CHOICES
Connecticut program for
Health insurance assistance,
Outreach, Information, Counseling,
& Eligibility Screening
1-800-994-9422

Medicare Advantage Options in CT

Tolland County Edition

With

- **Medicare Advantage Information**
- **2007 Plan Comparison Chart**
- **Medicare Advantage Plan Changes**
- **Important Resources**

for Medicare Beneficiaries
living in Connecticut

May, 2007

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A cooperative program of the State of Connecticut Department of Social Services, the Area Agencies on Aging, and the Center for Medicare Advocacy that provides Connecticut residents with direction to benefit and support programs 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 May, 2007. 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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PART I

Making an Informed Decision

MAKING AN INFORMED DECISION: "Quick Facts" About Your Medicare Choices and Common Concerns of Medicare Beneficiaries in CT

What is Medicare?

The federal health insurance program for people aged 65 or older and certain disabled individuals.

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

In Connecticut, unless you choose otherwise, you will receive benefits through the Original Medicare program. In 2007, all Connecticut residents have the option to receive benefits through a Medicare managed care plan, now referred to as Medicare Advantage.

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. All plans currently have open enrollment, however, those with capacity limits will close enrollment when they reach capacity. 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 2007, 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, this year some beneficiaries will also have the opportunity to enroll in a Special Needs Plan (SNPs).

Additionally in 2007, for the first time 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 Medicrae 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, "Original Medicare and Supplemental Options" which can be obtained by calling the CHOICES program at 1-800-994-9422.

What is the Original Medicare Program?

Original Medicare is similar to indemnity insurance in that it helps to cover the expenses of your health care. It has two separate coverage parts: Part A and Part B. Part A covers hospital, nursing home, hospice, and some home health care; Part B covers physician services, outpatient services, and some home health care. Although it provides for basic coverage it doesn't pay 100% of health care costs. Deductibles and copayments apply to some of the benefits under both parts. And in most cases other medical expenses -- such as prescription drugs, dental care, and routine physicals -- aren't covered at all. To help pay for some of these out-of-pocket expenses, beneficiaries often buy supplemental private insurance policies, called "Medigap" policies.

Under Original Medicare, you can receive services from any licensed medical provider anywhere in the country and use any facility certified by Medicare. Generally, Medicare pays a share of the cost; the patient pays what Medicare does not.

What is "Medigap" Insurance?

Medigap is a term for private insurance policies which are available to help pay health care expenses that Original Medicare covers only partially or not at all. Medigap insurance supplements or helps fill the "gaps" in Medicare coverage.

Medigap insurance is regulated by federal and state law. To make it easier for consumers to shop for a policy, there are only 12 standard Medigap plans, designated by letters "A" through "L." Companies that market their plans in Connecticut must offer at least Plan A, the "basic" benefit package, and make whichever of Plans A, B and/or C that they offer to persons over age 65, available to the beneficiaries who are under 65 and enrolled in Medicare due to a disability. Each of the other 11 plans include the basic package with a different combination of additional benefits.

In Connecticut, the premium you pay for a Medigap policy is based on a "community rate." That means that the rates may not be based on your age, gender, previous claim history or medical condition. No matter what your age or how sick you may be, you will pay the same premium for a given policy, within a company, that any other enrollee pays.

What are my rights in purchasing a Medigap policy?

State and federal laws also guarantee that, for a period of 6 months from the date you are both enrolled in Medicare Part B and age 65 or older, you have a right to buy the Medigap policy of your choice regardless of any health problems you have. This is called an open enrollment period. The company can, however, impose pre-existing condition restrictions if you have not had other "creditable" coverage for a certain period prior to your enrollment. In other words, treatment for that condition may not be covered for a certain period following enrollment. Companies can impose a waiting period of up to six months before pre-existing health conditions are covered.

Outside this "open enrollment" period, coverage cannot be denied to Medicare beneficiaries ages 65 and over for Medigap plans A through L.

➔ **What plans are you guaranteed to get into?**

- ⇨ Connecticut residents age 65 and over are guaranteed acceptance into Medigap plans A-L
- ⇨ Persons under 65 with disabilities are guaranteed acceptance into Medigap plans A, B, and C

➔ **What are the Pre-existing Condition Protections when choosing a Medigap policy in Connecticut?**

- ⇨ Pre-existing conditions are covered by Original Medicare and also by Medicare Advanatge plans. Medigap policies may have a waiting period between two (2) to six (6) months (maximum) for coverage of these conditions. After that, your pre-existing condition must be covered.
- ⇨ Some insurance companies selling Medigap policies do not have 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.
  - ⇨ If you have been in a Medicare Advantage plan for at least 6 months or are replacing employer group health insurance that you have had for at least 6 months, a pre-existing condition *must* be covered immediately, no waiting period.
  - ⇨ If you have been enrolled in a Medicare Advantage plan or had employer group health insurance for less than 6 months:
    - ➢ You are given credit for the number of months you spent in the MA plan.
    - ➢ For example, if you have had the Advantage plan for four months, and the Medigap policy you want to join has a 6 month waiting period, you will be given credit for 4 months. Your waiting period for your condition to be covered will be 2 months.

