Choosing a Medicare Managed Care Plan

A Guide for Medicare Beneficiaries

PHC4

Pennsylvania Health Care Cost Containment Council

Comparing Costs and Benefits

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

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This guide covers the Medicare Managed Care Plans (also known as Medicare Advantage), including Health Maintenance Organizations (HMOs), Point of Service (POS) Plans, and Preferred Provider Organizations (PPOs). This guide includes plans that were available at the time of publication; additional plans and products may be offered in 2007.

This guide ***does not include*** other Medicare options such as Private Fee-For-Service (PFFS) Plans, Special Needs Plans (SNP), Medical Savings Account (MSA) Plans, and Medigap/Medicare Supplement Insurance.

Check with the Pennsylvania APPRISE Health Insurance Counseling Program at 1-800-783-7067 for more information. APPRISE is a program sponsored by the Pennsylvania Department of Aging that provides assistance in understanding Medicare benefits and helping you select the best plan for your situation.

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

About Medicare Managed Care Plans

What is the purpose of this booklet?

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

- provides information about Managed Care Plans and how their coverage differs from Original Medicare,
- discusses the "Part D" prescription drug benefit,
- compares the services offered by different Managed Care Plans, and
- gives you guidance on who can answer any specific questions you have while making your decision.

Medicare Basics

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease. Most people get their Medicare health care coverage in one of two ways:

Original Medicare Plan

Part A (Hospital)	Part B (Medical)
Medicare provides Part A. Part B is optional – it covers doctors' services, outpatient care, and other services. You can go to any doctor or hospital that accepts Medicare.	

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Part D (Prescription Drug)

You can choose this coverage by selecting a stand-alone drug plan offered by private companies.

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Medigap Policy (Medicare Supplement Insurance)

You can choose to buy coverage from private companies (or an employer/union may offer similar coverage) to fill gaps in Part A and Part B.

OR

Medicare Managed Care Plan

Called "Part C," this option combines Part A (Hospital) and Part B (Medical)

Medicare-approved private companies provide this coverage. For many plans, generally there are extra benefits than in Original Medicare Plan. However, you may have to go to certain doctors and hospitals that belong to your plan's network.

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Part D (Prescription Drug)

Many, but not all, Medicare Managed Care Plans cover prescription drugs. You can choose this coverage by selecting a plan *with* drug benefits.

About Medicare Managed Care Plans

What is a Medicare Managed Care Plan?

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

Among the different types of Medicare Managed Care Plans offered are:

- Health Maintenance Organizations (HMOs) Plans,
- Point of Service (POS) plans, and
- Preferred Provider Organizations (PPOs) Plans.

These plans are described on page 7.

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

Yes. A Medigap policy (also known as Medicare Supplement Insurance) 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, Part D prescription drug coverage and other health insurance issues. APPRISE can also assist you in completing health insurance paperwork and forms or in resolving problems you encounter with billing and other issues. APPRISE provides objective, easy-to-understand information about your health insurance options. All services are free, and your information is kept confidential. Services are provided through 52 local Area Agencies on Aging, serving all 67 counties in Pennsylvania. Call 1-800-783-7067 to locate your nearest APPRISE counseling site.

About Medicare Managed Care Plans

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:

- ***Cost***

Most people will pay the standard monthly Medicare Part B premium, which is $93.50 in 2007. This amount may be higher if you didn't sign up for Part B when you first became eligible. Beginning January 1, 2007, your Part B premium will be based on income and therefore, some people will pay a higher premium. To get the 2007 rates, visit www.medicare.gov or call 1-800-MEDICARE. A few plans may pay all or part of your Part B premium for you, while some plans may charge an additional premium to belong to their plan. You may also be responsible for out-of-pocket costs, such as a copayment or coinsurance each time you visit a doctor or go to the hospital. These costs will vary from plan to plan. You will maximize your coverage by using doctors and hospitals 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.

- ***Benefits***

Managed Care Plans may offer extra benefits like vision, dental and/or hearing benefits.

- ***Doctor and hospital choice***

In a Managed Care Plan, you will receive most of your care from doctors, hospitals and other providers that are in your plan's "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. If you have out-of-network provider benefits, you are able to use doctors and hospitals that are not part of the plan's provider network for an additional cost.

- ***Drug coverage***

Some Medicare Managed Care Plans include prescription drug coverage. If you join a plan and it offers this coverage, you must take the drug coverage your plan offers. If you join a stand-alone drug plan, you will be automatically disenrolled from your Medicare Managed Care Plan and returned to the Original Medicare Plan. To pick a plan that best meets your needs, you will need to consider:

- Costs – compare monthly premiums, price for each of your prescriptions, and total out-of-pocket expenses.

About Medicare Managed Care Plans

- Formulary – check to see if the drugs you take are covered by the plan.
- Pharmacy network – check to see if your local pharmacy is in the plan's network.

- ***Quality of care***

Quality information about the plans included in this report begins on page 18. Additional information about health plans, hospitals, and physicians can be found at www.phc4.org.

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 will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area. 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. However, if you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan. To join a plan, request an enrollment form from the Managed Care Plan you choose, then complete and return the form to the plan. The toll-free telephone phone number for each plan is listed on page 28.

When can I join one of these plans?

1. **Initial Enrollment Period** – You can join when you first become eligible for Medicare (three months before the month you turn age 65 until three months after the month you turn age 65). If you qualify for Medicare due to a disability, you can join from three months before to three months after your 25th month of cash disability payments.

2. **Annual Enrollment Period** – Generally, if you didn't join when you were first eligible, you can join between November 15 - December 31, 2006. Your coverage will begin on January 1 if you join a Managed Care Plan during this time. In special circumstances, you may be able to join a Managed Care Plan at other times, such as if you move out of the plan's service area or have Medicaid.

3. **Open Enrollment Period** – During the open enrollment period from January 1 – March 31, 2007, you may generally make one change in how you receive your Medicare medical (doctor and hospital) and prescription drug coverage. You are limited to the type of current coverage whereby you can't add or drop

About Medicare Managed Care Plans

Medicare prescription drug coverage during this time. If you have a Medicare Managed Care Plan with prescription drug coverage, you can enroll in a new plan with drug coverage or return to Original Medicare and choose a stand-alone drug plan. If you have a Medicare Managed Care Plan that does not have drug coverage, then you can choose a new plan without drug coverage or return to Original Medicare only. If you have Original Medicare and a stand-alone drug plan, then you can enroll in a Medicare Managed Care Plan with drug coverage, but cannot switch to a different stand-alone drug plan or to a Medicare Managed Care Plan without drug coverage.

How do I switch my Medicare Managed Care Plan to a new plan?

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 will get a letter from your new plan confirming your enrollment.

Penalty for late enrollment into a prescription drug plan

With some exceptions, there is a penalty for signing up for drug coverage after you first are eligible for Medicare. The penalty is a higher premium – an extra 1% of the national average premium for each month (or 12% for each year) – that you delay in enrolling. Medicare recipients will not incur a penalty for delayed enrollment if they currently have comparable coverage – also known as creditable coverage – from another source. If you qualify for extra help, the penalty will be different. For assistance with figuring out penalty amounts, contact APPRISE at 1-800-783-7067.

Words to Know

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

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

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

Deductible – The amount you must pay for certain health care services before your Managed Care Plan begins to pay.

