



LOCAL HELP FOR PEOPLE WITH MEDICARE

Medicare Advantage

For Medicare Beneficiaries Living in Connecticut 2010

Compiled and Published by: CHOICES (800) 994-9422

A cooperative program of the State of Connecticut Department of Social Services, the CT Area Agencies on Aging, and the Center for Medicare Advocacy that provides Connecticut residents with direction to benefit and support program dealing with aging concerns.

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NOTE: This information, including any rates and services, is accurate to the extent available to CHOICES from the individual Medicare managed care plans and the Centers for Medicare and Medicaid Services as of July 2010. For more comprehensive information or clarification regarding an individual plan or product, please contact the plan directly at the telephone number listed in this booklet. For additional information on Medicare issues, including the Original Medicare Plan, Medigap Supplemental Insurance, Prescription Drug Assistance, and other health insurance issues generally, you should call the CHOICES health insurance counselor at your regional Area Agency on Aging (1-800-994-9422). CHOICES publications can also be found on the Department of Social Services, Aging Services web site at www.ct.gov/agingservices. CHOICES *counselors do not sell or market insurance*. They provide the necessary information and assistance to enable you to make your own health insurance CHOICES.

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Quick Facts" About Your Medicare Choices and Common Concerns of Medicare Beneficiaries in CT

Do I have choices about how I can receive my benefits?

It is important to note that Medicare Advantage plans can close enrollment once they reach their Centers for Medicare and Medicaid Services (CMS) approved capacity limit. Therefore, even if you have an Advantage plan in your county, if you have not already enrolled, it may not be available to you once the plan has closed enrollment. Current plan members are not affected.

Again in 2010, Medicare beneficiaries in certain regions of Connecticut will have the option of receiving their Medicare benefits through a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO) or a Private Fee for Services plan (PFFS). In addition, some beneficiaries will also have the opportunity to enroll in a Special Needs Plan (SNPs). In Connecticut, unless you choose otherwise, you will receive benefits through the Original Medicare program. In 2010, all Connecticut residents have the option to receive benefits through a Medicare managed care plan, now referred to as Medicare Advantage.

Additionally in 2010, beneficiaries in most counties of CT who have End Stage Renal Disease have the option of enrolling in a Medicare Advantage plan. A company specializing in the treatment of ESRD, Fresenius has received approval from the Centers for Medicare and Medicaid Services to run a demonstration project that will provide Medicare beneficiaries with ESRD the opportunity to receive their health benefits through this special Medicare Advantage plan.

Both Original Medicare and Medicare Advantage plans provide for the basic Medicare hospital and medical benefits, but there are important differences in the way services are delivered, how and when payment is made, and how much you may have to pay out of your own pocket.

For more information on Original Medicare and Medigap policies, please refer to the book, "Making Medicare Choices" which can be obtained by calling the CHOICES program at 1-800-994-9422.

MEDICARE OVERVIEW

Parts A & B

Medicare, (which began in 1965), is the national health insurance program, for older adults and people with disabilities. It is available to all those who are age 65 years or older and to younger people who are permanently disabled and have received Social Security benefits for at least 24 months. Individuals receiving railroad retirement benefits and individuals with end stage renal disease or Lou Gehrig's disease are also eligible for Medicare.

Eligibility for Medicare is not based on an individual's financial status. Income and assets are not a consideration in determining eligibility for Medicare. There is neither an income nor asset test for Medicare. Benefits are the same for all those who qualify.

You may choose to receive your Medicare coverage through:

- ◆ Original Medicare (available to all Medicare beneficiaries)
- ◆ Medicare Advantage plans: such as HMOs, PPOs & PFFS's (which are closed to those with end stage renal disease)

Coverage under Medicare is similar to that provided by private health insurance companies. Like health insurance, Medicare pays a portion of the cost of medical care, but not the entire bill. Deductibles and co-insurance (partial payment of initial and subsequent costs) are often required of the beneficiary.

How do you enroll in Medicare? If you already get Social Security Benefits you do not need to do anything. You will be automatically enrolled in Medicare Part A and Part B effective the month you are 65. For example, if your 65th birthday is February 20, 2010, your Medicare effective date would be February 1, 2010. (Note: if your birthday is on the 1st day of any month, Medicare Part A and Part B will be effective the 1st day of the prior month.) Your Medicare card will be mailed to you about three months before your 65th birthday. If you do not want Medicare Part B, follow the instructions that come with the card.

If you are close to turning 65 and are not getting Social Security benefits, you must apply for Medicare to receive it. You can do so by applying at www.ssa.gov. Simply select the "Retirement/Medicare" link in the middle of the page, calling your local Social Security office at 1-800-772-1213, or apply in person at your local Social Security Office. Apply three months before the month of your birthday to avoid a delay in receiving benefits. You can only apply for Medicare Part A on the Social Security Web Site

If you want to apply for both Social Security Retirement Benefits and Medicare at age 65, you can apply for both at the same time. To make sure that your Medicare Part B coverage start date is not delayed, you should apply three months before the month you turn 65, which is the beginning of your 7 month Initial Enrollment Period. If you wait until you are 65, or for the last three months of your Initial Enrollment Period, your Medicare Part B coverage start date will be delayed.

To apply, call or visit your local Social Security office or call Social Security at 1-800-772-1213.

For more Information on Medicare call CHOICES and ask for the publication "Making Medicare Choices", at 1-800-994-9422 or view the Medicare web site at www.medicare.gov

MEDICARE SUPPLEMENTAL INSURANCE (Medigap)

Health insurance that helps pay when Original Medicare doesn't cover the full cost of services is known as **Medical Supplemental Insurance** or **Medigap**, because it helps fill the gap in Medicare's coverage. Medigap insurance provides coverage for beneficiaries in the Original Medicare program. Medigap insurance is necessary because Medicare often covers less than the total cost of the beneficiary's health care. Both Medicare Parts A and B have gaps in coverage, some of which are covered by the various Medigap insurance plans. It is advisable to obtain Medigap insurance to cover these costs if you can afford it and if you are on Original Medicare.

There are ten standard Medigap policies which are labeled A through N. Policy A contain the basic or "core" benefit plan. The other nine policies contain one or more additional benefits. **NONE of the Medigap plans now offered for sale include drug coverage.**

The following is a list of the benefits for 2010 that are contained in the **core policy** (Plan A) and that must be contained in all Medigap policies:

- ◆ Part A hospital coinsurance for day's 61-90 \$275/day
- ◆ Part A hospital lifetime reserve coinsurance for days 91-150 \$550/day
- ◆ 365 lifetime hospital days beyond Medicare coverage
- ◆ Part A and B three pint blood deductible
- ◆ Part B 20% coinsurance

Additional benefits are offered in policies B through N. Each plan contains a different combination of these benefits in addition to the core benefits. Additional coverage may be offered for:

- ◆ Part A skilled nursing facility coinsurance for days 21-100 (\$137.50/day in 2010)
- ◆ Part A hospital deductible (\$1100 per benefit period in 2010)
- ◆ Part B deductible (\$155/year in 2010)
- ◆ Part B charges above the Medicare approved amount (if provider does not accept assignment)
- ◆ Foreign travel emergency coverage

For an updated Medigap Chart and more information on the Medigap Plans (Supplemental Insurance) listing all the companies approved by the State of Connecticut please contact CHOICES at 1-800-994-9422 or ask for the CHOICES Publication "Making Medicare Choices".

YOUR RIGHTS TO BUY A MEDIGAP POLICY

What is Guaranteed Issue?