➔ **Did you enroll in Medicare managed care upon turning 65 and less than 12 months ago?**
If yes, you have the right to choose between enrolling in another Medicare Advantage plan if any are available, or to disenroll and purchase *any* Medigap policy. Your pre-existing conditions will be covered immediately. You must purchase the Medigap policy within 63 days of disenrolling from the Medicare Advantage plan. Consider the cost of the plans and how much you can afford.

➔ Did you enroll in a Medicare Advantage plan for the first time after turning 65, but less than 12 months ago? If yes, as a Connecticut resident, you have the right to:

- ⇨ Enroll in another Medicare Advantage plan if any are available, *OR*
- ⇨ Disenroll from the Medicare Advantage plan and purchase the same Medigap coverage previously held (if any) from the same company if it is still being sold, *OR*
- ⇨ Disenroll from the Medicare Advantage plan and purchase Medigap plans A through L. Refer to the section above for information on rules for coverage of pre-existing conditions. Consider the cost of the plan and how much you can afford.

For more information on Medigap rights and protections, please contact the CHOICES program at 1-800-994-9422 and refer to the booklet *Original Medicare and Supplemental Options.*

Are there any programs to assist Medicare beneficiaries of modest means with paying Medicare premiums, deductibles, and copayments?

Medicare beneficiaries may qualify for help from the state to pay for certain costs under the **Medicare Savings Programs: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Additional Low-Income Medicare Beneficiary (ALMB*)** programs. To qualify for QMB or SLMB programs an individual must be eligible for Medicare with assets not exceeding $4,000 for one person and $6,000 for a couple. There is no asset limit for ALMB ("QI") Program*. Each program also has income limits ranging from $1,078 to $1,375.85 per month for one person and $1,595 to $1,994.35 per month for a couple. An application form can be obtained by contacting the Department of Social Services Regional offices located in the Blue Pages of your telephone book.

***ALMB Group 1 program has been extended through September 30, 2007. It is unclear if the program will be extended beyond that time. Contact your local Area Agency on Aging Counselor for more information on the status of the ALMB program.**

Does the state provide assistance in paying for prescription drugs?

CONNPACE – 2007!

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

Who is Eligible?

- You must be 65 or older or a person over age 18 with a disability; and
- Your income must not exceed maximum limits. Effective **January 1, 2006**: Single applicants: $23,100; married couple: $31,100. *Income limits increase each January 1st based on the Social Security Cost of Living increase; and
- You must have been living in Connecticut for at least 183 days prior to application.
- In most cases, you **may not** have another insurance plan that covers a portion of all of your prescriptions.
- You **may** have an insurance plan that provides a maximum of benefits. Eligibility will be granted when you have reached your maximum benefit.
- You **may** have an insurance plan that covers only generics; under certain circumstances, ConnPACE may cover brand name drugs for which there are no generic equivalents as well as brand name versions of drugs that have generics.
- If you are eligible for ConnPACE, you are also automatically eligible for the Connecticut ConnMAP program. ConnMAP requires Connecticut Medicare providers to accept assignment.

How much does it cost?

- Enrollment in the ConnPACE program is $30 per year per person.
- A maximum co-payment of $16.25 will be charged by the pharmacy for each prescription filled.

What is Prior Authorization?

There are two situations in which ConnPACE recipients need to have their physician or pharmacist obtain prior authorization in order to have ConnPACE pay the program's portion of the prescription drug costs. The two circumstances requiring Prior Authorization are:

- Being issued a prescription written as "Brand Medically Necessary" when there is a generic equivalent
- Seeking a refill when less than 75% of the previously issued drug has been utilized

Prior Authorization (PA) for brand name prescriptions and for some early refills (controlled drugs) requires the prescribing physician to complete certain forms in order to obtain PA for you. In instances when you are obtaining a refill early (most drugs) the Pharmacist will initiate the PA process for you. You should not have to do anything except remind your prescribing physician that you are on ConnPACE and may need PA.

For more information on Prior Authorization and to view Prior Authorization forms log onto www.ctpharmacyprogram.com or call ACS the Department of Social Services' contractor for Prior Authorization at 1-866-759-4113.

What are the changes to ConnPACE?

In 2006 the ConnPACE program underwent some changes. Important changes to the program that you should know about are:

- ConnPACE wraps-around the new Medicare prescription drug benefit (also called Medicare Rx or Medicare Part D)
- Every ConnPACE recipient who has Medicare Part A and/or B is required to enroll in a Medicare Rx plan
- Individuals with incomes below $15,315 (single) or $20,535 (couple) and countable assets below $10,210 (single) and $20,410 (couple) are also required to apply for Extra Help through the Social Security Administration to help cover costs associated with Medicare Rx.