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

Health Maintenance Organization (HMO) – A Managed Care Plan option that is available in some service areas. You can only go to doctors, hospitals or other providers that belong to the plan's network except in an emergency. A referral from your primary care doctor is required to see a specialist provider.

Point of Service (POS) – A Managed Care Plan option that is similar to an HMO, but allows you to go to other doctors and hospitals that are not a part of the plan (out-of-network) for an additional cost. You can also see a specialist provider without a referral but for an additional cost.

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. You can use doctors, hospitals or other providers that are not a part of the plan (out-of-network) for an additional cost.

Appeal Rights

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

Medicare Managed Care Plans with Prescription Drug Coverage

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

- Drug coverage is offered to everyone with Medicare. No one can be denied based on income level, health reasons or current prescription drug costs.
- The program is voluntary. If you already have good coverage through another program, you do not need to enroll.
- There is additional help for people with limited incomes (less than $14,700 a year for a single person or $19,800 for a married couple in 2006). Amounts will change in early 2007.
- There is no single Medicare drug plan. You must enroll in one of the Medicare-approved drug plans offered by private companies. These plans vary by what drugs are covered and how much you will have to pay.
- If you decide not to enroll in a Medicare Part D plan when you are first eligible, you may pay a penalty if you choose to join later.

How does the program work?

To participate, you must enroll in one of the Medicare-approved private drug plans. These plans vary in terms of drugs covered and monthly premiums paid. However, each plan must meet a **minimum standard** set by law, which is outlined in the following section. Still, you will have to carefully compare your options.

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

- A "stand-alone" plan that only covers prescription drugs. Joining this type of plan enables people to get their other Medicare benefits through the Original Medicare Plan and Medigap policies.
- A comprehensive Medicare Managed Care Plan that covers both prescription drugs and other medical care.

What are the costs and benefits of the program?

If you are currently taking prescription drugs or you may need to in the future, Medicare Part D will protect you from very high costs. It is important to know that drug prices are not the same for every plan. Each participating plan negotiates directly with the drug manufacturers to get discounts on the drugs they purchase. Also remember that plans can change their formulary lists of covered drugs, and can impose other restrictions, such as changing the drugs that require prior authorization. While expenses vary by plan, the **minimum standards** set by law includes the following components:

Monthly Premium

The premium is the amount you pay each month to receive drug coverage. While some plans will charge more and others less, Medicare estimates

an average premium of about $27 a month for standard drug coverage in 2007. Each person must pay an individual premium as there are no discounts for married couples. You will pay one monthly premium to your Medicare Managed Care Plan for your doctor, hospital, and drug benefits *in addition* to the monthly premium for Medicare Part B.

Annual Deductible

The amount you pay in out-of-pocket costs before your drug coverage kicks in to pay for your expenses is called the deductible. In 2007, deductibles are capped at $265. You will not have to pay more than this amount in a deductible, and some plans may set lower deductibles or not require one at all.

Copayment/Coinsurance

After you meet your annual deductible, most plans will cover 75% of the next $2,135 of your drug costs, and you will pay for 25%. With this type of initial coverage, the plan would pay for $1,601.25, and you would pay $533.75 in copayments and coinsurance amounts. However, some plans will offer a different coinsurance formula, instead of the 75-25 split, and will have varying copayment amounts.

Coverage Gap

After the initial level of benefits, there is a gap in coverage, known as the "donut hole." This gap begins once you have met your $265 deductible and reached the $2,135 threshold (of which your plan paid for 75% of your drug costs). This gap means that your plan will pay nothing toward your next $3,051.25 in drug costs. Unless you have extra coverage from another program, you will be responsible for 100% of the drug costs during this gap. A few plans may eliminate the coverage gap for generic drugs, or in limited cases, some brand name drugs – typically at a higher premium. However, you will probably have to pay a small copayment or coinsurance amount. Still, it is important to point out that people with limited income may qualify for additional help.

Catastrophic Coverage

Once your drug costs go above the coverage gap, your "catastrophic" coverage begins. Under the standard drug benefit for 2007, catastrophic coverage begins after you have spent $3,850 in out-of-pocket drug costs throughout a calendar year. This $3,850 does not include the amount you have spent on premiums, but it does include your deductible ($265), coinsurance ($533.75), and your expenses during the coverage gap ($3,051.25).

At this level, you will pay 5% of your prescription drug costs, or a $2.15 copay for generic drugs and a $5.35 copay for brand name drugs – whichever is higher. Your drug plan will pay 95% of your drug costs for the rest of the calendar year. There is no limit to this catastrophic coverage in one year. However, it is important to remember that you must reach this catastrophic limit each year.

Medicare Managed Care Plans with Prescription Drug Coverage

It is important to note that the Plan benefits may change from year to year.

The deductible, the initial amount of drug charges the plan covers (after which the plan stops helping with drug costs), and the amount that you pay to qualify for catastrophic coverage could all increase. Remember, that a plan may not cover all of the drugs you take. If the plan you are considering does not cover all of your medications, talk to your doctor and find out if it is possible to switch to a drug that is covered. If switching is not an option, talk to a plan representative about whether you are eligible for an exception. Medicare's Web site (www.medicare.gov) will allow you to compare the plans point by point.

What if I already have drug coverage from another source?

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

Current Job or Retiree Benefit

Your current/former employer or union may change its drug coverage because of the Medicare drug program. Employers and unions can offer coverage that takes the place of the Medicare prescription drug coverage or adds to it. Before you enroll in a Medicare drug plan, you should get information from your employer or union about how your drug coverage through them may change. Remember, if you drop your employer or union coverage, you may not be able to rejoin it later.

State Pharmacy Assistance Program (PACE)

PACE and PACENET cardholders are given the option to enroll in a Medicare prescription drug plan. They can remain enrolled in PACE or PACENET and enroll in Part D at the same time. Individuals enrolled in the two programs receive comprehensive prescription drug benefits and have an opportunity to save money on their medication costs. If you are enrolled in PACE and Part D, PACE will pay your Part D monthly premium, up to the regional average benchmark, for you. The program will also cover any deductibles, medications the plan does not cover, and also cover any copayments in excess of the PACE copayments. If you are enrolled in PACENET and Part D, you will receive the same benefits, except you will pay the Part D premium to the plan. In this instance, however, you will not have to pay the PACENET deductible at the pharmacy. For more information, call PACE/PACENET at 1-800-225-7223.

Medicare Managed Care Plans with Prescription Drug Coverage

Veterans or Military Retiree Drug Benefits

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

Manufacturer's Patient Assistance Program

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

Low-Cost Drugs from Canada or Other Countries

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

Is there extra help for people with limited incomes?

Medicare provides extra financial help to pay prescription drug costs for people with limited incomes and assets. For 2006, a single person with income less than $14,700 a year and assets below $11,500 (or a married couple with income less than $19,800 and assets below $23,000) may qualify for extra help. Amounts will change in early 2007. If you have dependent children or grandchildren living with you, you may be able to earn more and qualify. Assets include bank accounts, stocks, bonds, and life insurance policies. They do not include the house you live in, cars and other personal possessions.

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

Where do I go for more information?

