



CHOICES

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

Medicare Advantage Options in CT

With

- Medicare Advantage Information
- 2006 Plan Comparison Chart for CT
- Advantage Plan Changes and new PFFS Plan
- Important Resources

*for Medicare Beneficiaries
living in Connecticut*

February, 2006

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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.

**Department of Social Services, Aging Services Division
25 Sigourney Street, Hartford, CT 06106**

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 February, 2006. 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 2006, 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 2006, Medicare beneficiaries in certain regions of Connecticut will have the option of receiving their Medicare benefits through either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). In addition, this year some beneficiaries will also have the opportunity to enroll in a Private-Fee-For-Services Plan (PFFS).

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.

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.

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 managed care 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 \$1,024 to \$1,309.95 per month for one person and \$1,514 to \$1,899 per month for a couple. A new, simpler application form and procedure for applying have recently been implemented by the Dept. of Social Services and can be obtained by contacting DSS 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 – 2006!

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: \$22,300; married couple: \$30,100. *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 co-payment of \$16.25 will be charged by the pharmacy for each prescription filled.

What is Prior Authorization?

There are three 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 three circumstances requiring Prior Authorization are:

- Being issued a prescription written as "Brand Medically Necessary" when there is a generic equivalent
- Being issued a drug that costs over \$500
- 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) or picking up a prescription costing over \$500 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 has been undergoing some changes. Important changes to the program that you should know about are:

- ◆ ConnPACE will wrap-around the new Medicare prescription drug benefit (also called Medicare Rx and 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 \$14,335 (single) or \$19,245 (couple) and have countable assets below \$10,000 (single) and \$20,000 (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 or wait for ConnPACE to select one for you. You will not lose ConnPACE, but the way you get your prescription drugs will change in 2006.

On December 1, 2005 Governor Rell signed into law a Bill that allows ConnPACE to "wrap-

around” (meaning “work 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 \$14,335 (single) or \$19,245 (couple) and countable assets below \$10,000 (single) and \$20,000 (couple) are required to apply for Extra Help available to cover costs associated with Medicare Rx.

Will my ConnPACE benefits change when I enroll in Medicare Rx?

Yes, you will have some changes but most will save you money. Here is a summary of how some things will change and others will stay the same:

- The 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 may also be able to get prescriptions by mail if this feature is available in the plan you select.
- You’ll still pay your annual \$30 ConnPACE membership fee.
- You won’t have to pay any monthly premiums for Medicare 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.
- You’ll still be able to get all of the drugs you take now but may have to go through an exceptions process to do so if the drugs are not covered by your Medicare Rx plan.
- You’ll 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/\$5 (for generic or brand-name drugs).

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. **Select and enroll in a Medicare Rx plan on your own.** Individuals can select and enroll into any one of the 44 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.
2. **Wait for ConnPACE to enroll you in a Medicare Rx plan.** If you do not select and enroll in a plan on your own ConnPACE will select a plan for you and enroll you in that plan. See the next question for more information on the auto-enrollment process.

Will ConnPACE select and enroll me into a Medicare Rx plan?

Yes. If you do not select and enroll in a Medicare Rx plan on your own ConnPACE will select one for you. ConnPACE will enroll recipients in groups between now and May 15, 2006. ConnPACE recipients will be enrolled in the following order:

Group 1 - Individuals with both ConnPACE and a Medicare Savings Program (QMB,SLMB,ALMB/QI)

Group 2 – Individuals with both ConnPACE and the Extra Help who are not on a Medicare Savings Program

Group 3 – All other ConnPACE recipients who are not receiving the Extra Help or on a Medicare Savings Program

Because ConnPACE is enrolling people into the Medicare prescription drug program on an ongoing basis you may not hear from ConnPACE until the spring of 2006. Don't worry. ConnPACE will continue as usual for you until you are enrolled into a Medicare Rx plan.

ConnPACE will send you a letter in the mail telling you which Medicare Rx plan has been selected for you. You will have a certain amount of time to let ConnPACE know if you would like to enroll into a different plan. If you do nothing ConnPACE will enroll you into the plan named in your letter.

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.