How will ConnPACE work with the new Medicare prescription drug program (Medicare Rx)?

January 1, 2006 a new prescription drug program became available to people on Medicare. The program known as Medicare Rx or Medicare Part D pays for outpatient prescription drugs, insulin and insulin supplies and "stop smoking" drugs. If you have Medicare and ConnPACE, you need to enroll in a Medicare prescription drug plan. If you were enrolled in ConnPACE prior to January 1, 2006 you are most likely already enrolled into a Medicare Rx plan.

On December 1, 2005 Governor Rell signed into law a Bill that allows ConnPACE to "wrap-around" (meaning "work with" or "coordinate benefits with") the new Medicare prescription drug program. ConnPACE recipients who are also enrolled in Medicare Part A and/or B are required to

select and enroll in a Medicare Rx plan. Additionally, those recipients with incomes below $15,315 (single) or $20,535 (couple) and countable assets below $10,210 (single) and $20,410 (couple) are required to apply for Extra Help available to cover costs associated with Medicare Rx.

How does ConnPACE work together with the Medicare Rx program?
Here is a summary of how the program works:

- The Medicare Rx plan that you enroll in will give you a member card that you will use at the pharmacy, just like you use your ConnPACE card now.
- You'll still pay your annual $30 ConnPACE membership fee.
- You won't have to pay any monthly premiums for Medicare Rx coverage.
- The plan you select may have an annual deductible; however, during the time that you are meeting this deductible you'll never pay more than $16.25 for each prescription you fill.
- You won't have any gaps in coverage. The most you will pay in the coverage gap is $16.25.
- You will still be able to get all of the drugs you started taking prior to January 1, 2006 but may have to go through an exceptions process to do so if the drugs are not covered by your Medicare Rx plan.
- You will still have a co-pay. The amount you pay will depend on the amount of your income and assets, but it will never be more than $16.25. It may even be less – as low as $2.15/$5.35 (for generic or brand-name drugs).
- The most you may be able to receive is a 90 day supply of medication at one time. This will depend on the pharmacy that you use.

How do I select and enroll in a Medicare Rx plan?
ConnPACE recipients have a few options for selecting and enrolling into a Medicare prescription drug plan. If you are on ConnPACE you can:

1. **If you are new to ConnPACE you need to select and enroll in a Medicare Rx plan on your own.** Individuals can select and enroll into any one of the Medicare Rx plans on their own by logging onto www.Medicare.gov and using the online Medicare Rx plan finder tool. You can also call 1-800-Medicare or CHOICES at 1-800-994-9422 and a trained counselor will assist you. If you wish, you may also request on your application that ConnPACE select and enroll you into a plan.

2. **If you were on ConnPACE prior to January 1, 2006 you have most likely already been enrolled into a Medicare Rx plan.** If you did not select and enroll into a plan on your own last year ConnPACE selected a plan for you and enrolled you into that plan. You should have received a informing you which plan ConnPACE chose for you. For more information on the ConnPACE auto-enrollment process call ConnPACE at 1-800-423-5026 or a CHOICES counselor at 1-800-994-9422.

Can I change plans if I have ConnPACE?

Yes. You can change plans during the Annual Coordinated Enrollment Period, which is from November 15th – December 31st of each year. Your new coverage will be effective January 1st of the following year. Additionally, ConnPACE members are entitled to a one time special enrollment period each year to change or enroll into a Medicare Rx plan.

NOTE: **If you have a Medicare Savings Program you are not limited to the Annual Coordinated Enrollment Period. You can change plans any time**

How do I change plans?

To change plans, you just need to enroll in the new plan that you want. You don't need to disenroll from your existing plan! Your enrollment in the new plan will automatically cancel your enrollment in your former plan. **To avoid delays or problems with enrollment, it is strongly advised that you enroll in your new plan before the 8th of the month.** For example, if you want to be in your new plan by July 1, 2007, you should enroll by June 8, 2007.

You can enroll in your new plan by calling the plan directly, calling 1-800-MEDICARE, or by calling CHOICES at 1-800-994-9422.

NOTE: if you are satisfied with the plan that you have you do not need make a change each year. You can remain in your current plan. You do not need to do anything to remain in your current plan.

I am on ConnPACE (or enrolling in ConnPACE for the 1st time) and qualify for the Extra Help to pay for the costs associated with Medicare Rx. Do I have to apply for the Extra Help?

Yes. ConnPACE recipients with incomes below $15,315 (single) or $20,535 (couple) and countable assets below $10,210 (single) and $20,410 (couple) are required to apply for Extra Help available to cover costs associated with Medicare Rx.