- ◆ Connecticut residents age 65 and over are guaranteed acceptance into Medigap plans A-L (and into plans M & N after June 1, 2010).
- ◆ Persons under 65 with disabilities are guaranteed acceptance into Medigap plans A, B, and C only

What Pre-existing Condition Protections do you have when choosing a Medigap policy in Connecticut?

- ◆ Pre-existing conditions are covered by Original Medicare. Medigap policies may have a **waiting period** of between **2 and 6 months** for coverage of these conditions. After that, your pre-existing condition must be covered.
- ◆ Some insurance companies selling Medigap policies do not impose a pre-existing condition waiting period. That means that if you have a medical condition before you join the plan, it will be covered as soon as the plan starts. For more information, please refer to the CHOICES Medigap rate chart on pages 23 and 24.
- ◆ If you have been in a **Medicare Advantage** plan for at least six months or are replacing employer group health insurance that you have had for at least six months, you are given credit for the number of months you spent in the Medicare Advantage or employer group health insurance plan. For example, if you have had the Medicare Advantage plan for four months and the Medigap policy you want to join has a six month waiting period, you will be given credit for the four months, and your waiting period will be reduced to two months.

Have you dropped Medigap coverage to join a Medicare Advantage Plan? If you have done so for the first time, you may leave your Advantage Plan at any time during the calendar year and re-enroll in a Medigap plan of your choice. You may enroll in a stand-alone Medicare Prescription Drug Plan if you are leaving an MA-PD.

For more information on Medigap rights and protections, please contact the CHOICES program at 1-800-994-9422.

MEDICARE WRAP-AROUND PROGRAMS (Low Income Assistance)

The programs listed below assist Medicare beneficiaries of modest means with paying Medicare premiums, deductibles, and co-payments

MEDICARE SAVINGS PROGRAM (MSP)

The **MSP** consists of three programs offered by the Department of Social Services (**QMB, SLMB & ALMB**). There is **NO ASSET Test** for any of these three programs. The income levels on these programs usually change April 1st of every year. The income levels for these programs range for a single: \$1778.92- \$2091.67 per month and for a couple the monthly income ranges between \$2393-55- \$2816.67. All of these programs will pay your Part B premium of \$96.40 for 2010, if new to Medicare in 2010 the premium of \$110.50 will be paid. The cost of your drugs will be \$2.50 for a generic and \$6.30 for a brand name drug as long as the drug is on the Plan's Formulary, (list of drugs the plan covers).

What is counted for income for these three programs?

- ◆ Social Security
- ◆ SSI
- ◆ Social Security Disability
- ◆ Unemployment
- ◆ Alimony
- ◆ Rental income
- ◆ Income from an annuity or CD
- ◆ IRA or 401K withdrawals

CONNPACE

ConnPACE, the Connecticut Pharmaceutical Assistance Contract to the Elderly, helps eligible persons pay for prescription drugs.

Who is Eligible?

- ◆ Those 65 or older who are enrolled in Medicare Part A or Part B
- ◆ Those over age 18 with a disability
- ◆ Your income must not exceed maximum limits: Single: \$25,100; Married: \$33,800. (Income limits increase each January 1st based on the Social Security Cost of Living increase.)
- ◆ You must have been living in Connecticut for at least 183 days prior to application.

NOTE: ConnPace will not pay for an Rx which is not on the list of drugs covered by

your Medicare PDP, except if that drug is a benzodiazepine or a barbiturate.

If you are disabled collecting Social Security Disability, you are not yet on Medicare, ConnPACE will pay for your drug costs. Some of those drugs may require prior authorization.

How much does it cost?

- ◆ Enrollment in the ConnPACE program is \$45 per year per person.
- ◆ A maximum co-payment of \$16.25 will be charged by the pharmacy for each prescription filled.
- ◆ That maximum co-pay applies even if you are in your PDP's Initial Deductible period or in the Doughnut Hole.

ConnPACE will not cover drugs purchased outside of Connecticut (including mail orders).

When Can You Enroll? Those on Medicare can join ConnPACE:

- ◆ Within 30 days of joining Medicare
- ◆ Between Nov. 15 & Dec. 31 of any year for coverage to start Jan 1 of the following year

Those who are disabled and not on Medicare can join ConnPACE within 30 days of certification of disability.

For more information on the ConnPACE, call CHOICES for the publication "Making Medicare Choices" or "Prescription Drug Assistance" at 1-800-994-9422.

Applications for, and information about, the above mentioned programs are available online at <http://www.ct.gov/dss/site/default.asp>

LOW INCOME SUBSIDY (LIS)/EXTRA HELP

It is a federal government program which helps you pay for Medicare's Prescription Drug coverage.

- ◆ It pays a portion of your premium, deductibles and co-pay amounts in all cases.
- ◆ It pays the entire premium for any Basic Benchmark PDP whose cost is below \$34.57.
- ◆ It will reduce the co-pays for any medications on a Prescription Drug Plan's formulary, even if you are in a deductible period.
- ◆ If you qualify for the LIS Full Subsidy amount you will pay no more than \$2.50 for a generic and \$6.30 for a brand name drug.
- ◆ To qualify, your yearly income must be under \$16,245 (single) or \$21,855 (couple) and countable assets below \$12,510 (single) and \$25,010 (couple) (including \$1,500 burial allowance per person).

For people who qualify for this program also qualify for the Medicare Savings Program, which will provide them with additional benefits.

For Assistance in applying for Extra Help or more information please Contact CHOICES at 1-800-994-9422, Social Security at 1-800-772-1213 or go online to <https://secure.ssa.gov/apps6z/i1020/main.html>

NOTE: The "Wrap Around Programs" mentioned above will work with Medicare Advantage Plans lowering the cost of your drugs and the Medicare Advantage Part D premium. On some Medicare Advantage Plans there may be no Part D premium.

For more information on any of the above mentioned programs call CHOICES for the publication "Making Medicare Choices"" or "Prescription Drug Assistance", at 1-800-994-9422

What is Medicare Advantage?

What Is Medicare Advantage?

Connecticut Medicare beneficiaries can choose to receive their Medicare benefits through a Medicare Advantage plan. Medicare Advantage plans are often referred to as HMOs, which means "Health Maintenance Organizations;" PPOs, which means "Preferred Provider Organizations;" PFFSs, which means "Private Fee for Service plans;" SNPs, which means "Special Needs Plans" for people with certain chronic conditions, institutionalized or dual eligible, (Medicare/Medicaid) and MSAs, which means "Medicare Savings Accounts." The Medicare Advantage plan benefits are different from the Original Medicare "fee-for-service" system.

Medicare Advantage plans use a limited network of health care providers and facilities and a system, in some cases, of prior approval from a primary care physician. Most plans allow you to select a primary care doctor from those that are part of the plan. Generally, the doctor authorizes, arranges for, and coordinates your care, and decides what care is reasonable and necessary.

In Connecticut, each plan usually requires co-payments most times that you go to the doctor or use other services. You also must continue to pay the Part B premium. You will get all of the Medicare hospital and medical benefits to which you are entitled through the plan and retain all of your Medicare protections and appeal rights.

HMOs

In 2010, there are several HMOs marketing plans in the State of Connecticut. Each plan has a network of providers operating through private practice offices.

All of the Medicare Advantage plans available in Connecticut have an in network provider requirement. That means that you generally must receive all covered care from the doctors, hospitals, and other health care providers who are affiliated with the plan. Exceptions include emergency care and urgent care.

PPOs

A PPO is also a Medicare Advantage plan similar to an HMO. There is a preferred network of service providers and medical facilities. However, unlike an HMO, a PPO allows members to utilize out of network providers and facilities, usually at a higher cost than if the beneficiary had used in-network physicians and hospitals.