I enrolled into a Medicare Rx plan on my own but just received a letter from ConnPACE informing me that the State has selected a different plan for me. Why did I receive this letter? Do I have to change to the plan that ConnPACE selected for me?

If you have already enrolled in a Medicare Rx plan on your own you will still receive a letter from ConnPACE telling you which plan the state has identified as the best choice for you. You may change to the plan that ConnPACE selected for you or you can remain in the plan you chose on your own. ***If you wish to stay in the plan you selected on your own no action is necessary.*** If you want to switch to the plan that ConnPACE selected for you, you will need to let ConnPACE know this within a few days of receiving the plan selection notice. Keep in mind that changing to the plan that ConnPACE selected for you will count as your one allowable Medicare Rx plan change for the year.

I am on ConnPACE 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 \$14,335 (single) or \$19,245 (couple) and countable

assets below \$10,000 (single) and \$20,000 (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/\$5 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 (according to ConnPACE records) is below the Extra Help income limit. Both Medicare and ConnPACE mailed Extra Help applications to many people during the summer of 2005. If you received an application but haven't filled it out yet, please do so right away. If you lost or discarded the Extra Help application, you can get another one from ConnPACE, Social Security or CHOICES.

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

For more information about how ConnPACE will work with the new 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.

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 and the new ConnPACE co-pay structure, 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). 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 an HMO. In Connecticut, many of the HMO plans require an additional monthly premium. Most also offer prescription drug coverage through the new 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.

Although there are other forms of managed care such as PPOs & PFFSs, the health maintenance organization (HMO) model is the only one currently available to most beneficiaries in Connecticut. Each plan has a network of providers operating through private practice offices. The following companies are currently marketing plans for Medicare beneficiaries: Health Net, Oxford and WellCare

All of the plans available in Connecticut have a "lock-in" 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**.

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)

Medicare beneficiaries living in Fairfield, Hartford and New Haven Counties who are confined to a nursing home with minimal chance of being discharged have the option of selecting a plan through a preferred provider organization (PPO). A PPO is also a Medicare Managed Care 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.

United HealthCare offers the Evercare Choice PPO plan in CT. It is the only Medicare Advantage PPO plan available to Medicare beneficiaries in the state. In order to qualify for participation in the Evercare Choice PPO plan you must live in Fairfield, Hartford or New Haven Counties and be enrolled in both Medicare Part A and Part B. Evercare Choice is designed to meet the needs of frail elderly and those confined to a nursing home. This specific PPO plan has benefits that vary according to the condition of the member. Therefore, beneficiaries in the poorest health condition

will receive the greatest benefit from the plan. This plan may not be the best choice for individuals who are not living in an institutional setting as the Evercare preferred provider network is established within nursing facilities. Using out of network providers can be very expensive.

PFFSs – New Option in CT!

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.

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.

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:** Enroll by the last day of the month to be effective the first of the next month.
 - **Example:** Enroll by October 31, 2006 for an effective date of November 1, 2006
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.
- **Annual:** This occurs November 15 – December 31, 2006. During this time you may enroll in a Medicare managed care plan effective January 1, 2007.
- **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.
- **Special:** 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.

Additional time restrictions are being phased in beginning January 1, 2006. Please turn to [page 15](#) for updated lock-in information.

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.

MEDICARE ADVANTAGE LOCK-IN ALERT: Lock-In Delayed and the Annual Election Period Changed

What is a Medicare Advantage Plan Lock-In?

Lock-in refers to the inability of a Medicare beneficiary who enrolls in a Medicare Advantage (MA) plan to disenroll from that plan for a set period of time.

On December 8, 2003 President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173). This law includes provisions related to MA plan enrollment and disenrollment. The new law:

- Permanently moves the annual election period (AEP) for beneficiaries to select an MA plan to **November 15 – December 31** each year.
- Provides that from January 1 – June 30, 2006, beneficiaries can make one change and enroll in an MA plan, change from one MA plan to another MA plan, or disenroll from an MA plan. Beginning July 1, 2006, beneficiaries will be locked into their choice for the remainder of the calendar year.
- Provides that starting in 2007, beneficiaries will be allowed one change from January 1 – March 31 each year and will be locked into that choice for the remainder of the calendar year.