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

Medicare Managed Care Plans with Prescription Drug Coverage

2007 Payments Under Medicare Part D

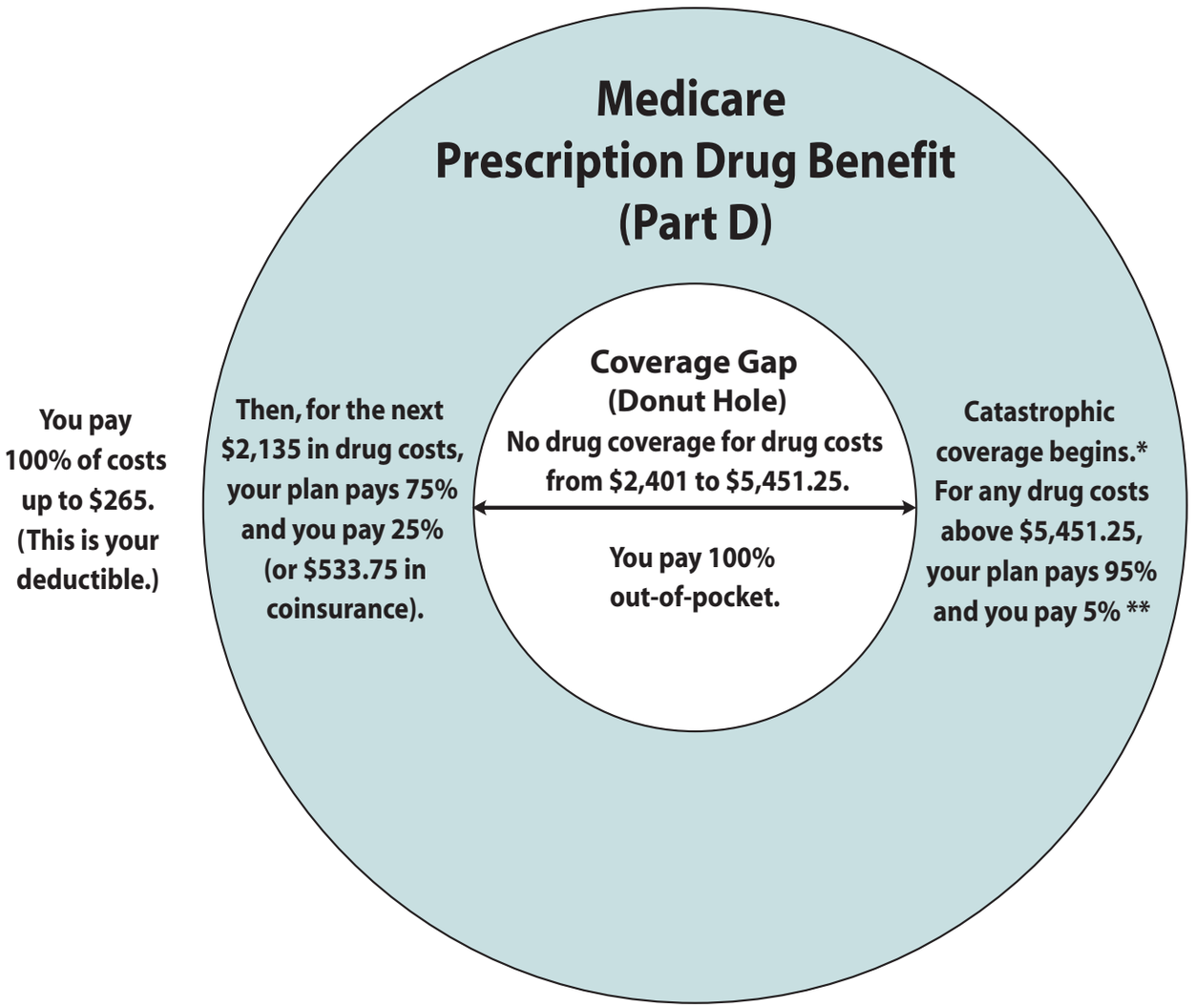
The following chart shows what the average person can expect under a standard Medicare plan. Please note that it does not include the amount you will pay in monthly premiums or take into account additional drug coverage that you may have. Remember, out-of-pocket costs may vary by Medicare drug plan.

Prescription Drug Spending *	Medicare-Approved Plan Pays	You Pay *
$0-$265	$0	Up to $265 Deductible
$266-$2,400	75% of drug costs – Up to $1,601.25	25% of drug costs – Up to $533.75
$2,401-$5,451.25 Coverage Gap/Donut Hole	0% of drug costs – $0	100% of drug costs – Up to $3,051.25
Subtotal:	Up to $1,601.25	Up to $3,850 out-of-pocket
Over $5,451.25 (Catastrophic Benefit)	95%	5% or $2.15 copay/generic, $5.35 copay/brand name, whichever is higher

* if you have no drug coverage other than Medicare

Medicare Managed Care Plans with Prescription Drug Coverage

In addition to an average monthly premium of about $27 (estimated by Medicare), you will have other out-of-pocket costs.



This chart identifies out-of-pocket costs for the **minimum standard benefit** in 2007. Out-of-pocket costs may vary by Medicare drug plan.

* Catastrophic coverage begins after you have spent $3,850 out-of-pocket, including:
  - Deductible ($265)
  - Coinsurance ($533.75)
  - Expenses during coverage gap ($3,051.25)

** or $2.15 copay for generic, $5.35 for brand name, whichever is higher.

Available Medicare Managed Care Plans

by County

	Adams	Allegheny	Armstrong	Beaver	Bedford	Berks	Blair	Bradford	Bucks	Butler	Cambria	Cameron	Carbon	Centre	Chester	Clarion	Clearfield
Aetna Health, Inc. Golden Medicare						✓			✓						✓		
Aetna Life Insurance Company Golden Choice PPO									✓						✓		
Capital Advantage Insurance Company SeniorBlue PPO	✓					✓								✓			
Geisinger Health Plan Geisinger Gold						✓	✓				✓		✓				✓
Geisinger Health Plan Geisinger Gold Preferred PPO							✓				✓		✓				✓
HealthAmerica Pennsylvania, Inc. Advantra		✓	✓	✓		✓				✓				✓			
HealthAssurance Pennsylvania, Inc. Advantra PPO		✓															
Health Partners Senior Partners																	
Highmark, Inc. FreedomBlue PPO	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓				✓	✓
Humana Insurance Company HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO									✓						✓		
Keystone Health Plan Central, Inc. SeniorBlue						✓								✓			
Keystone Health Plan East, Inc. Keystone 65									✓						✓		
Keystone Health Plan West, Inc. SecurityBlue		✓	✓	✓	✓		✓			✓	✓						
Unison Health Plan of Pennsylvania, Inc. Unison Advantage	✓	✓	✓	✓		✓	✓			✓	✓					✓	
UPMC Health Network For Life PPO		✓	✓	✓	✓		✓			✓	✓						
UPMC Health Plan For Life HMO		✓	✓	✓	✓		✓			✓	✓						✓