PFFSs

A PFFS plan is also a Medicare Advantage plan. However, unlike HMOs or PPOs, PFFS plans set their own fees for services, not Medicare. PFFS plans decide how much they will pay for any covered Medicare service. Beneficiaries in a PFFS may see any Medicare-approved physician who accepts the rates set by the plan. Physicians who accept the terms of a PFFS plan may not charge more than 115% of the contracted rate. Similar to HMOs and PPOs, PFFS plans may offer benefits in addition to Original Medicare coverage such as, extra days in a hospital.

MSAs

A Medicare Medical Savings Account (MSA) plan is a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account. The plan deposits money from Medicare into the savings account at the beginning of each year. Enrollees of Medicare MSA plans can initially use their savings account to help pay for health care, and then will have coverage through a high-deductible insurance plan once they have met their deductible. Enrollees cannot deposit their own money into the account.

It is important to know both the deposit amount that will go into the savings account and the deductible amount of a plan before enrolling. Enrollees use the account to help pay for health care, and then will also have to pay out of pocket for care, until the MSA plan deductible is met. Then the plan pays for coverage.

Note: **The MSA plan is only available in Pennsylvania in 2010**

SNPs

Special Needs Plans are designed to meet the needs of beneficiaries in specific circumstances such as living in a nursing home, being eligible for both Medicare and Medicaid (dual eligible) or living with a chronic illness. Special Needs plans often take the approach of coordinating care services to manage the health of clients in order to avoid hospitalization. Although any beneficiary may enroll in a Special Needs plan they are not the best option for beneficiaries who do not fall into one of the three categories listed above. It is a good idea to carefully review the plan's network of providers before enrolling in an SNP as it can be costly to use out-of-network providers.

Conclusion

While the benefits of Medicare Advantage plans vary from plan to plan, every plan is required by Medicare law to provide all of the Original Medicare benefits. You must get all of your Medicare benefits through the plan.

A Medigap policy will be of little or no value to you if you enroll in a managed care plan in Connecticut since it will not pay any co-payments or premiums charged by the plan. The only situation where a policy might be of value is if you left the plan to return to Original Medicare.

For more information about Medigap, refer to the CHOICES booklet, "Making Medicare Choices" available from the CHOICES program at 1-800-994-9422.

Am I Eligible to Join a Medicare Advantage Plan?

- ◆ To enroll in a Medicare Advantage plan, the only requirements are:
- ◆ You must be enrolled in Medicare Parts A and B, and continue to pay the Part B premium;
- ◆ You must not be medically determined to have end-stage renal disease,
- ◆ You must live within the area served by the plan
- ◆ The Medicare Advantage plan must be open to new enrollees.
- ◆ Except for the current end-stage renal disease prohibition, you may not be denied membership because of otherwise poor health, a disability, or other pre-existing condition.

When Can I Enroll/Disenroll?

There are several different enrollment periods: **Open, Annual, Initial, and Special**. Note that if a Medicare Advantage plan has a capacity limit, then, when that plan reaches the limit, it will be closed to new enrollees, with only a few exceptions. **Check with the plan before filling out an application, to make sure that the plan is accepting applications.**

Coverage usually begins on the first day of the month after your enrollment application has been received by the plan. Once you have confirmed that your membership has been activated, you should notify all the people who may be involved in helping you obtain the medical services of your new plan and the primary care physician that you have selected.

- ◆ **Open:** Open enrollment is the time when Medicare beneficiaries can enroll in, disenroll from or change Medicare Advantage plans. It occurs from January 1 – March 31st of each year (**Note: this is changing for 2011 see below**). Enroll by the last day of the month to be effective the first of the next month.
- ◆ Please be aware that your completed application must be reviewed and approved by the plan before you are accepted into it. Make sure you receive your effective date in writing from the plan so that when you begin using services, they will be covered.

New Medicare Advantage enrollment rules for 2011

- ◆ Medicare Advantage members will have only one chance to change their Advantage plan later this year, between November 15th and December 31st 2010. After January 1, 2011 you will be locked into the Advantage plan for 2011 unless you decide to dis-enroll from the Advantage plan and go back to Medicare. From January 1st to February 15th, 2011, people enrolled in Medicare Advantage plans will be allowed to sign up for a stand-alone Part D plan if they drop out of their Advantage plan.

- ◇ **Annual:** This occurs November 15 – December 31, 2010. During this time you may enroll in a Medicare Advantage plan effective January 1, 2011.
- ◇ **Initial:** For your enrollment to be effective the first month in which you are entitled to Medicare Parts A and B, you must enroll during the previous three months
- ◇ **Special:** This is a period of time when beneficiaries can change plans outside of the other designated enrollment periods. Special Enrollment periods usually occur as a result of a qualifying event or special circumstance. This includes many different situations:
 - Example: If you enroll in a plan and later move out of its service area, you will have to disenroll and either return to Original Medicare or enroll in another Medicare Advantage plan that serves your new location.

Disenrollment initiated by the beneficiary

Currently, beneficiaries have the option to leave a Medicare Advantage Plan at any time during an election period. The individual may:

- ◇ **Choose another Medicare Advantage Plan** – An individual may switch from one Medicare managed care plan to another simply by enrolling in the new plan. The beneficiary is automatically disenrolled from the first plan on the day the new Medicare Advantage Plan coverage begins.
- ◇ **Return to Traditional Medicare** – To disenroll, **state in writing** that you want to withdraw from the plan and return to Original Medicare coverage. Give or send the written statement either to the plan's administrative office or to your local Social Security Administration Office (or the Railroad Retirement Board Office if appropriate). You may want to send your disenrollment letter to your plan by **certified mail** so that you have proof the plan received it. In any case, you should notify Social Security (1-800-772-1213) to make sure that you are re-entered in Original Medicare. Another method of disenrolling is to call 1-800-MEDICARE (1-800-633-4227) and ask for the Disenrollment Dept. Your coverage under Original Medicare will begin the **first day of the month following receipt of your notification**.
- ◇ **Cancel before Medicare Advantage Plan takes effect** - If an individual wishes to cancel his or her enrollment in the plan so that it never goes into effect, he or she must contact the Medicare Advantage Plan directly. The individual cannot go to the Social Security office.
- ◇ **Return to their previous Medicare supplement (Medigap)** – If the beneficiary decides to try a Medicare Advantage this must be the first time they are enrolled in an HMO Plan or Medicare Select Plan: they must have to decided to leave the plan within one year after joining; and they must apply for the Medicare supplement within 63 days after leaving the other plan.

Note: There may be some delay in processing a disenrollment from a Medicare Advantage Plan so that initial claims filed with fee-for-service Medicare within two weeks of disenrollment may still be denied for Medicare managed care enrollment. The individual should ask his or her health care provider to resubmit the bill to Medicare for processing a second time.

POSSIBLE ADVANTAGES

No Claims and Nearly "Paperwork Free"

A beneficiary need not submit any claims to the managed care plan, unless he or she received emergency or urgent care outside the service area. Also, you don't have to worry about whether your physician accepts "assignment."

The Emphasis is on Preventive Care

Medicare Advantage plans encourage preventive care, including annual physical exams, as well as health care screening services not covered under Original Medicare program.

There are economic incentives for managed care plans to encourage members to have regular checkups, take screening tests (like mammograms) and make lifestyle changes that promote good health.

Comprehensive Services & Coordination of Care

Medicare Advantage plans generally cover, or partially cover, a larger variety of services than Original Medicare and Medigap service coverage such as vision care, prescription drugs, and hearing exams.

Your primary care physician will monitor your medical condition, the interaction of all of your treatments and medications, and coordinate the delivery of all needed services.

This is especially important in older age, when there is a greater likelihood of having more than one chronic condition.