If you have more questions or concerns about how you are affected by the lock-in changes, please contact your local Area Agency on Aging CHOICES counselor listed in the back of this book.

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 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 "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.

➤ Lock-In

Effective 2006 you will be “locked-in” to your HMO Choice. [See Page 15](#) for details.

➤ 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.

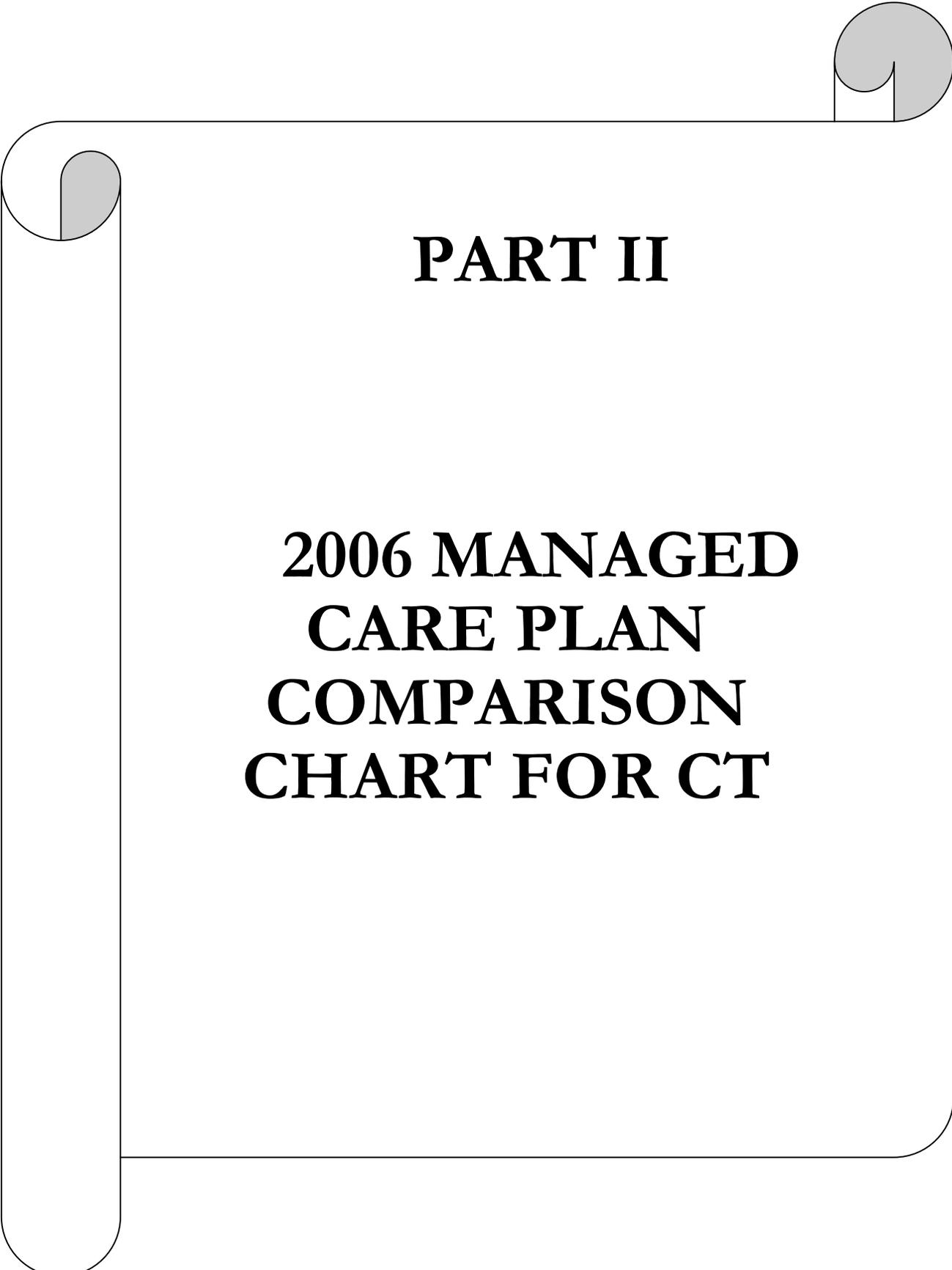
- Contact the National Committee on Quality Assurance (NCQA), which has a program to accredit managed care plans. Although accreditation is relatively new and therefore as yet untested for reliability, it is the only source of comparative data on quality of care. For information on plan accreditation 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

✓

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.