Available Medicare Managed Care Plans

by County

	Clinton	Columbia	Crawford	Cumberland	Dauphin	Delaware	Elk	Erie	Fayette	Forest	Franklin	Fulton	Greene	Huntingdon	Indiana	Jefferson
Aetna Health, Inc. Golden Medicare						✓										
Aetna Life Insurance Company Golden Choice PPO						✓										
Capital Advantage Insurance Company SeniorBlue PPO		✓		✓	✓						✓	✓				
Geisinger Health Plan Geisinger Gold	✓	✓		✓	✓									✓		
Geisinger Health Plan Geisinger Gold Preferred PPO	✓	✓			✓									✓		
HealthAmerica Pennsylvania, Inc. Advantra				✓	✓			✓	✓				✓			
HealthAssurance Pennsylvania, Inc. Advantra PPO					✓				✓				✓			
Health Partners Senior Partners																
Highmark, Inc. FreedomBlue PPO			✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓
Humana Insurance Company HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO						✓										
Keystone Health Plan Central, Inc. SeniorBlue		✓		✓	✓											
Keystone Health Plan East, Inc. Keystone 65						✓										
Keystone Health Plan West, Inc. SecurityBlue			✓					✓	✓				✓		✓	
Unison Health Plan of Pennsylvania, Inc. Unison Advantage				✓	✓			✓	✓				✓		✓	✓
UPMC Health Network For Life PPO			✓					✓	✓						✓	✓
UPMC Health Plan For Life HMO			✓					✓	✓				✓		✓	✓

Available Medicare Managed Care Plans

by County

	Juniata	Lackawanna	Lancaster	Lawrence	Lebanon	Lehigh	Luzerne	Lycoming	McKean	Mercer	Mifflin	Monroe	Montgomery	Montour	Northampton	Northumberland	Perry
Aetna Health, Inc. Golden Medicare						✓						✓	✓		✓		
Aetna Life Insurance Company Golden Choice PPO						✓						✓	✓		✓		
Capital Advantage Insurance Company SeniorBlue PPO	✓		✓		✓	✓					✓			✓	✓	✓	✓
Geisinger Health Plan Geisinger Gold	✓	✓	✓		✓		✓	✓			✓	✓		✓		✓	✓
Geisinger Health Plan Geisinger Gold Preferred PPO	✓	✓	✓		✓		✓	✓			✓	✓		✓			
HealthAmerica Pennsylvania, Inc. Advantra			✓	✓	✓	✓				✓					✓		✓
HealthAssurance Pennsylvania, Inc. Advantra PPO			✓	✓	✓												
Health Partners Senior Partners																	
Highmark, Inc. FreedomBlue PPO		✓	✓	✓	✓	✓	✓		✓	✓					✓		✓
Humana Insurance Company HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO													✓				
Keystone Health Plan Central, Inc. SeniorBlue	✓					✓					✓			✓	✓	✓	✓
Keystone Health Plan East, Inc. Keystone 65													✓				
Keystone Health Plan West, Inc. SecurityBlue				✓						✓							
Unison Health Plan of Pennsylvania, Inc. Unison Advantage		✓	✓	✓		✓	✓			✓					✓		✓
UPMC Health Network For Life PPO				✓						✓							
UPMC Health Plan For Life HMO				✓						✓							

Available Medicare Managed Care Plans

by County

	Philadelphia	Pike	Potter	Schuylkill	Snyder	Somerset	Sullivan	Susquehanna	Tioga	Union	Venango	Warren	Washington	Wayne	Westmoreland	Wyoming	York
Aetna Health, Inc. Golden Medicare	✓			✓													
Aetna Life Insurance Company Golden Choice PPO	✓			✓													
Capital Advantage Insurance Company SeniorBlue PPO				✓	✓					✓							✓
Geisinger Health Plan Geisinger Gold				✓	✓		✓	✓		✓						✓	✓
Geisinger Health Plan Geisinger Gold Preferred PPO				✓	✓					✓						✓	
HealthAmerica Pennsylvania, Inc. Advantra													✓		✓		
HealthAssurance Pennsylvania, Inc. Advantra PPO															✓		
Health Partners Senior Partners	✓																
Highmark, Inc. FreedomBlue PPO			✓			✓					✓	✓	✓		✓		✓
Humana Insurance Company HumanaChoice PPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence Blue Cross Personal Choice 65 PPO	✓																
Keystone Health Plan Central, Inc. SeniorBlue				✓	✓					✓							
Keystone Health Plan East, Inc. Keystone 65	✓																
Keystone Health Plan West, Inc. SecurityBlue						✓							✓		✓		
Unison Health Plan of Pennsylvania, Inc. Unison Advantage				✓		✓							✓		✓		✓
UPMC Health Network For Life PPO						✓					✓		✓		✓		
UPMC Health Plan For Life HMO						✓					✓		✓		✓		

Comparing Quality

Key Quality Measures

Staying Healthy ..... Pages 18-19

A Managed Care Plan covers services for prevention or early detection of health problems, usually at little or no cost to the members. The graphs can help you evaluate how well the Managed Care Plans are providing preventive care to help their members stay healthy. Generally, Managed Care Plans with a higher percentage score are doing a better job of providing preventive care.

Managing Ongoing Illnesses..... Pages 20-21

Three graphs show how well the Managed Care Plans are helping their members with diabetes to manage their condition. One graph on page 21 shows how well plans encourage the use of "beta blocker" medication to prevent future heart attacks. Generally, Managed Care Plans with a higher percentage score are doing a better job of providing services to manage ongoing illnesses.

Member Satisfaction ..... Pages 22-23

These graphs show several member satisfaction measures from the annual Consumer Assessment of Health Plans Survey®.

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

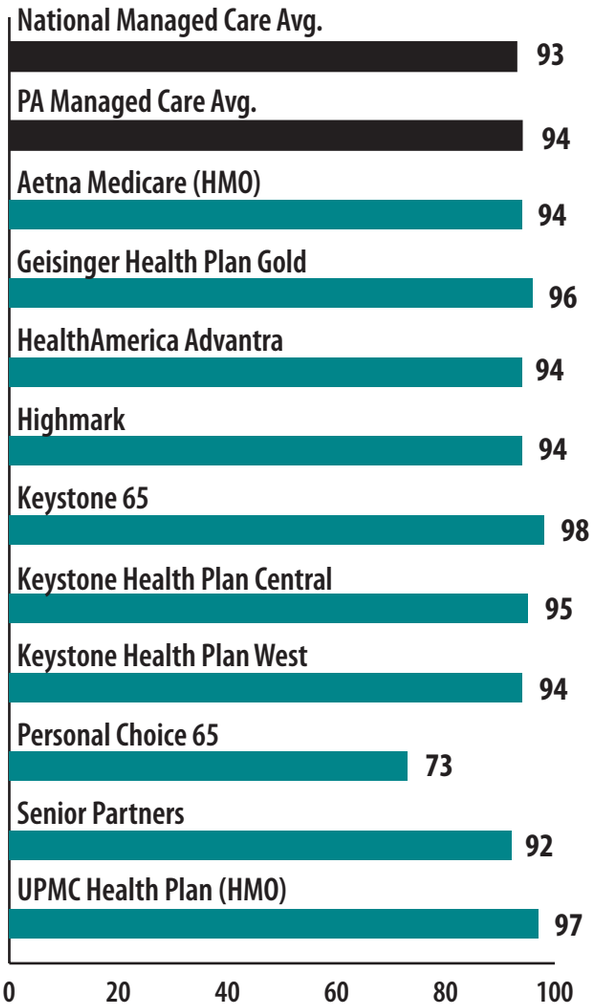
Some plans offering coverage in 2007 are not included in this section because they were too new to provide data or the data was not available.