No Need for Medigap Insurance

Medicare Advantage plans provide beneficiaries with many of the benefits offered by a Medigap policy.

No "Health Screening" Based on Pre-existing Conditions

All Medicare beneficiaries, **except those with permanent kidney failure** (End Stage Renal Disease) can join any Medicare managed care plan in their area. Enrollment cannot be denied based on a pre-existing condition.

POSSIBLE DISADVANTAGES or "TRADE OFFS"

Limitations on Procedures for Receiving Specialized Care

In some CT Medicare Advantage Plans, a beneficiary must have the prior approval of his or her primary care physician to see a specialist. Because of financial incentives, some primary care physicians may resist making referrals.

Must Use Only Plan Providers

Except for emergencies, unforeseen out-of-area urgently needed care or if you have a PFFS plan, a beneficiary is generally not free to go to any physician or hospital he or she may choose. You must use the Plan's providers and facilities.

Out-of-Area Care Limitations

If a beneficiary lives outside a Plan service area for more than twelve months at a time, the Plan may not enroll a beneficiary or may subsequently automatically disenroll a beneficiary.

Members who travel outside their Plan's service area are only covered for emergency or unforeseen out-of-area urgently needed care. For most plans, members will have to submit a claim for these out of area services.

Providers Can Terminate Their Contracts with Plans During the Course of Your Benefit Year

Although you should receive notice when one of your providers will no longer be affiliated with your plan, you will either have to change plans to continue using that provider or find a new provider within your existing plan.

Plans May Alter Their Benefit Packages, Premiums, Payments and Service Areas Annually

Plans must always provide all the Medicare-covered services you are entitled to through Parts A and B of Original Medicare. Because plans contract with the Health Care Financing Administration to provide beneficiary services on an annual basis, they may alter their premiums, co-payments, and additional covered services each calendar year. At that time, a plan may also decide to withdraw from providing services to beneficiaries in a certain county.

Disenrollment

- ◆ The disenrollment deadline is the last day of the month, to be effective the 1st of the next month.
- ◆ A beneficiary must continue to use the plan until the disenrollment takes effect.
- ◆ Even after the disenrollment becomes effective, Medicare's computers may not be updated and some Original Medicare claims will be erroneously rejected.

Regulatory Authority

- ◆ The Centers for Medicare and Medicaid Services (CMS) contracts with and directly monitors approved plans. Unlike Medigap policies, there are no guidelines requiring "standardized" plans.

What You Need To Know If Currently Enrolled in a Medicare Advantage Plan (And steps to follow before enrolling)

✓ **Read the membership materials carefully.**

What does it pay for? When is the enrollment period? How easy is it to switch plans in case you don't like the plan you have chosen?

✓ **Determine the nature and extent of plan coverage.**

- What plan services are provided at additional cost and how much? All preventive services should be identified, as well as any limitations associated with visits or services. You should fully understand where to go for emergency, urgently needed, and routine care.

- Mental Health coverage is important, so find out how many sessions per year are covered and who makes the decision about whether or not you need mental health treatment.

- If you travel a lot, find out what sort of coverage the plan provides when you are away from home. Will they cover you while you are out of the country?

- Does the plan cover alternative therapies that may be of interest to you, such as chiropractic, acupuncture, or homeopathy?

- What medical services, such as transplants, are not covered?

- Does the plan offer Medicare Rx drug coverage?

✓ **Compare benefits, costs and features of a plan for a price you can afford.**

- Be sure to check that the benefits most important to you are included.

✓ **Check into the plan physicians and other providers (such as hospitals and pharmacies) and determine their availability to you.**

- If you have a doctor that you like, is she or he already affiliated with a plan you can join? Are your doctors currently satisfied with their affiliation with the plan? Do they intend to continue their affiliation?

- How easy is it to switch doctors within a given plan in case you don't like your first choice?

- How easy is it to get advice and care? Is there someone to call in the evening or on weekends if you need advice? How long do you have to wait for an appointment?

- Where are the plan's physician services located? Which hospitals, laboratories and pharmacies does it use? Are they conveniently located?
- How many primary care physicians are in the network? How many are accepting new patients?
- How many providers dropped out of the network last year? How many providers did the plan drop? Why?

Check into the quality of care.

- Check with friends/family about what their experiences have been.
- Learn how to use the plans complaint system and how the grievances and appeals are handled. For assistance with the above mentioned please contact CHOICES at 1-800-994-9422
- Contact the National Committee on Quality Assurance (NCQA), which has a program to accredit managed care plans. Although accreditation is relatively new and therefore as yet untested for reliability, it is the only source of comparative data on quality of care. For information on plan accreditation status or for a Guide to choosing a health plan, please contact NCQA at 1-888-275-7585 or visit their website at www.ncqa.org.
- For an online Health Plan Report Card log onto: www.healthchoices.org.

Read, ask questions, consider, and evaluate. Following these steps is a good start to making sure that you choose the best medical program for your needs. You may be prepared to join a certain Medicare Advantage plan, or you may determine that the Original Medicare program better suits your needs. An informed and intelligent decision whether to stay in the Original Medicare program or choose a Medicare Advantage plan is the key to your long term well being.



Medicare Advantage Plans for Beneficiaries Living in Connecticut

Each year, Medicare Advantage plans have to choose whether to continue doing business with the Medicare program, and whether to raise or lower premiums and benefits. Some Medicare Advantage plans make business decisions to leave Medicare in certain areas. Your plan must let you know if it intends to leave Medicare at the end of the year.

Important Information about Using the Plan Comparison Charts in This Book Please Read Carefully.

A Medicare Advantage plan comparison chart for plans available in CT as of January 1, 2010 can be found on the following pages of this booklet. There is also a detailed chart that includes the revised co-payments and fees effective January 1, 2010 for select plan services. Before selecting and enrolling into a Medicare Advantage plan it is important to review the plan's complete summary of benefits. For more information on a specific plan, and/or to request a copy of the plan's full summary of benefits, please contact the plan directly. A listing of the plans and their contact information is included in the back of this booklet.

NOTE: The plan comparison chart in this booklet lists the Medicare Advantage Options for the State of Connecticut only. Please contact the CHOICES unit if you have any questions at 1-800-994-9422

Medicare Advantage Plans in Connecticut 2010

Company	Plan Types	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham
AARP (Secure Horizons)	HMO					X			
AARP (Secure Horizons)	PPO	X	X	X	X	X	X	X	X
Aetna	Not accepting enrollment at this time	X	X	X		X			
Anthem Blue Cross & Blue Shield	HMO	X	X			X			
Anthem Blue Cross & Blue Shield	PFFS			X	X		X	X	X
ConnectiCare	HMO	X	X	X	X	X	X	X	X
Evercare IP	SNP (PPO)	X	X	X		X		X	X
Evercare MP	SNP (PPO)					X			
Fresenius*	SNP (PFFS)	X	X	X	X	X		X	X
Health Net	HMO/POS	X	X	X	X	X	X	X	X
Today's Options (Universal American)	PFFS	X	X	X	X	X	X	X	X
Unicare Life & Health	PFFS				X				
WellCare	HMO/POS	X	X			X		X	

***Fresenius is a Medicare demonstration project open to Medicare beneficiaries with End Stage Renal Disease. It is the only Medicare Advantage option in Connecticut for individuals with ESRD. Note: Special Needs Plans (SNPs) are not for everyone, carefully review eligibility criteria before selecting one of these plans.**

Medicare Advantage Plans (HMO, PPO and PFFS) Comparison Chart

- All Monthly Premiums are in Addition to the \$96.40 Monthly Medicare Part B Premium