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



A decorative graphic of a scroll with a black outline and three grey-shaded circular elements at the top-left, top-right, and bottom-left corners. The text is centered within the scroll's frame.

PART II

**2006 MANAGED
CARE PLAN
COMPARISON
CHART FOR CT**



**Medicare Advantage
Plan Comparison Chart for 2006
For Beneficiaries Living in Connecticut**

1-800-994-9422

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.

All companies offering Medicare Advantage plans in 2005 will remain in the market for 2006. In addition, several plans, some including a Private-Fee-For-Service option, will be available in some parts of the State.

A Medicare Advantage plan-comparison chart for plans available in CT as of January 1, 2006, can be found on the following pages of this booklet. The chart includes the revised co-payments and fees effective January 1, 2006.

**Medicare Advantage Plans (HMO, PPO & PFFS) in Connecticut
by County for January 1, 2006**

County	Oxford (HMO)	Health Net (HMO)	United HealthCare (PPO)	WellCare (HMO)	Secure Horizons (PFFS)
Fairfield		X*	X*	X	
Hartford		X*	X*	X	
Litchfield		X*			X
Middlesex		X*			X
New Haven	X	X*	X*	X	
New London		X*			
Tolland		X*			
Windham		X*			

* This company offers multiple plan options. At least one plan offered by the company is available in this county. There may be some plan options offered by this company that are not available in this county. See chart for details.

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
Original Medicare	All areas	You pay the Medicare Part B premium of \$88.50 each month.	CHOICES State Health Insurance Program 1-800-994-9422	You may go to any doctor, specialist or hospital that accepts Medicare.
Health Net HMO SmartChoice Ruby Option I*	Statewide	<p>\$99/month - includes \$81.31 medical plus \$17.69 for Medicare Rx drug coverage. If you qualify for Extra Help with Medicare RX costs premiums may be less.</p> <p>You also continue to pay the Medicare Part B premium of \$88.50 each month.</p>	<p>One Far Mill Crossing Box 904 Shelton, CT 06484 1-800-977-7524 1-888-747-2424 (TDD) www.healthnet.com</p>	<p>You must go to network doctors, specialists, and hospitals. You do not need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
Health Net HMO SmartChoice Ruby Option II*	Statewide	<p>\$20/month – Includes \$2.31 medical plus \$17.69 for Medicare Rx drug coverage. If you qualify for Extra Help with Medicare Rx costs premiums may be less</p> <p>You also continue to pay the Medicare Part B premium of \$88.50 each month.</p>	One Far Mill Crossing Box 904 Shelton, CT 06484 1-800-977-7524 1-888-742-2424 (TDD) www.healthnet.com	<p>You must go to network doctors, specialists, and hospitals. You do not need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
Health Net HMO SmartChoice Green Plan*	Statewide	\$0/month – No Medicare Rx drug coverage You also continue to pay the Medicare Part B premium of \$88.50 each month.	One Far Mill Crossing Box 904 Shelton, CT 06484 1-800-977-7524 1-888-747-2424 (TDD) www.healthnet.com	You must go to network doctors, specialists, and hospitals. You do not need a referral to go to network hospitals and certain doctors, including specialists for certain services. A separate doctor office visit copayment may apply for certain services.