Like the Medicare prescription drug benefit itself, the Extra Help subsidy will save you money. With ConnPACE and the Extra Help together, you will pay no premiums, and as little as $2.15/$5.35 per prescription. It will also save money for the State of Connecticut. For this reason, ConnPACE may have asked you to complete an application for Extra Help *if* your income is below the Extra Help

income limit. If your are joining ConnPACE for the first time it is a good idea to complete an application for Extra Help before applying for the ConnPACE program. Contact the Social Security Administration at 1-800-772-1213 to receive an application for the Extra Help.

Who do I call if I have specific questions about Medicare Rx and the ConnPACE wrap-around?

For more information about how ConnPACE works with the Medicare prescription drug program contact CHOICES at 1-800-994-9422 and a trained counselor will be able to assist you. You may also request the CHOICES booklet "Medicare Prescription Drug Coverage: Information for ConnPACE Recipients".

Who do I call if I have specific questions about ConnPACE?

You may call ConnPACE directly from within the state at 1-800-423-5026 or you may call the CHOICES Program from within the state at 1-800-994-9422 and a trained counselor will assist you.

How Do I Apply for ConnPACE?

Call 1-800-423-5026 for an application or for more information.

Please be aware that there may be additional changes to the ConnPACE Program in the future. For information regarding any new program changes please contact your regional Area Agency on Aging CHOICES Counselor listed at the back of this booklet.

What is Medicare Advantage?

The other option through which Medicare beneficiaries can receive their Medicare benefits is Medicare managed care now called Medicare Advantage. Medicare Advantage plans are often referred to as "HMOs," (which means "health maintenance organizations"), PPOs (which means Preferred Provider Organization) and PFFSs (which means Private-Fee-For-Service). In 2007 there are also new Special Needs Plans (SNPs). The Medicare Advantage benefit is different from the Original Medicare "fee-for-service" system both in the additional benefits you receive and the manner in which you receive them. Medicare Advantage plans attempt to coordinate all health care services an individual receives. Plans use a limited network of health care providers and facilities and a system of "prior approval" from a primary care physician, sometimes referred to as a "gatekeeper," to achieve these goals. 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.

Health Maintenance Organizations (HMOs)

All Medicare beneficiaries living in CT have the choice of selecting a Medicare advantage plan. In Connecticut, many of the HMO plans require an additional monthly premium. Most also offer prescription drug coverage through the mew Medicare prescription drug program, Medicare Rx. Plans require copayments most times that you go to the doctor or use other services. **You also must continue to pay the Part B premium, but you do not have to pay Original Medicare's deductible and coinsurance.** 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.

Each plan has a network of providers operating through private practice offices. 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.

While benefits vary from plan to plan, every plan is required by Medicare law to provide all of the Medicare benefits generally available in the plan's service area. **You must get all of your Medicare benefits through the plan.**

Preferred Provider Organization (PPO)

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, PPOs allow 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.

Private Fee For Service (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 those covered by original Medicare such as, extra days in a hospital.

Special Needs Plans (SNPs)

Special Needs Plans are designed to meet the needs of beneficiaries in specific circumstances such as living a 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 plans 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.

Medicare Medical Savings Account Plan (MSA) – *Only Available in Middlesex County*

Medicare Medical Savings Account Plans (MSAs) are a new Medicare Advantage option available in CT in 2007. MSA plans combine traditional Medicare HMO plans with Medical Savings Accounts. This option has a high deductible that must be met before coverage begins for most services. This option is only available in Middlesex County.

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 copayments 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, "Original Medicare Care and Supplemental Options" 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; and
- 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.

*In CT there is currently a Demonstration project available to individuals with End Stage Renal Disease through the Fresenius Medical Care Health Plan. To learn more about this program contact CHOICES at 1-800-994-9422 or contact Fresenius directly at 1-800-238-1143.

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 Centers for Medicare and Medicaid Services-approved capacity limit, then, when that plan reaches the limit, they will close 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 including 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. Enroll by the last day of the month to be effective the first of the next month.
  - Example: Enroll by January 31, 2008 for an effective date of February 1, 2008

  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.

  NOTE: You may not add or drop prescription drug coverage during open enrollment. Therefore if you have a plan that contains prescription drug coverage you may only change to a plan that includes prescription drug coverage. Conversely, if you do not have drug coverage you may only enroll into a plan that does not offer prescription drug coverage.

- **Annual**: This occurs November 15 – December 31, 2007. During this time you may enroll in a Medicare Advantage plan effective January 1, 2008.

- **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 three months immediately before your entitlement to both Medicare Part A and Part B.

- **Limited:** For 2007 and 2008 ONLY, there is also a Limited Enrollment Period. The LEP is a time when individuals enrolled in Original Medicare can enroll into a Medicare Advantage plan that **does NOT** contain prescription drug coverage. Beneficiaries who are currently enrolled in a Medicare Advantage plan may also disenroll and return to Original Medicare at this time. It is important to carefully consider the pros and cons of changing plans during this enrollment period as you could be terminating your prescription drug coverage.