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
AARP County available: New Haven	AARP Medicare Complete from Secure-Horizons	HMO	\$0	\$0	No gap coverage	\$10	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted within 24 hours	\$175 per day for days 1 - 7/ \$0 days 8 - 90	Days 1 - 10: \$0 per day. Days 11 - 100: \$85 per day
AARP County available: All CT Counties	AARP Medicare-Complete Choice from Secure-Horizons	PPO	\$0	\$0	No gap coverage	\$15	\$50 co pay for Medicare-covered visits. You do not pay if you are admitted within 24 hours	\$275 per day for days 1 - 6/ \$0 per day thereafter	Days 1 – 28: \$90 per day. Days 29 – 100: \$0 per day

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Aetna Medicare Counties available: Fairfield, Hartford, Litchfield and New Haven	Aetna Medicare Premier Plan	PPO	\$0	Not accepting enrollment at this time	\$15 co-pay for preferred generics; 100% of discounted costs for all other covered Part D drugs	\$5 co-pay in Network	\$50 for each Medicare-covered visit. You do not pay if you are admitted	\$75 co-pay per day for days 1 – 7 in Network. 30% coinsurance out of Network	You pay: \$0 per day, days 1 -20; \$100 per day, days 21 – 100 in Network. 30% per stay out of Network
Aetna Medicare Counties available: Fairfield, Hartford, Litchfield and New Haven	Aetna Medicare Standard Plan	PPO	\$0	Not accepting enrollment at this time	No gap coverage	\$15 co-pay in Network	\$50 for each Medicare-covered visit. You do not pay if you are admitted	\$150 co-pay per day for days 1 – 7 in Network. 30% coinsurance out of Network	You pay: \$0 per day, days 1 -20; \$100 per day, days 21 – 100 in Network. 30% per stay out of Network
Aetna Medicare Counties available: Fairfield, Hartford, Litchfield and New Haven	Aetna Medicare Premier Plan	HMO	\$0	Not accepting enrollment at this time	\$15 co-pay for preferred generics; 100% of discounted costs for all other covered Part D drugs	\$5	\$50 for each Medicare-covered visit. You do not pay if you are admitted	\$125 co-pay per day for days 1 – 7 in Network	You pay: \$0 per day, days 1 -20; \$100 per day, days 21 – 100 in Network
Aetna Medicare	Aetna Medicare Standard	HMO	\$0	Not accepting enrollment	No gap coverage	\$10	\$50 for each Medicare-covered visit.	\$150 co-pay per day for days 1 – 7 in Network	You pay: \$0 per day, days 1 -20; \$100 per day,

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Counties available: Fairfield, Hartford, Litchfield and New Haven	Plan			at this time			You do not pay if you are admitted		days 21 – 100 in Network
Aetna Medicare Counties available: Fairfield, Hartford, Litchfield and New Haven	Aetna Medicare Value Plan	HMO	\$0	Not accepting enrollment at this time	No gap coverage	\$20	\$50 for each Medicare-covered visit. You do not pay if you are admitted	\$200 co-pay per day for days 1 – 7 in Network	You pay: \$0 per day, days 1 -20; \$100 per day, days 21 – 100 in Network
Anthem Blue Cross & Blue Shield Counties available: Fairfield, Hartford, and New Haven	MediBlue HMO Plus	HMO	\$0	\$72	Many generics	In Network: \$20 co-pay for each primary care doctor visit for Medicare-covered benefits. \$30 co-pay for each in-area, Network urgent care Medicare-covered visit. \$30 co-pay for each specialist	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted for the same condition within 72 hours	\$200 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 100: \$60 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
						visit for Medicare-covered benefits			
Anthem Blue Cross & Blue Shield Counties available: Fairfield, Hartford, and New Haven	MediBlue HMO Select	HMO	\$0	\$122	Many generics	In Network: \$10 co-pay for each primary care doctor visit for Medicare-covered benefits. \$20 co-pay for each in-area, Network urgent care Medicare-covered visit. \$20 co-pay for each specialist visit for Medicare-covered benefits	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted for the same condition within 72 hours	\$100 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 100: \$50 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Anthem Blue Cross & Blue Shield Counties available: Fairfield, Hartford, and New Haven	MediBlue HMO Value	HMO	\$0	\$0	Many generics	In Network: \$25 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each in-area, Network urgent care Medicare-covered visit. \$35 co-pay for each specialist visit for Medicare-covered benefits	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted for the same condition within 72 hours	\$250 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 100: \$60 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
Anthem Blue Cross & Blue Shield Counties available: Fairfield, Hartford, and New	Essential	HMO	\$0	\$0	No drug coverage in this Plan	In Network: \$25 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted for the same condition within 72 hours	\$250 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 100: \$60 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
<i>Haven</i>						each in-area, Network urgent care Medicare-covered visit. \$35 co-pay for each specialist visit for Medicare-covered benefits			
Anthem Blue Cross & Blue Shield <i>Counties available: Litchfield, Middlesex, New London, Tolland and Windham</i>	Smart Value Classic	PFFS	\$0	\$15	No drug coverage in this Plan	In Network: \$25 to \$35 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each specialist visit for Medicare-covered benefits	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted for the same condition within 72 hours	\$280 each day days 1 – 6; \$0 each day days 7 - 90	Days 1 - 20: \$0 co-pay per day. Days 21 – 100: \$130 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
Anthem Blue Cross & Blue Shield	Smart Value Plus	PFFS	\$0	\$34.50	Many generics	In Network: \$25 to \$35 co-pay for each primary	\$50 co-pay for Medicare-covered visits. You do not pay	\$280 each day days 1 – 6; \$0 each day days 7 - 90	Days 1 - 20: \$0 co-pay per day. Days 21 – 100: \$130 co-pay per

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
<i>Counties available: Litchfield, Middlesex, New London, Tolland and Windham</i>						care doctor visit for Medicare-covered benefits. \$35 co-pay for each specialist visit for Medicare-covered benefits	if you are admitted for the same condition within 72 hours		day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
ConnectiCare, Inc. <i>Counties available: All counties in Connecticut</i>	VIP Option 1	HMO/POS	\$0	\$168	Many generics	\$10	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted within 24 hours	\$100 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 10: \$0 co-pay per day. Days 11 - 100: \$100 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
ConnectiCare, Inc. <i>Counties available: All</i>	VIP Option 2	HMO/POS	\$0	\$119	No gap coverage	\$10	\$50 co-pay for Medicare-covered visits. You do not pay if you are	\$100 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 10: \$0 co-pay per day. Days 11 - 100: \$100 co-pay per day. Plan

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
<i>counties in Connecticut</i>							admitted within 24 hours		covers up to 100 days each benefit period. No prior hospital stay is required
ConnectiCare, Inc. <i>Counties available: All counties in Connecticut</i>	VIP Prime 1	HMO	\$0	\$0	No gap coverage	\$25	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted within 24 hours	\$250 each day days 1 – 10; \$0 each day days 11 - 90	Days 1 - 10: \$0 co-pay per day. Days 11 - 100: \$100 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
ConnectiCare, Inc. <i>Counties available: All counties in Connecticut</i>	VIP Prime 2	HMO	\$0	\$68	No gap coverage	\$20	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted within 24 hours	\$200 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 10: \$0 co-pay per day. Days 11 - 100: \$100 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
Connecticare <i>Counties available: All counties in Connecticut</i>	VIP Prime 3	HMO	\$0	\$129	Many generics	\$10	\$50 co-pay for Medicare-covered visits. You do not pay if you are	\$100 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 10: \$0 co-pay per day. Days 11 - 100: \$100 co-pay per day. Plan