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

Visits to the Doctor

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

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

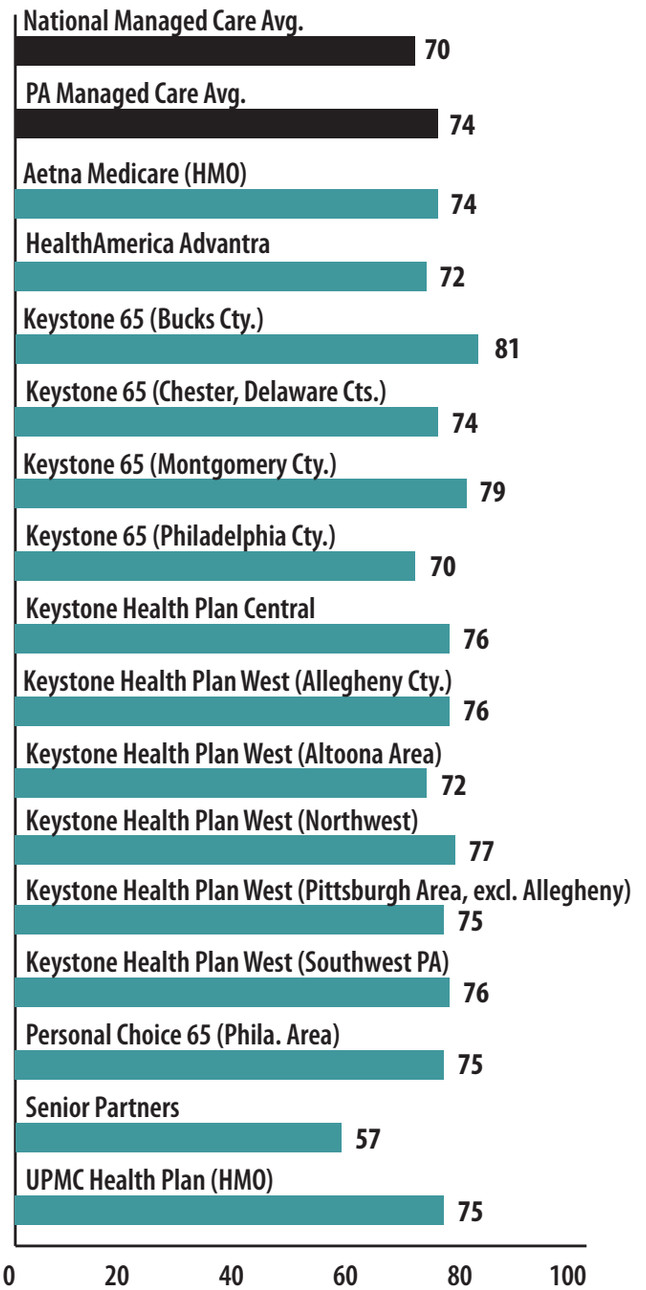


Comparing Quality

Flu Shots

The flu, also called influenza, is a highly contagious respiratory infection. People over 65 are at a higher risk of having medical problems from the flu and should receive a flu shot annually.

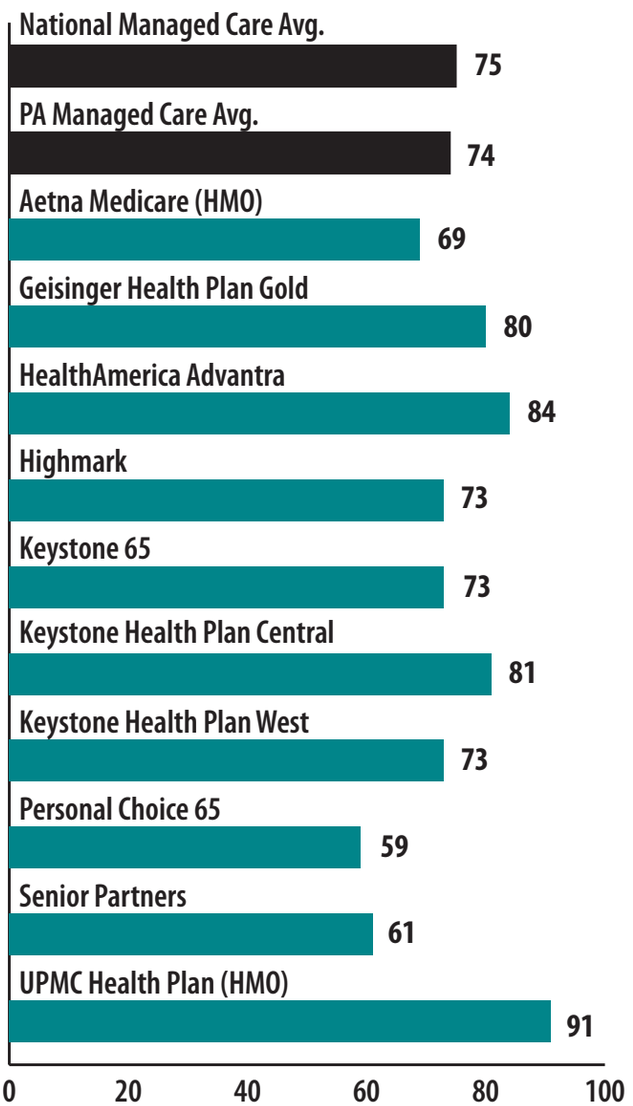
Percent of members over age 65 who received flu shots in a year



Breast Cancer Screening

A mammogram (x-ray of the breast) can help find cancer in the breast when the tumor is too small to be felt. When breast cancer is found early, it is more likely to be treated successfully. Medicare covers one screening mammogram every 12 months for women age 40 and older.