- **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.

How Do I Disenroll from a Plan?

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 reentered 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.**

If you want to change from one Medicare Advantage plan to another, you may do so by enrolling in the other plan. You will automatically be disenrolled from the first plan.

MAKING AN INFORMED DECISION:
Consider the Advantages and Disadvantages of Medicare Advantage Plans

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 Advanatge 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 "gatekeeper" 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, copayments, 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 contracts with and directly monitors approved plans. Unlike Medigap policies, there are no guidelines requiring "standardized" plans.

MAKING AN INFORMED DECISION:
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 Plans' 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.

- 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

Learn how to use the Plan complaint system and how the grievances and appeals are handled.

✓ ——————————————————————————————

Read, ask questions, consider, 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 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.

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PART II

2007 MEDICARE ADVANTAGE PLAN COMPARISON CHART

1-800-994-9422

Medicare Advantage
Plan Comparison Chart for 2007
For Beneficiaries Living in Tolland County, 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, 2007, 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, 2007 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 **Tolland County only**. If you do not live in this county please contact CHOICES at 1-800-994-9422 and request the Medicare Advantage Options booklet for your county.

Medicare Advantage Plans (HMO, PFFS, Demonstration) Available by County – CT 2007

* Indicates no Medicare Rx coverage

Company	Plan	Plan Type	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham
Aetna	Aetna Golden Medicare Value Plan	HMO	X	X			X			
	Aetna Golden Medicare Standard Plan	HMO	X	X			X			
	Aetna Golden Medicare Premier Plan	HMO	X	X			X			
	Aetna Golden Medicare Open Plan	PFFS			X					
Anthem Blue Cross & Blue Shield	MediBlue HMO Essential	HMO*	X	X			X			
	MediBlue HMO Plus	HMO	X	X			X			
	MediBlue HMO Select	HMO	X	X			X			
	SmartValue Classic	PFFS*				X				
	SmartValue Plus	PFFS				X				
Fresenius Medical Care Health Plan	Fresenius Medical Care Health Plan	Demo*^	X	X	X	X	X		X	X
Health Net	HN Green	HMO*	X	X	X	X	X	X	X	X
	HN Navy	HMO	X	X	X	X	X	X	X	X
	HN Ruby 1	HMO	X	X	X	X	X	X	X	X
	HN Ruby 2	HMO	X	X	X	X	X	X	X	X
	HN Ruby 3	HMO	X	X	X	X	X	X	X	X

Company	Plan	Plan Type	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham
	HN Pearl 5	PFFS*		X		X	X	X	X	X
	HN Pearl 6	PFFS		X		X	X	X	X	X
Humana	Humana Gold Choice 249	PFFS		X	X	X			X	
	Humana Gold Choice 247	PFFS		X	X	X			X	
	Humana Gold Choice 248	PFFS		X	X	X			X	
Secure Horizons	Medicare Direct 10	PFFS*				X				
	Medicare Complete	HMO					X			
Today's Options	Premier	PFFS*	X	X	X	X	X	X	X	X
	Premier Plus	PFFS	X	X	X	X	X	X	X	X
	Value	PFFS*	X	X	X	X	X	X	X	X
	Value Plus	PFFS	X	X	X	X	X	X	X	X
UniCare	SecurityChoice Plus	PFFS				X				
UniCare Life & Health Co.	Save Well	MSA				X				
WellCare	WellCare Choice	HMO	X	X			X			
	WellCare Premium	HMO	X	X			X			
	WellCare Advance	HMO*	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.

*** Indicates no Medicare prescription drug coverage**

Medicare Advantage Special Needs Plans Available by County – CT 2007
*All plans provide prescription drug coverage through Medicare Part D

Company	Plan	Plan Type	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham
Health Net	HN Amber	SNP	X	X	X	X	X	X	X	X
Senior Whole Health, LLC	Senior Whole Health	SNP		X		X	X			
United Health Care	Evercare Plan MP	SNP		X						
	Evercare Plan DP	SNP	X	X			X			
	Evercare Plan IP	SNP	X	X			X			
	Evercare DH-POS	SNP			X				X	X
	EverCare IH-POS	SNP			X				X	X
WellCare	WellCare Access	SNP	X	X			X			
	WellCare Select	SNP	X	X			X			

*** Note: Special Needs Plans are not for everyone, carefully review eligibility criteria before selecting one of these plans.**

Medicare Advantage Plans (HMO, PFFS & Demonstration) Comparison Chart - Tolland County
*Indicates no Medicare prescription drug coverage