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
							admitted within 24 hours		covers up to 100 days each benefit period. No prior hospital stay is required
ConnectiCare, Inc. <i>Counties available: All counties in Connecticut</i>	VIP Prime 4	HMO	\$0	\$0	No drug coverage	\$20	\$50 co-pay for Medicare-covered visits. You do not pay if you are admitted within 24 hours	\$200 each day days 1 – 7; \$0 each day days 8 - 90	Days 1 - 10: \$0 co-pay per day. Days 11 - 100: \$75 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
Health Net of Connecticut <i>Counties available: All counties in Connecticut</i>	Health Net Green	HMO	\$0	\$5	No drug coverage	In Network: \$20 co-pay for each primary care doctor visit for Medicare-covered benefits. \$20 co-pay for each in-area, Network urgent care Medicare-covered visit. \$30 co-pay for each specialist	In Network: \$50 co-pay for Medicare-covered emergency room visits. Out-of-Network: \$50,000 limit for emergency services outside the U.S. every year. In and Out-of-Network: If you are admitted to the	For Medicare-covered hospital stays: Days 1 - 8: \$200 co-pay per day. \$0 co-pay for additional hospital days. \$3,000 out of pocket limit every year. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are	For SNF stays: Days 1 - 20: \$0 co-pay per day. Days 21 - 100: \$100 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
						visit for Medicare-covered benefits	hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit	going to be admitted to the hospital	
Health Net of Connecticut Counties available: All counties in Connecticut	Health Net Navy 1	HMO	\$0	\$162	The Plan covers many generics (65%-99% of formulary generic drugs) AND few brands (less than 10% of formulary brand drugs) through the coverage gap	In Network: \$20 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each in-area, Network urgent care Medicare-covered visit. \$35 co-pay for each specialist visit for Medicare-covered benefits	In Network: \$50 co-pay for each Medicare-covered visit. Out-of-Network: \$50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit	For a Medicare-covered stay at a Network hospital you pay: \$100 per day, days 1 - 3; \$150 per day, days 4 - 5; \$0 for additional days. \$1,200 out of pocket limit every year. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital	You pay: \$0 per day, days 1 - 20; \$100 per day, days 21 – 100. No prior hospital stay required. You are covered for 100 days each benefit period
Health Net of	Health Net	HMO/P	\$0	\$89	No gap	In Network:	In Network: \$50	For a Medicare-	You pay: \$0 per

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Connecticut <i>Counties available: All counties in Connecticut</i>	Navy 2	OS			coverage	\$15 co-pay for each primary care doctor visit for Medicare-covered benefits. \$25 co-pay for each in-area, Network urgent care Medicare-covered visit. \$25 co-pay for each specialist visit for Medicare-covered benefits	co-pay for each Medicare-covered visit. Out-of-Network: \$50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit	covered stay at a Network hospital you pay: \$100 per day, days 1 – 10; \$0 for additional days. \$1,500 out of pocket limit every year. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital	day, days 1 - 20; \$100 per day, days 21 – 100. No prior hospital stay required. You are covered for 100 days each benefit period
Health Net of Connecticut <i>Counties available: All counties in Connecticut</i>	Health Net Ruby Option 1	HMO	\$0	\$122	Preferred generics only, \$8 co-pay	In Network: \$10 co-pay for each primary care doctor visit for Medicare-covered benefits. \$10 co-pay for each in-area, Network urgent care Medicare-covered visit.	\$50 for each Medicare-covered visit. You do not pay if you are admitted within 24 hours for the same condition	For a Medicare-covered stay at a Network hospital you pay: \$50 per day, days 1 - 3; \$100 per day, days 4 - 10; \$0 for additional days	You pay: \$0 per day, days 1 - 20; \$100.00 per day, days 21 – 100. No prior hospital stay required. No limit to the number of days covered by the plan each benefit period.

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
						\$20 co-pay for each specialist visit for Medicare-covered benefits			
Health Net of Connecticut <i>Counties available: All counties in Connecticut</i>	Health Net Ruby Option 2	HMO	\$0	\$12	Preferred generics only, \$8 co-pay	In Network: \$20 co-pay for each primary care doctor visit for Medicare-covered benefits. \$20 co-pay for each in-area, Network urgent care Medicare-covered visit. \$30 co-pay for each specialist visit for Medicare-covered benefits	\$50 for each Medicare-covered visit. You do not pay if you are admitted within 24 hours for the same condition	For a Medicare-covered stay at a Network hospital you pay: \$250 per day, days 1 - 7; \$0 for additional days	You pay: \$0 per day, days 1 - 20; \$100.00 per day, days 21 – 100. No prior hospital stay required. No limit to the number of days covered by the plan each benefit period.
Health Net of Connecticut <i>Counties available: All counties in</i>	Health Net Ruby Option 3	HMO	\$0	\$71	Preferred generics only, \$8 co-pay	In Network: \$15 co-pay for each primary care doctor visit for Medicare-	\$50 for each Medicare-covered visit. You do not pay if you are admitted within	For a Medicare-covered stay at a Network hospital you pay: \$100 per day, days 1 - 10; \$0 for additional days	You pay: \$100 per day, days 1 – 10. No prior hospital stay required. No limit to the

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
<i>Connecticut</i>						covered benefits. \$15 co-pay for each in-area, Network urgent care Medicare-covered visit. \$25 co-pay for each specialist visit for Medicare-covered benefits	24 hours for the same condition		number of days covered by the plan each benefit period
Unicare Life & Health <i>County available: Middlesex</i>	Security Choice Plus	PFFS	\$0	\$56	Many generics	\$25 to \$35 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each specialist visit for Medicare-covered benefits. General: You may go to any doctor,	\$50 for each Medicare-covered visit. You do not pay if you are admitted within 72 hours for the same condition	For Medicare-covered stays you pay: \$280 per day for days 1 - 6; \$0 for additional days	You pay: \$0 per day, days 1 – 20. \$130 per day, days 21 – 100. No prior hospital stay required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
						specialist, or hospital that accepts the Plan's terms and conditions of payment			
Unicare Life & Health County available: Middlesex	Security Choice Classic	PFFS	\$0	\$55	This plan does not offer drug coverage	\$25 to \$35 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each specialist visit for Medicare-covered benefits. General: You may go to any doctor, specialist, or hospital that accepts the Plan's terms and conditions of payment	\$50 for each Medicare-covered visit. You do not pay if you are admitted within 72 hours for the same condition	For Medicare-covered stays you pay: \$280 per day for days 1 - 6; \$0 for additional days	You pay: \$0 per day, days 1 – 20. \$130 per day, days 21 – 100. No prior hospital stay required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Universal American Counties available: All counties in Connecticut	Today's Options Premier Powered by CCRx	PFFS	\$0	\$160 with drug coverage; \$119 without drug coverage	For the Plan with drug coverage many generics are covered in the gap	\$15 to \$35 co-pay for each primary care doctor visit for Medicare-covered benefits. \$40 co-pay for each specialist visit for Medicare-covered benefits. General: You may go to any doctor, specialist, or hospital that accepts the Plan's terms and conditions of payment	\$50 co-pay for Medicare-covered emergency room visits. \$25,000 limit for emergency services outside the U.S. every year. If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit. If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit	For a Medicare-covered stay at a provider that accepts the Plan's terms and conditions of payment except in emergencies, you pay: \$250 per day for days 1 – 5; \$0 for additional days.	Days 1 - 20: \$0 co-pay per day. Days 21 - 100: \$100 co-pay per day. Plan covers up to 100 days each benefit period No prior hospital stay is required
Universal American Counties available: All counties in Connecticut	Today's Options Value Powered by CCRx	PFFS	\$0	\$89 with drug coverage; \$75 without drug coverage	No gap coverage for Plan with drug coverage	\$25 to \$35 co-pay for each primary care doctor visit for Medicare-covered benefits. \$50	\$50 co-pay for Medicare-covered emergency room visits. \$25,000 limit for emergency services	For a Medicare-covered stay at a provider that accepts the Plan's terms and conditions of payment except in emergencies, you	Days 1 - 20: \$0 co-pay per day. Days 21 - 100: \$100 co-pay per day. Plan covers up to 100 days each benefit period