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
<p>Health Net POS SmartChoice Navy POS Plan*</p>	<p>Statewide</p>	<p>\$119/month - Includes \$101.31 medical plus \$17.69 for Medicare Rx drug coverage. If you qualify for Extra Help with Medicare Rx costs premiums may be less.</p> <p>You also continue to pay the Medicare Part B premium of \$88.50 each month.</p>	<p>One Far Mill Crossing Box 904 Shelton, CT 06484 1-800-977-7524 1-888-747-2424 (TDD) www.healthnet.com</p>	<p>You must go to network doctors, specialists, and hospitals. You need a referral to go to certain network hospitals & certain doctors including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
<p>Health Net SNP SmartChoice Amber Plan*</p> <p>Special Needs Plan for Dual Eligible Individuals Only</p>	<p>Statewide</p>	<p>\$17.12/month includes \$0 for medical plus \$17.12 for Medicare Rx drug coverage.</p> <p>You also continue to pay the Medicare Part B premium of \$88.50 each month.</p>	<p>One Far Mill Crossing Box 904 Shelton, CT 06484 1-800-977-7524 1-888-747-2424 (TDD) www.healthnet.com</p>	<p>You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>
<p>Oxford Health Medicare Advantage*</p>	<p>New Haven County</p>	<p>None (\$0/mo)</p> <p>You also continue to pay the Medicare Part B premium of \$88.50 each month.</p>	<p>44 South Broadway White Plains, NY 10601 1-800-303-6720 www.oxfordhealth.com</p>	<p>You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialist for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
WellCare HMO WellCare Advance*	Fairfield, Hartford & New Haven Counties	None (\$0/mo) You also continue to pay the Medicare Part B premium of \$88.50 each month.	P.O. Box 25885 Tampa, FL 33622 1-866-238-4344 1-877-247-6272 (TTY/TDD) www.wellcare.com/medicare	You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialist for certain services.
WellCare HMO WellCare Choice*	Fairfield, Hartford & New Haven Counties	None (\$0/mo) Includes \$0 for medical benefits and Medicare Rx coverage. You also continue to pay the Medicare Part B premium of \$88.50 each month.	P.O. Box 25885 Tampa, FL 33622 1-866-238-4344 1-877-247-6272 (TTY/TDD) www.wellcare.com/medicare	You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialist for certain services.

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
<p>WellCare SNP WellCare Access*</p> <p>Special Needs Plan for Dual Eligible Individuals Only</p>	<p>Fairfield, Hartford & New Haven Counties</p>	<p>None (\$25.64/mo) Includes \$0 for medical benefits plus \$25.64 for Medicare Rx drug coverage.</p> <p>You also continue to pay the Medicare Part B premium of \$88.50 each month.</p>	<p>P.O. Box 25885 Tampa, FL 33622 1-866-238-4344 1-877-247-6272 (TTY/TDD) www.wellcare.com/medicare</p>	<p>You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialist for certain services.</p>

HMO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals	Fairfield, Hartford & New Haven Counties	None (\$7.57/mo) Includes \$0 for medical benefits plus \$7.57 Medicare Rx drug coverage. You also continue to pay the Medicare Part B premium of \$88.50 each month.	P.O. Box 25885 Tampa, FL 33622 1-866-238-4344 1-877-247-6272 (TTY/TDD) www.wellcare.com/medicare	You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialist for certain services.

PPO Plan Comparison Chart 2006

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
United HealthCare Evercare Choice Plan P*	Fairfield, Hartford, & New Haven	\$20.39/mo Includes \$0 for medical	450 Columbus Boulevard Hartford, CT 06115 1-800-393-0993 or	United HealthCare has a network of doctors, specialists, and hospitals. You do not need a

PLAN NAME	SERVICE AREA	MONTHLY PREMIUM	FOR CONSUMER INFORMATION	DOCTOR AND HOSPITAL CHOICE
	Counties	<p>benefits plus \$20.39 for Medicare Rx drug coverage.</p> <p>You continue to pay the Medicare Part B premium of \$88.50 each month.</p>	1-888-685-8480 (TTY)	referral to go to network hospitals doctors and specialists. You may use out-of-network doctors and facilities but at a much higher cost. Special rules may apply for out-of-network services.
<p>United HealthCare SNP Evercare Choice Plan DP* Special Needs Plan for Dual Eligible Individuals</p>	Hartford County	<p>\$0/mo</p> <p>You continue to pay the Medicare Part B premium of \$88.50 each month.</p>	450 Columbus Boulevard Hartford, CT 06115 1-800-393-0993 or 1-888-685-8480 (TTY)	United HealthCare has a network of doctors, specialists, and hospitals. You do not need a referral to go to network hospitals doctors and specialists. You may use out-of-network doctors and facilities but at a much higher cost. Special rules may apply for out-of-network services.