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
Fresenius Medical Care Health Plan	Fresenius Medical Care Health Plan	Demo* **^ See Note below**	**$131**	**$0/** month plus **$93.50** Medicare Part B monthly premium	No Medicare Part D Drug Coverage	You pay: **20%** of the cost for each visit to a primary care physician or specialist for Medicare covered services.	You pay: **20%** of the cost (**up to $50**) for each Medicare covered visit. You do not pay if admitted within 3 days for the same condition.	For services at a network hospital you pay: Initial deductible of **$992.** After that you pay: **$0** per day, days 1-60; **$248** per day, days 61-90. You have 60 lifetime reserve days. You pay: **$496** each day, days 1-60.	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$124** per day for days 21-100 3 day prior hospital stay required. You are covered for 100 days each benefit period.
Health Net	HN Green	HMO*	**$0**	**$0/** month plus **$93.50** Medicare Part B monthly premium	No Medicare Part D Drug Coverage	**$15** for each visit to a primary care physician & **$25** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$100** per day, days 1-5; **$0** per day, days 6-90. You pay: **$0** for additional days. $1,000 max out of pocket limit every year.	For a Medicare covered stay you pay: **$0** per day, days 1-15; **$75** per day for days 16-100 No prior hospital stay required. You are covered for 100 days each benefit period.
Health Net	HN Navy *** Information listed here is for services received in-**	HMO	**$0**	**$ 119/** month plus **$93.50** Medicare Part B	No Coverage in Gap	**$10** for each visit to a primary care physician & **$15** for each visit to a specialist for	You pay: **$50** for each Medicare covered ER visit. You do	For a Medicare covered stay at a network hospital you pay: **$0** per day, days 1-90 and **$0** for	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$50** per day for days

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
Health Net (continued)	**network. In general, services received out of network will cost more. Contact Health Net for details.**			monthly premium		Medicare covered services	not pay this if admitted within 24 hrs for the same condition.	additional days. You are covered for unlimited days each benefit period.	21-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	HN Ruby 1	HMO	**$0**	**$ 99/** month plus **$93.50** Medicare Part B monthly premium	Yes Generics Only	**$5** for each visit to a primary care physician & **$15** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$0** per day, days 1-90 and **$0** for additional days. You are covered for unlimited days each benefit period.	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$50** per day for days 21-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	HN Ruby 2	HMO	**$0**	**$ $0/** month plus **$93.50** Medicare Part B monthly premium	No Coverage in Gap	**$15** for each visit to a primary care physician & **$30** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$200** per day, days 1-7 and **$0** for days 8-90; **$0** for additional days. You are covered for unlimited days each benefit period. $2,400	For a Medicare covered stay you pay: **$0** per day, days 1-15; **$75** per day for days 16-100 No prior hospital stay required. You are covered for 100 days each

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
Health Net (continued)	HN Ruby 2 (continued)							max out of pocket limit each year.	benefit period.
	HN Ruby 3	HMO	**$0**	**$45/** month plus **$93.50** Medicare Part B monthly premium	No Coverage in Gap	**$15** for each visit to a primary care physician & **$25** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$75** per day, days 1-7; **$0** per day, days 8-90; **$0** for additional days. You are covered for unlimited days each benefit period. $1,000 max out of pocket limit each year.	For a Medicare covered stay you pay: **$0** per day, days 1-15; **$75** per day for days 16-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	HN Pearl 5	PFFS*	**$0**	**$139/** month plus **$93.50** Medicare Part B monthly premium - There is a $500 max out of pocket limit for all plan services each year.	No Medicare Part D Drug Coverage	**$5** for each visit to a primary care physician & **$5** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$0** per day, days 1-90; **$0** for additional days. You are covered for unlimited days each benefit period. You may go to any hospital that accepts plan's payment.	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$50** per day for days 21-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	HN Pearl 6	PFFS	**$0**	**$159/** month plus **$93.50**	No Coverage in Gap	**$5** for each visit to a primary care physician & **$5** for	You pay: **$50** for each Medicare	For a Medicare covered stay at a network hospital you	For a Medicare covered stay you pay: **$0** per day, days

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
Health Net (continued)	HN Pearl 6 (continued)			Medicare Part B monthly premium - There is a $500 max out of pocket limit for all plan services each year.		each visit to a specialist for Medicare covered services	covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	pay: **$0** per day, days 1-90; **$0** for additional days. You are covered for unlimited days each benefit period. You may go to any hospital that accepts plan's payment.	1-20; **$50** per day for days 21-100 No prior hospital stay required. You are covered for 100 days each benefit period.
Humana	Humana Gold Choice 249	PFFS	**$265** for Medicare Rx coverage only	**$89/** month plus **$93.50** Medicare Part B monthly premium There is a $5,000 out of pocket max for Medicare covered plan services each year.	No Coverage in Gap	**$15** for each visit to a primary care physician & **$30** for each visit to a specialist for Medicare covered services	You pay: **20%** of the cost up to **$50** for each Medicare covered ER visit.	For a Medicare covered stay at a hospital you pay: **$550** per stay. You are covered for unlimited days each benefit period. You may go to any hospital that accepts plan's payment.	For a Medicare covered stay you pay: **$0** per day, days 1-3; **$90** per day for days 4-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	Humana Gold Choice 247	PFFS	**$0**	**$99/** month plus **$93.50**	No Coverage in Gap	**$15** for each visit to a primary care physician & **$30** for	You pay: **20%** of the cost up to **$50** for	For a Medicare covered stay at a hospital you pay: **$550**	For a Medicare covered stay you pay: **$0** per day, days