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
						co-pay for each specialist visit for Medicare-covered benefits. General: You may go to any doctor, specialist, or hospital that accepts the Plan's terms and conditions of payment	outside the U.S. every year. If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit. If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit	pay: \$350 per day for days 1 – 5; \$0 for additional days.	No prior hospital stay is required
WellCare Counties available: Fairfield, Hartford, New Haven and Tolland	WellCare Access	HMO	\$0	\$34.60	Contact Plan for details	Contact Plan for details	\$0 for each Medicare-covered visit. You pay \$0 if you are admitted within 24 hours for the same condition	You will not be charged additional cost sharing for professional services	Call Plan for details
WellCare	WellCare	HMO/P	\$0	\$99	No gap	\$0 co-pay for	\$50 for each	For a Medicare-	Days 1 - 100:

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Counties available: Fairfield, Hartford, New Haven and Tolland	Premium	OS			coverage	primary care doctor visits for Medicare-covered benefits. \$15 co-pay for specialist visits	Medicare-covered visit. You pay \$0 if you are admitted within 24 hours for the same condition	covered stays you pay: \$50 per day for days 1 – 7; \$0 for additional days	\$0 per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
Counties available: Fairfield, Hartford, New Haven and Tolland	WellCare Choice	HMO/P OS	\$0	\$29	No gap coverage	\$10 co-pay for primary care doctor visits for Medicare-covered benefits. \$30 co-pay for specialist visits	\$50 for each Medicare-covered visit. You pay \$0 if you are admitted within 24 hours for the same condition	For a Medicare-covered stays in Network you pay: \$200 per day for days 1 – 7; \$0 for additional days	Days 1 - 20: \$0 per day. Days 21 – 100: \$137.50 per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required

Special Needs Plan (SNP) Comparison Chart

Note: Special Needs Plans are not for everyone, they are for people with certain chronic or disabling conditions. Become familiar with the beneficiary population for which the plan was designed to serve and carefully examine the plan's network of providers before enrolling.

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Offers Part D Drug Coverage	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Evercare Health Plans Counties available: Fairfield, Hartford, Litchfield, New Haven, Tolland and Windham	Evercare Plan IP	SNP (PPO)	\$0	\$34.60	No gap coverage	Contact Plan for details	\$50 co-pay for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit	Days 1 - 60: \$1,100 deductible. Days 61 – 90: \$275 co-pay per day. Days 91 – 150: \$550 per lifetime reserve day. No limit to the number of days covered by the plan each benefit period.	Days 1 – 100: \$0 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
Evercare Health Plans Counties available: New Haven	Evercare Plan MP	SNP (PPO)	\$0	\$0	No gap coverage	\$15 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each specialist visit for Medicare-covered benefits	\$50 co-pay for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours for the	Days 1 - 6: \$275 co-pay per day. Days 7 - 90: \$0 co-pay per day. \$0 co-pay for additional hospital days. No limit to the number of days covered by the plan each benefit period	Contact plan for 2010 coverage

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Offers Part D Drug Coverage	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Evercare Health Plans <i>Counties available: Fairfield, Hartford, Litchfield, New Haven, Tolland and Windham</i>	Evercare Plan IP	SNP (PPO)	\$0	\$34.60	No gap coverage	Contact Plan for details	\$50 co-pay for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit	Days 1 - 60: \$1,100 deductible. Days 61 – 90: \$275 co-pay per day. Days 91 – 150: \$550 per lifetime reserve day. No limit to the number of days covered by the plan each benefit period.	Days 1 – 100: \$0 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
							same condition, you pay \$0 for the emergency room visit		
Fresenius <i>Counties available: Fairfield, Hartford, Litchfield, Middlesex, New Haven, Tolland and Windham</i>	Fresenius Medical Care Health Plan	SNP (PFFS)	\$155	\$0	This plan does not offer drug coverage	20 % of the cost for each primary care doctor visit for Medicare-covered benefits. 20 % of the cost for each specialist visit for Medicare-covered benefits	20 % of the cost for Medicare-covered emergency room visits. If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit. If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the	Days 1 - 60: \$1,100 deductible. Days 61 - 90: \$275 per day. Days 91 - 150: \$550 per lifetime reserve day. You will not be charged additional cost sharing for professional services. Plan covers 90 days each benefit period	Days 1 - 20: \$0 per day. Days 21 - 100: \$137.50 per day. You will not be charged additional cost sharing for professional services. Plan covers up to 100 days each benefit period. A 3- day prior hospital stay is required

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Offers Part D Drug Coverage	Primary Care Co-pay	Emergency Care	Inpatient Hospital Stay	Skilled Nursing
Evercare Health Plans <i>Counties available: Fairfield, Hartford, Litchfield, New Haven, Tolland and Windham</i>	Evercare Plan IP	SNP (PPO)	\$0	\$34.60	No gap coverage	Contact Plan for details	\$50 co-pay for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit	Days 1 - 60: \$1,100 deductible. Days 61 – 90: \$275 co-pay per day. Days 91 – 150: \$550 per lifetime reserve day. No limit to the number of days covered by the plan each benefit period.	Days 1 – 100: \$0 co-pay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required
							emergency room visit		

If you are on Medicare and Medicaid or Medicare and/or have Medicare and an MSP, the State most likely pays your Medicare Part B monthly premium

Medicare Managed Care Terminology

Board Certified: Doctor or other health professional that has completed the educational requirements and passed a certification examination in a particular specialty.

Copayment: The amount a member pays at the time a medical service is provided, typically \$5 to \$35, or a percentage of the cost, such as 20%.

Disenroll: End your health care coverage with a health plan.

Emergency Services: Services which are needed to evaluate or stabilize an emergency medical condition. Such a condition manifests itself by acute symptoms of sufficient severity, including severe pain, such that a "prudent" - careful, cautious - person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to a person's health; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

End-Stage Renal Disease (ESRD): Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Medicare, although they cannot enroll in a Medicare Advantage plan unless they have been affected by a plan non-renewal or live in a county offering the Fresenius demonstration project.

Evidence of Coverage: Legal document which is the agreement between the plan and the members which details the coverage available to members under the plan.

Gatekeeper: Primary care physician who coordinated a beneficiary's care and refers to other specialists for care as medically necessary.

Centers for Medicare and Medicaid Services

(CMS): CMS is a part of the U. S. Department of Health and Human Services, and is the federal agency that administers the Medicare program. CMS works to assure that the beneficiaries enrolled in this program have access to high quality care.

Medicaid: A federal program, jointly funded by State and Federal governments and run by individual States, to provide medical benefits to certain low income people. Persons who qualify for Medicaid may be covered for custodial long-term care.

Medically Necessary: Services or supplies which meet the following:

- They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition;
- They are provided for the diagnosis or direct care and treatment of medical conditions;
- They meet the standards of good medical practice within the medical community in the service area;
- They are not primarily for the convenience of the patient or provider;
- They are the most appropriate level or supply of service which can safely be provided.

Medicare: The nationwide, federal health insurance program for people aged 65 and older, and certain other qualified persons with disabilities. There is no income or asset test for eligibility. Medicare Part A covers hospital insurance; Medicare Part B covers physicians' services. Medicare *does not* cover custodial long-term care, also referred to as Original Medicare.