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

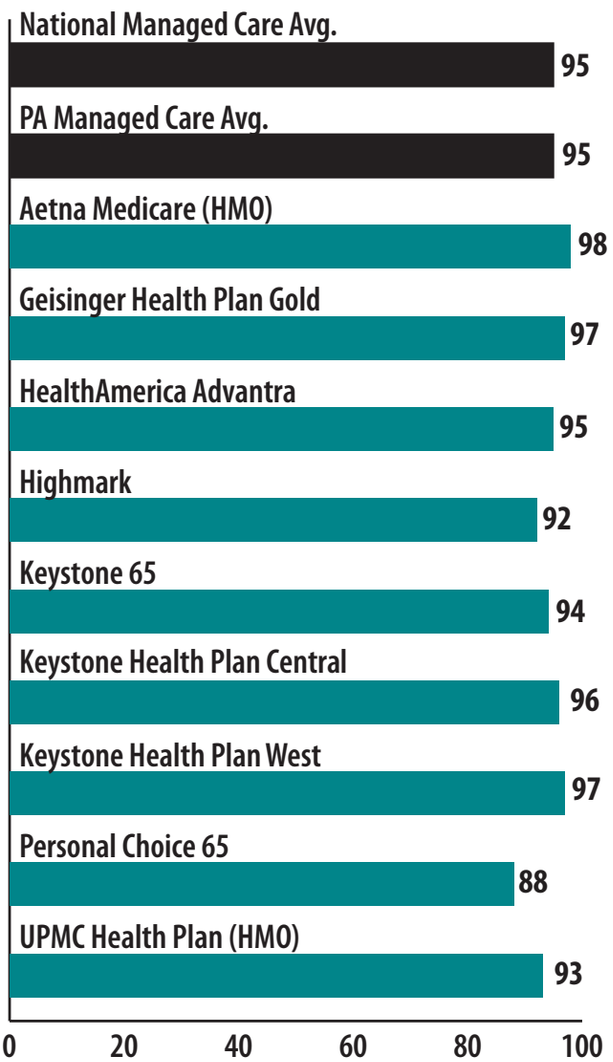


Comparing Quality

Cholesterol testing for members with diabetes

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

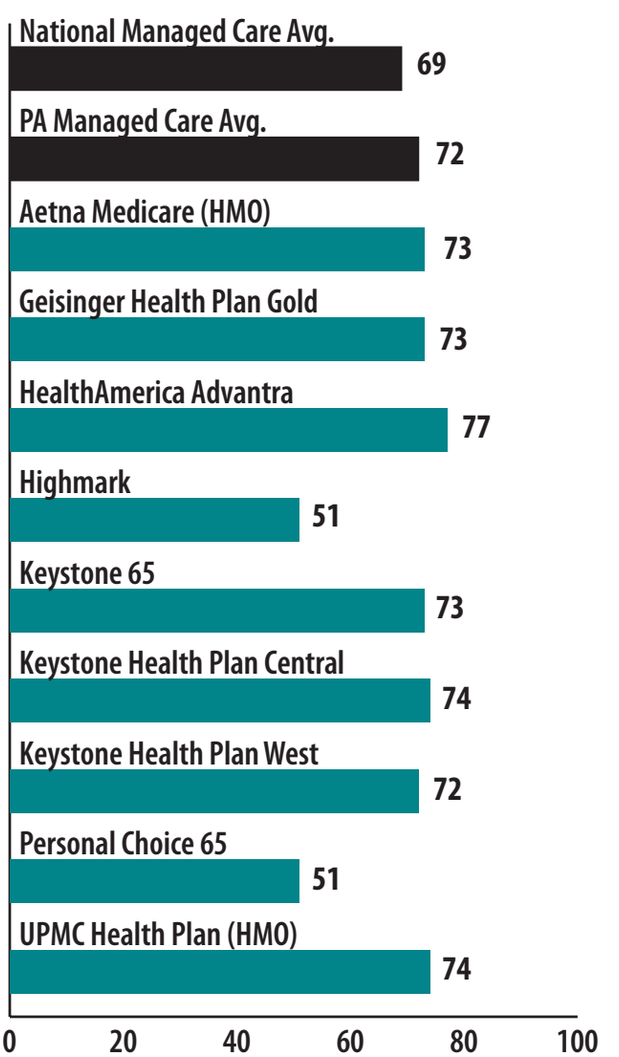
Percent of members with diabetes who received a test for cholesterol levels in a two-year period



Annual eye exams for members with diabetes

Members with diabetes have a greater risk of developing serious eye diseases that can lead to loss of vision. It is important that members with diabetes have an annual eye exam to find eye problems early, when they can be treated.

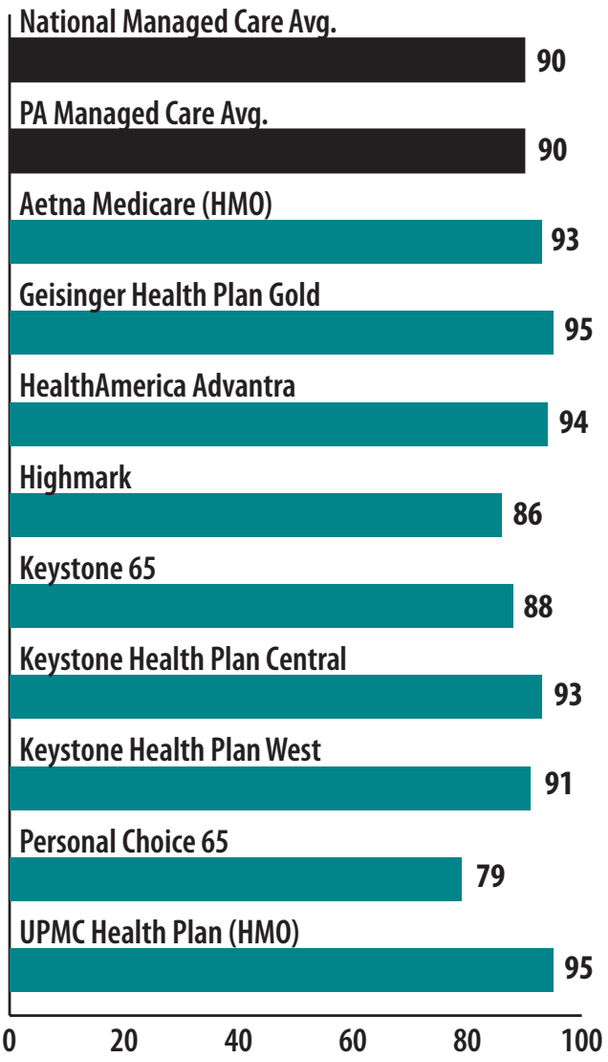
Percent of members with diabetes who received an eye exam



Glucose control testing for members with diabetes

Poor control of blood sugar levels can cause problems with the eyes, feet or kidneys. The Hemoglobin A1c test measures blood sugar control over the past three months. Your doctor may work with you to make changes in your diet, exercise and medications to control your blood sugar levels.

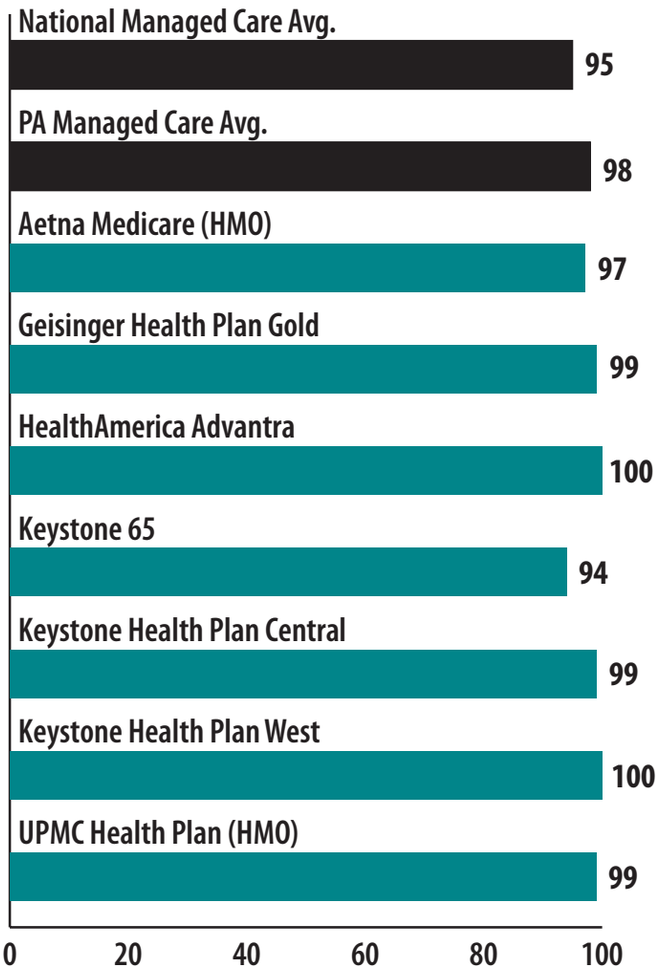
Percent of members with diabetes who received a blood sugar control (Hemoglobin A1c) test during the last year