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
Humana (continued)	Humana Gold Choice 247 (continued)			Medicare Part B monthly premium There is a $5,000 out of pocket max for Medicare covered plan services each year.		each visit to a specialist for Medicare covered services	each Medicare covered ER visit.	per stay. You are covered for unlimited days each benefit period. You may go to any hospital that accepts plan's payment.	1-3; **$90** per day for days 4-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	Humana Gold Choice 248	PFFS	**$0**	**$129/** month plus **$93.50** Medicare Part B monthly premium There is a $5,000 out of pocket max for Medicare covered plan services each year.	No Coverage in Gap	**$15** for each visit to a primary care physician & **$30** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit.	For a Medicare covered stay at a hospital you pay: **$180** per day, days 1-5; **$0** per day, days 6-90; **$0** for additional days. You are covered for unlimited days each benefit period. You may go to any hospital that accepts plan's payment.	For a Medicare covered stay you pay: **$0** per day, days 1-3; **$90** per day for days 4-100 No prior hospital stay required. You are covered for 100 days each benefit period.
Today's Options	Premier Plan	PFFS*	**$0**	**$46/** month plus	No Medicare	**$5** for each visit to a primary care	You pay: **$35** for each	For a Medicare covered stay at a	For a Medicare covered stay you

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Rx Coverage in Gap?	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
Today's Options (continued)	Premier Plan (continued)			**$93.50** Medicare Part B monthly premium There is a $2,500 out of pocket max for Medicare covered plan services each year.	Part D Drug Coverage	physician & **$15** for each visit to a specialist for Medicare covered services - You may go to any Doctor that accepts the plan's payment.	Medicare covered ER visit. You do not pay this if admitted within 72 hrs for the same condition.	network hospital you pay: **$150** per stay*; **$0** for additional days. You are covered for unlimited days each benefit period. $600 max out of pocket limit each year. *Must notify plan in advance	pay: **$0** per day, days 1-20; **$100** per day for days 21-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	Premier Plus	PFFS	**$0**	**$85/** month plus **$93.50** Medicare Part B monthly premium There is a $2,500 out of pocket max for Medicare covered plan services each year.	Yes Generics Only	**$5** for each visit to a primary care physician & **$15** for each visit to a specialist for Medicare covered services - You may go to any Doctor that accepts the plan's payment.	You pay: **$35** for each Medicare covered ER visit. You do not pay this if admitted within 72 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$150** per stay*; **$0** for additional days. You are covered for unlimited days each benefit period. $600 max out of pocket limit each year. *Must notify plan in advance	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$100** per day for days 21-100 No prior hospital stay required. You are covered for 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	In-Patient Hospital Stay	Skilled Nursing
Today's Options (continued)	Value Plan	PFFS*	**$0**	**$15/** month plus may take as much as **$27.80** off of the **$93.50** Medicare Part B monthly premium There is a $3,000 out of pocket max for Medicare covered plan services each year.	No Medicare Part D Drug Coverage	**$15** for each visit to a primary care physician & **$30** for each visit to a specialist for Medicare covered services - You may go to any Doctor that accepts the plan's payment.	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 72 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$175** per day, days 1-4 stay*; **$0** for days 5-90; **$0** for additional days. You are covered for unlimited days each benefit period. $1,700 max out of pocket limit each year. *Must notify plan in advance	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$100** per day for days 21-100 No prior hospital stay required. You are covered for 100 days each benefit period.
	Value Plus	PFFS	**$0**	**$43/** month plus the **$93.50** Medicare Part B monthly premium There is a $3,000 out of pocket max for	No Coverage in Gap	**$15** for each visit to a primary care physician & **$30** for each visit to a specialist for Medicare covered services - You may go to any Doctor that accepts the plan's payment.	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 72 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$175** per day, days 1-4 stay*; **$0** for days 5-90; **$0** for additional days. You are covered for unlimited days each benefit period. $1,700 max out of pocket limit each year.	For a Medicare covered stay you pay: **$0** per day, days 1-20; **$100** per day for days 21-100 No prior hospital stay required. You are covered for 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	In-Patient Hospital Stay	Skilled Nursing
Today's Options (continued)	Value Plus (continued)			Medicare covered plan services each year.				*Must notify plan in advance	

^ 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.