Medicare Advantage: A health care option that beneficiaries can choose to receive their Medicare benefits. Managed care plans have contracts with the Centers for Medicare and Medicaid Services (CMS) to provide a member's Medicare benefits. When a beneficiary enrolls in a Medicare Advantage plan, the member selects a doctor from the plan's list of primary care physicians. The primary care physician is then responsible for coordinating all of the member's health care needs.

Medicare Supplement Insurance (or Medigap): Private health insurance that pays certain costs not covered by Original Medicare, such as Medicare coinsurance and deductibles.

Network: The panel of doctors, hospitals, and other health care providers offered by a managed care plan.

Premium: The monthly or annual fee charged for being a member of a health care plan.

Preventive Care: Care to keep you healthy or prevent illness, such as routine checkups and some tests like colorectal cancer screening, yearly mammograms, and flu shots.

Primary Care Physician: Doctor such as an internist, family practitioner, or general practitioner, selected by the member, who treats and is responsible for coordinating the treatment of that member.

Provider: A health care provider or facility that is part of the managed care plan's network, having formal arrangements to provide services to the plan's members.

Service Area: The geographical area defined by a managed care plan where a member must reside in order to receive adequate health care services from the plan.

Urgently Needed Services: Services provided when a patient is temporarily absent from a plan's service area, or when the patient's plan provider network is temporarily unavailable or inaccessible when such services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through the health plan network.

2010 Medicare Advantage Plan Contact Information

<p><i>AARP (Secure Horizons)</i></p> <p>1.800.547.5514</p> <p>www.securehorizons.com</p>	<p><i>Aetna</i></p> <p>1.800.282.5366</p> <p>www.aetnamedicare.com</p>	<p><i>Anthem Blue Cross & Blue Shield</i></p> <p>1.800.797.0984</p> <p>www.anthem.com</p>
<p><i>ConnectiCare</i></p> <p>1.877.224.8220</p> <p>www.connecticare.com/medicare</p>	<p><i>Evercare</i></p> <p>1.888.834.3721</p> <p>www.evercarehealthplans.com</p>	<p><i>Fresenius Medical Health Care Plan</i></p> <p>1.866.307.3625</p> <p>www.fmchp.com</p>
<p><i>Health Net</i></p> <p>1.800.949.2516</p> <p>www.healthnet.com</p>	<p><i>Today's Options (Universal American)</i></p> <p>1.800.996.8867</p> <p>www.todaysoptions.com</p>	<p><i>Unicare</i></p> <p>1.800.797.6470</p> <p>www.unicare.com/medicare</p>
		<p><i>WellCare</i></p> <p>1.866.238.4344</p> <p>www.wellcare.com</p>

Medicare Advantage Resources

Find CHOICES about your Health Insurance concerns at ...

Your Regional Area Agency on Aging

Each of Connecticut's regional Area Agencies on Aging are staffed with a CHOICES Program Coordinator and informational assistants who have received special training in health insurance matters such as Medicare, Medicaid, Medicare Supplement Insurance (Medigap), Long Term Care Insurance and other related state and federal programs. Trained volunteers are also available to meet with seniors and other Medicare beneficiaries at sites throughout Connecticut. Call your Area Agency on Aging for free written information or advice, or referral to a counselor for further assistance. Counselors do not sell insurance. They provide the information and assistance necessary for consumers to understand their rights, receive benefits to which they are entitled, and make informed CHOICES about health insurance and other aging concerns.

Connecticut's Area Agencies on Aging are private, nonprofit organizations which serve the needs of older persons as a focal point and resource center for information, program development and advocacy.

Senior Resources/Eastern CT Area Agency on Aging 4 Broadway 3rd Floor Norwich, CT 06360; 860-887-3561 www.seniorresourcesec.org	North Central Area Agency on Aging 151 New Park Avenue Hartford, CT 06106; 860-724-6443 www.ncaaaact.org
Agency on Aging of South Central Connecticut One Long Wharf Drive New Haven, CT 06511; 203-785-8533 www.aopartnerships.org	Southwestern CT Agency on Aging 10 Middle Street Bridgeport, CT 06604; 203-333-9288 www.swcaa.org
Western CT Area Agency on Aging 84 Progress Lane Waterbury, CT 06705; 203-757-5449 www.wcaaa.org	Or call them toll-free through the CHOICES Health Insurance Hotline 1-800-994-9422 (in state only)

Agencies on Aging - CHOICES Hotline

Eastern CT AAA/Senior Resources	860-887-3561 or 1-800-994-9422
North Central CT AAA	860-724-6443 or 1-800-994-9422
South Central CT AA	203-785-8533 or 1-800-994-9422
Southwestern CT AA	203-333-9288 or 1-800-994-9422
Western CT AAA	203-757-5449 or 1-800-994-9422

Center for Medicare Advocacy, Inc.

860-456-7790 / 1-800-262-4414

Centers for Medicare and Medicaid Services (CMS)

Beneficiary Services Branch 1-617-565-1232
CMS Hotline 1-800-638-6833 (To request CMS Publications)

Qualidigm (Formerly CPRO)

Immediate hospital review determination:
1-800-553-7590 (in-state only)
860-632-2008 (Will take out of state collect calls)

Connecticut Insurance Department, Consumer Affairs 1-860-297-3800

CHOICES Health Insurance Assistance Program

CHOICES is coordinated by the Aging Services Division of the CT Department of Social Services and operated through CT's five Area Agencies on Aging. Specifically, the acronym "CHOICES" represents **C**onnecticut's program for **H**ealth insurance assistance, **O**utreach, **I**nformation and referral, **C**ounseling, and **E**ligibility **S**creening. The purpose of this is to enable older persons to understand and exercise their rights, receive benefits to which they are entitled, and make informed choices about quality of life issues. For more information, including publications such as "Original Medicare and Supplemental Options" and "Prescription Drug Assistance," please go to www.ct.gov/agingservices.

CHOICES has been designated as the official State Health Insurance Program (SHIP) for the State of Connecticut. It is funded in large part by the Centers for Medicare and Medicaid Services (CMS) of the U. S. Dept. of Health and Human Services, which administers the Medicare program for the federal government. CMS publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can request these publications by calling the Medicare Hotline at 1-800-638-6833. You can also see or print them from the Internet at: www.medicare.gov.

**The Center for Medicare Advocacy, Inc.
P. O. Box 350, Willimantic, Connecticut 06226
860-456-7790 or 1-800-262-4414**

The Center for Medicare Advocacy is staffed by attorneys, nurses, paralegals, and technical assistants and provides legal advice, self-help materials, and representation to elders and people with disabilities who are unfairly denied Medicare coverage. The Center's advice, written materials, and legal assistance are free to residents of Connecticut.

The Center also produces a wide array of self-help packets, booklets, and brochures. These materials are free to all residents of Connecticut as a part of the state's comprehensive Medicare Information, Education, and Representation program.

The Center's staff members serve as consultants and trainers for groups which are interested in learning about Medicare coverage and appeals. The Center also responds to approximately 6,000 calls each year on its Connecticut toll-free line and provides legal support and training for Connecticut's CHOICES program. In addition, the organization is involved in policy development, education, and litigation activities of importance to Medicare beneficiaries nationwide and has an office in Washington, DC.

The Center is an integral member of the CHOICES team, funded in large part by a grant from the State of Connecticut Department of Social Services.

For up-to-date Medicare information and advocacy tips, **visit the Center Web Site:**
www.medicareadvocacy.org

*** Information in this booklet is subject to change. For updates and more details contact your regional CHOICES counselor at 1-800-994-9422.**

Your Notes