co-payment for: Medicare-covered hearing exam. Routine hearing test. Hearing aids (1 every 3 years). $500 allowance for hearing aids every 3 years.

Company Profiles

	Medicare Enrollment January 2001	Percent Change in Enrollment from January 2000	Percent of Appeals Settled in Favor of Member	NCQA Accreditation Status
Aetna U.S. Healthcare *	108,599	-19.1%	13.1%	Excellent
AmeriChoice	1,205	New plan in 2000	Too new	Commendable
Health Net of PA	8,241	-22.0%	50.0%	Not Accredited
Independence Blue Cross (PPO)	15,057	27.0%	21.4%	Full
Keystone Health Plan East	126,302	1.0%	18.3%	Excellent
Senior Partners	8,531	103.7%	NA**	Commendable
**** Enrollment listed for Aetna is statewide.***	This is the total number of members in each Medicare HMO as of January 31, 2001.	This is the change in each HMO's enrollment from the previous year.	This figure shows the percentage of appeals for denial of care or payment that were decided in favor of the member who filed the appeal.	National Committee for Quality Assurance (NCQA) is a non-profit agency that rates the overall quality of HMOs. **Excellent** is the highest rating given to HMOs; **Commendable** is the next highest. **Full** is the highest rating given to PPO plans. Check www.ncqa.org for the latest status.

*** Not applicable. Sample size too small.*

Important Questions...

...to ask yourself

- What will my "out of pocket" expenses (such as co-pays 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 HMO network convenient for me?
- Is (are) my preferred hospital(s) in the HMO's network?
- If I travel or spend several months in a second home, will the HMO 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 HMO's network?
- Do I live in an area where the long-term care facilities are part of an HMO network?

...to ask your doctor or HMO

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

Company Contact Phone Numbers

For more details about the HMOs in this booklet, contact:

Aetna U.S. Healthcare	1-800-832-2640
AmeriChoice	1-800-692-9105
Health Net of PA	1-800-747-1823
Independence Blue Cross	1-877-393-6733
Keystone Health Plan East	1-877-393-6733
Senior Partners	1-888-667-7367

Agencies Providing Information for Seniors

Medicare 1-800-633-4227 *Web site: www.medicare.gov*
U.S. Government hotline for information about the Medicare program

APPRISE 1-800-783-706 *Web site: www.aging.state.pa.us*
Help for Pennsylvanians on health insurance, from the Pennsylvania Department of Aging

Social Security Administration 1-800-772-1213

Pennsylvania Department of Public Welfare Help Line
1-800-692-7462
Financial assistance programs for low-income seniors

Legal Hotline for Older Americans 1-800-262-5297
A non-profit agency providing legal advice for seniors

Medicare Fraud and Abuse Hotline 1-800-447-8477
To report cases of abuse of the Medicare billing program

Pharmaceutical Assistance (PACE) 1-800-225-7223
State program to provide financial assistance for seniors' prescription drugs
(Hearing Impaired) 1-800-222-9004

Veterans Affairs (Benefits Information) 1-800-827-1000
Provides information and programs to military veterans

Alzheimer's Association 1-800-272-3900

Pennsylvania Dental Association 1-800-692-7256
Information on programs providing dental care for seniors

American Diabetes Association
1-800-DIABETES (1-800-342-2383) *Web site: www.diabetes.org*
Support and information for seniors with diabetes

AARP Pennsylvania 1-717-238-2277 *Web site: www.aarp.org*
Advocacy group for older Americans

Pennsylvania Health Care Cost Containment Council
Marc P. Volavka, Executive Director
225 Market Street, Suite 400
Harrisburg, PA 17101
Phone: 717-232-6787
Fax: 717-232-3821
Web site: www.phc4.org

Pennsylvania Department of Aging
Richard Browdie, Secretary
555 Walnut Street, 5th floor
Harrisburg, PA 17101-1919
Phone: 717-783-1550
Fax: 717-783-6842
Web site: www.aging.state.pa.us