* **Indicates no Medicare prescription drug coverage**

Special Needs Plan Comparison Chart - Tolland County

Note: Special Needs Plans are not for everyone. 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	In-Patient Hospital Stay	Skilled Nursing
Health Net	HN Amber	SNP for Dual Eligibles	**$0**	**$ 20.10/** month plus **$93.50^** Medicare Part B monthly premium	Yes	**$0** for each visit to a primary care physician & **$15** for each visit to a specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$50** per day, days 1-6; **$0** per day, days 7-90; **$0** for additional days. You are covered for unlimited days each benefit period. $600 max. out of pocket limit each year.	For a Medicare covered stay you pay: **$0** per day, days 1-15; **$75** per day for days 16-100 No prior hospital stay required. You are covered for 100 days each benefit period.
United Health Care	Evercare Plan DH-POS	SNP for Dual Eligibles	**$0**	**$ 0-$24/** month plus **$93.50^** Medicare Part B monthly premium There is a $1,650 out of pocket max for many plan services	Yes	**$0** for each visit to a network primary care physician & **$10** for each visit to a network specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$150** per day, days 1-11; **$0** per day, days 12-90; **$0** for additional days. You are covered for unlimited days each benefit period.	For a Medicare covered stay at a network SNF you pay: **$0** per day, days 1-20; **$120** per day, days 21-34; **$0** per day for days 35-100 No prior hospital stay required. You are covered for

Company	Plan	Plan Type	Annual Deductible	Monthly Premium (includes C+D)	Offers Part D Drug Coverage	Primary Care Co-pay	Emergency Care	In-Patient Hospital Stay	Skilled Nursing
									100 days each benefit period.
United Health Care (continued)	Evercare Plan IH-POS	SNP Institution	**$0**	**$ 25.10/** month plus **$93.50^** Medicare Part B monthly premium	Yes	**$0** for each visit to a network primary care physician & **$10** for each visit to a network specialist for Medicare covered services	You pay: **$50** for each Medicare covered ER visit. You do not pay this if admitted within 24 hrs for the same condition.	For a Medicare covered stay at a network hospital you pay: **$150** per day, days 1-11; **$0** per day, days 12-90; **$0** for additional days. You are covered for unlimited days each benefit period.	For a Medicare covered stay at a network SNF you pay: **$0** per day, days 1-100. No prior hospital stay required. You are covered for 100 days each benefit period.

^ 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

PART III

MEDICARE ADVANTAGE RESOURCES

- **Medicare Advantage Terminology**
- **Area Resources**
- **The Area Agencies on Aging, CHOICES & The Center for Medicare Advocacy, Inc.**

MANAGED CARE RESOURCES
Medicare Managed Care Terminology

Board Certified: Doctor or other health professional who 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 Advanatge: 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.

Medicare Advantage Resources

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

2007 Medicare Advantage Plan Contact Information

Aetna Current Members:1-800-282-5366 Prospective members: 1-800-628-3323 www.aetnamedicare.com	***Anthem Blue Cross & Blue Shield*** Current Members: 1-888-445-8916 Prospective Members: 1-800-238-1143 www.anthem.com	***Fresenius Medical Health Care Plan*** Current & Prospective Members: 1-866-660-4728 www.fmchp.com
Health Net Current members: 1-800-547-8734 Prospective Members: 1-800-709-4192 www.healthnet.com	***Humana*** Current Members: 1-877-511-5000 Prospective Members: 1-800-833-2312 www.humana-medicare.com	***Secure Horizons*** Current Members: 1-800-234-1228 Prospective Members: 1-888-834-3721 www.securehorizons.com
Senior Whole Health, LLC Current & Prospective Members: 1-866-404-9505 www.seniorwholehealth.com	***Today's Options*** Current Members: 1-888-445-8699 Prospective members: 1-800-486-7613 www.todaysoptions.com	***UniCare*** For Standard Medicare Advantage Information Current Members: 1-888-445-8916 Prospective Members: 1-866-892-5334 www.unicare.com
UniCare Life & Health Company For MSA Plan Information Current Members: 1-888-445-8916 Prospective Members: 1-888-949-5384 www.unicare.com	***United Health Care*** Current Members: 1-877-702-5110 Prospective Members: 1-888-834-3721 www.evercarehealthplans.com	***WellCare*** Current Members: 1-877-579-8006 Prospective Members: 1-866-238-4344 www.wellcare.com

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

Agency on Aging of South Central Connecticut
One Long Wharf Drive
New Haven, CT 06511; 203-785-8533
www.agencyonaging-scc.org

North Central Area Agency on
Two Hartford Square West, Suite 101
Hartford, CT 06106; 860-724-6443
www.geocities.com/ncaaaus

Southwestern CT Area 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)

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**.

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