Beta blockers after a heart attack

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

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

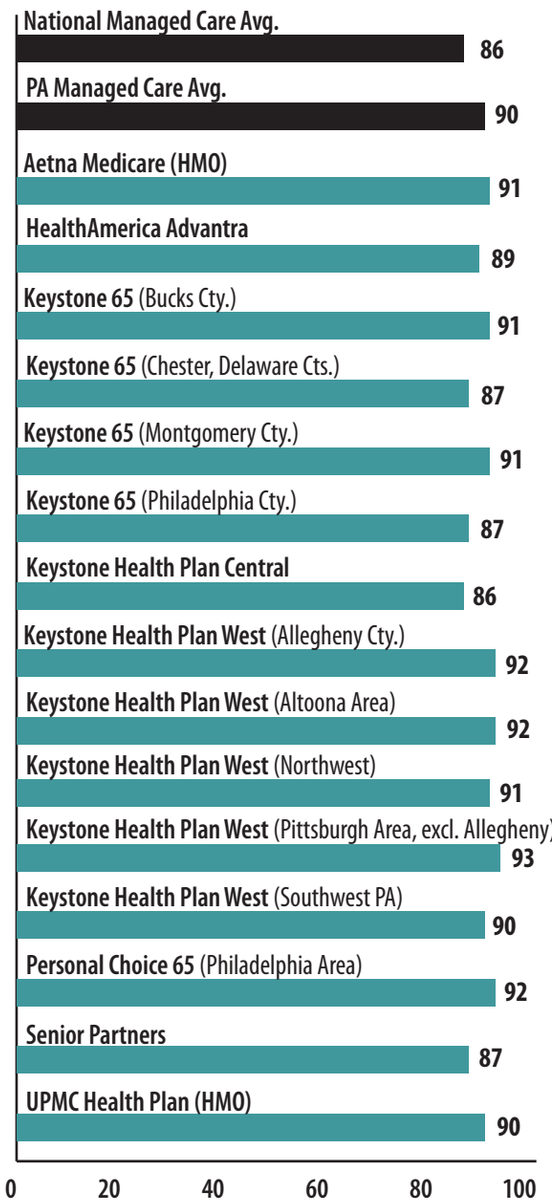


Comparing Quality

No problems getting care

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

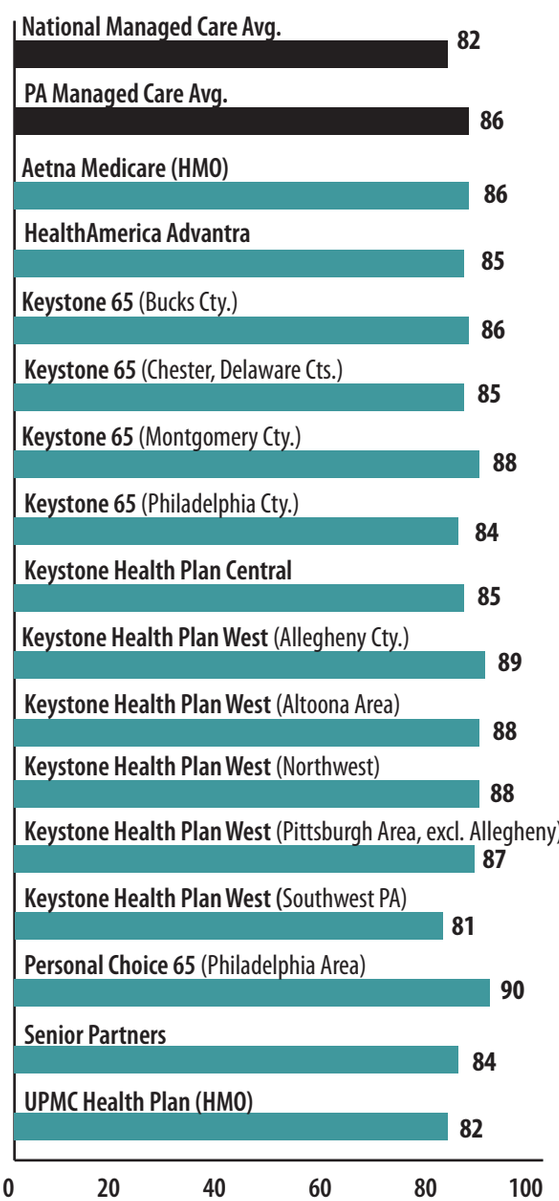
Percent of members who said they had no problems getting the care they needed



No problem seeing a specialist

Most Managed Care Plans require you to get a referral from your primary care doctor if you need to see a specialist.

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

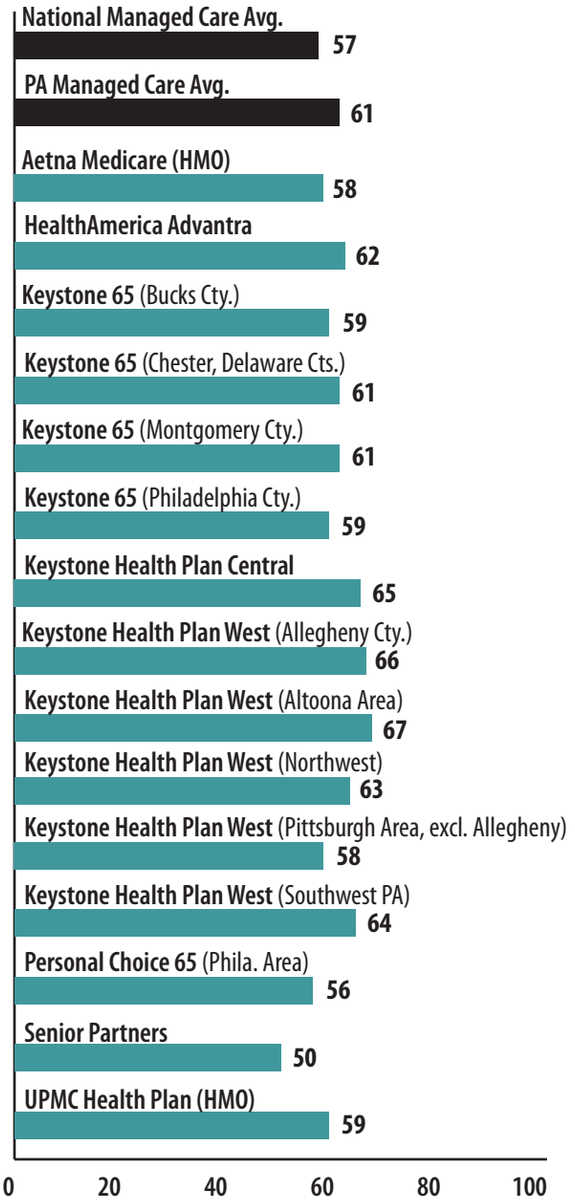


Comparing Quality

Getting care quickly

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

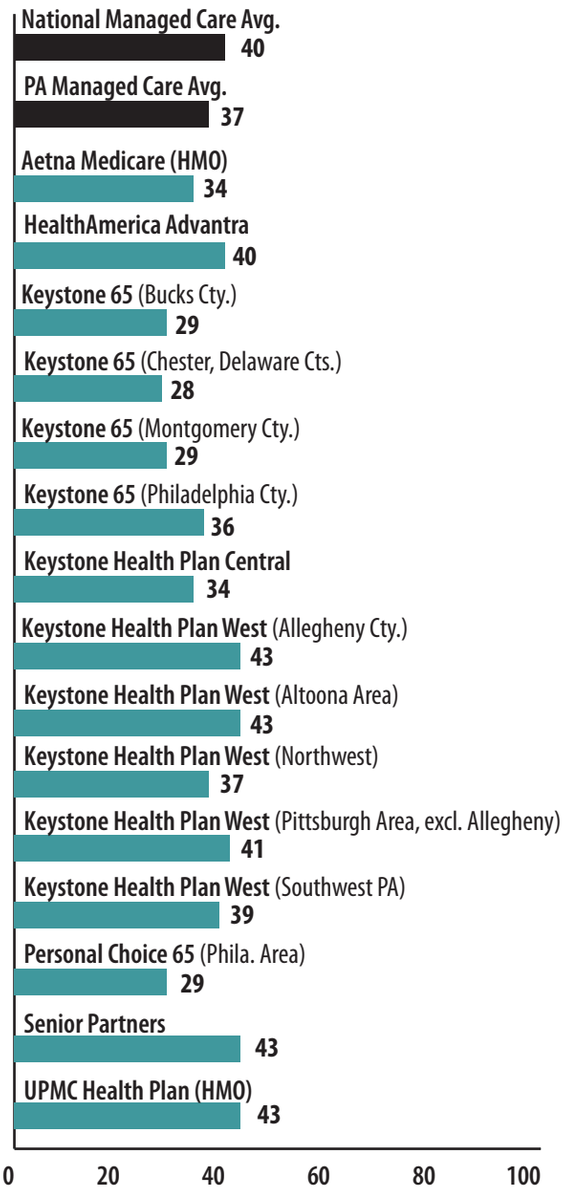
Percent of members who said they always got care when they needed it, without a long wait



Overall rating of plan

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

Percent of members who gave their own Medicare Managed Care Plan the highest rating



Agencies Providing Information to Seniors

Agency	Telephone Number	Web Site
APPRISE A program sponsored by the Pennsylvania Department of Aging that provides assistance in understanding Medicare benefits and finding programs that may help with the costs of prescription drugs or Medicare Part B premiums, help in comparing and selecting Medicare supplemental insurance or a Medicare Managed Care Plan, assistance with filing a Medicare appeal and help in selecting long-term care insurance. Language translation is available for most languages.	1-800-783-7067 Monday-Friday 9 a.m. to 4 p.m.	www.aging.state.pa.us
Medicare U.S. government hotline for information about the Medicare program, Medicare bills and services, Medicare fraud, and to obtain Medicare publications. English and Spanish speaking operators are available.	1-800-MEDICARE (1-800-633-4227) 24 hours, 7 days a week	www.medicare.gov
Medicare Fraud and Abuse Hotline Call or email to report cases of abuse of the Medicare billing program.	1-800-HHS-TIPS (1-800-447-8477) Email: HHSTips@oig.hhs.gov	www.medicare.gov
PA Insurance Department To file a complaint about a Medicare Managed Care Plan.	1-877-881-6388 8:30 a.m. to 5 p.m.	www.ins.state.pa.us
Social Security Administration Call to sign up for Medicare Parts A or B, for Medicare eligibility information, to obtain a new Medicare card, to change your address or to obtain information about your Social Security benefits. English and Spanish speaking operators are available.	1-800-772-1213 Monday-Friday 7 a.m. to 7 p.m.	www.ssa.gov
Quality Insights of Pennsylvania Organization providing assistance in filing Medicare appeals and help if you believe you have been prematurely discharged from a hospital or Skilled Nursing Facility.	1-800-322-1914 or call 1-800-MEDICARE	www.qipa.org

Agencies Providing Information to Seniors

Agency	Telephone Number	Web Site
AARP Pennsylvania Advocacy group for older Americans	1-866-389-5654 Monday-Friday 9 a.m. to 5 p.m.	www.aarp.org
Alzheimer's Association Helpline Information, referral and support	1-800-272-3900 24 hours, 7 days a week	www.alz.org
American Diabetes Association Support and information for persons with diabetes	1-800-DIABETES (1-800-342-2383) Monday-Friday 8:30 a.m. to 8 p.m.	www.diabetes.org
Pennsylvania Office of Attorney General Health Care Unit Provides assistance to consumers on health care practices	1-877-888-4877 Monday-Friday 10 a.m. to 3 p.m.	www.attorneygeneral.gov
Pennsylvania Dental Association Information on programs providing dental care for seniors	717-234-5941 Monday-Friday 8:30 a.m. to 5 p.m.	www.padental.org
Pennsylvania Department of Public Welfare Hotline Financial assistance programs for low-income seniors	1-800-692-7462	www.dpw.state.pa.us
Veterans Affairs (Benefits Information) Provides information and programs to military veterans	1-800-827-1000	www.va.gov

Prescription Drug Assistance

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

Important Questions

…to ask yourself

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

…to ask your doctor or Managed Care Plan

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

10 Things to Know about Medicare Managed Care Plans with Prescription Drug Coverage

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

2. Annual enrollment period starts November 15, 2006 and runs to December 31, 2006 – it is the one chance this year most people with Medicare have to make a change or join a prescription drug plan. If you join during this time, your coverage will begin January 1, 2007.

3. If you are going to make a change or join a new plan, enrolling by December 8 helps to ensure that you get the prescriptions you need on January 1.

4. A late-enrollment penalty may be incurred if you did not sign up during the initial open enrollment period that ended May 16, 2006, or did not have coverage as good as the standard Medicare drug benefit, known as credible coverage.

5. During the open enrollment period from January 1 – March 31, 2007, you may generally make one change in how you receive your Medicare medical (doctor and hospital) and prescription drug coverage. You are limited to the type of current coverage whereby you can't add or drop Medicare prescription drug coverage during this time.

6. Medicare sets the **minimum standard benefit** guidelines for the Medicare prescription drug program. Many plans offer better benefits than the minimum guidelines for 2007. For example, some plans have no deductible and/or some coverage in the coverage gap.

7. Plans vary by what drugs are covered and how much you will have to pay. Make sure that the drugs you take are covered by a plan before you join.

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

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

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

Plans included in this Guide

Plan Name	Product Name	Toll-Free Number
Aetna Health	Golden Choice Golden Medicare	1-800-832-2640
Capital Advantage Insurance Company	SeniorBlue PPO	1-800-990-4201
Geisinger Health Plan	Geisinger Gold Geisinger Gold Preferred	1-800-631-1656
HealthAmerica/HealthAssurance	Advantra Advantra PPO	1-800-470-4272
Health Partners	Senior Partners	1-888-776-9466
Highmark, Inc. (East Central PA)	FreedomBlue PPO	1-800-511-0589
Highmark, Inc. (Western PA)	FreedomBlue PPO	1-800-350-1973
Humana Insurance Company	HumanaChoice PPO	1-800-833-2364
Independence Blue Cross	Personal Choice 65 PPO	1-877-393-6733
Keystone Health Plan Central, Inc.	SeniorBlue	1-800-990-4201
Keystone Health Plan East, Inc.	Keystone 65	1-877-393-6733
Keystone Health Plan West, Inc.	SecurityBlue	1-800-576-6343
Unison Health Plan	Unison Advantage	1-877-786-4766
UPMC Health Plan, Inc.	UPMC For Life UPMC For Life PPO	1-877-381-3765

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

Pennsylvania Health Care Cost Containment Council

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