PFFS Plan Comparison Chart 2006

SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	Litchfield & Middlesex Counties	\$45/month You continue to pay the Medicare Part B premium of \$88.50 each month.	P.O. Box 489 Cypress, CA 90630 1-800-776-8876 1800-387-1074 (TTY/TDD) www.securehorizons.com	You may go to any doctor, specialist or hospital that accepts the plan's payment. Contact the plan directly for details.
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HMO Plan Comparison Chart 2006: Inpatient Care

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
Original Medicare	You pay for each benefit period: Days 1-60: an initial deductible of \$952 Days 61-90: \$238 each day Days 91-150: \$476 each lifetime reserve day	You pay for each benefit period following at least a 3-day covered hospital stay: Days 1-20: \$0 each day Days 21-100: \$119 each day There is a limit of 100 days for each benefit period.	There is no copayment for covered home health visits.
Health Net HMO SmartChoice Ruby Option I*	For a Medicare-covered stay in a network hospital: - You pay \$35 per day for days 1-14 \$0 15-90 - There is no copayment for additional days in a network hospital. -There is a \$490 maximum out-of-pocket limit every year. -You are covered for unlimited days each benefit period.	You pay: \$0 each day for days 1-20 \$50 each day for days 21-100 for a stay in a Skilled Nursing Facility. - You are covered for 100 days each benefit period. - No prior hospital stay is required.	You pay \$0 for Medicare-covered home health visits. Prior Authorization rules may apply.

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly.

HMO Plan Comparison Chart 2006: Inpatient Care

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
Health Net HMO SmartChoice Ruby Option II*	For a Medicare-covered stay in a network hospital: <ul style="list-style-type: none"> - You pay \$150 per day for days 1-6 - You pay \$0 for days 7-90. - There is a \$1800 annual out-of-pocket maximum. - You are covered for unlimited days each benefit period. 	You pay: <ul style="list-style-type: none"> \$0 each day for days 1-15 \$75 each day for days 16-100 for a stay in a Skilled Nursing Facility. - You are covered for 100 days each benefit period. - No prior hospital stay is required. 	You pay \$0 for Medicare-covered home health visits.
Health Net HMO SmartChoice Green Plan*	For a Medicare-covered stay in a network hospital: <ul style="list-style-type: none"> - You pay \$150 per day for days 1-6 - You pay \$0 for days 7-90. - There is a \$1800 annual out-of-pocket maximum. - You are covered for unlimited days each benefit period. 	You pay: <ul style="list-style-type: none"> \$0 each day for days 1-15 \$75 each day for days 16-100 for a stay in a Skilled Nursing Facility. - You are covered for 100 days each benefit period. - No prior hospital stay is required. 	You pay \$0 for Medicare-covered home health visits.

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
Health Net POS SmartChoice Navy POS Plan*	For a Medicare-covered stay in a network hospital: <ul style="list-style-type: none"> - You pay \$35 per day for days 1-14 - You pay \$0 for days 15-90. - There is a \$490 annual out-of-pocket maximum. - You are covered for unlimited days each benefit period. 	You pay: <ul style="list-style-type: none"> \$0 each day for days 1-20 \$50 each day for days 21-100 for a stay in a Skilled Nursing Facility. - You are covered for 100 days each benefit period. - No prior hospital stay is required. 	You pay \$0 for Medicare-covered home health visits.
Health Net SNP SmartChoice Amber Plan* Special Needs Plan for Dual Eligible Individuals Only	For a Medicare-covered stay in a network hospital: <ul style="list-style-type: none"> - You pay \$125 per day for days 1-8 - You pay \$0 for days 9-90. - There is no copayment for additional days in a network hospital. - You are covered for unlimited days each benefit period. 	You pay: <ul style="list-style-type: none"> \$0 each day for days 1-15 \$75 each day for days 16-100 for a stay in a Skilled Nursing Facility. - You are covered for 100 days each benefit period. - No prior hospital stay is required. 	You pay \$0 for Medicare-covered home health visits.

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
Oxford Health HMO Medicare Advantage*	<p>You pay \$135 per day for days 1-15, \$0 for days 16-90. There is a \$2,025 maximum for each Medicare-covered stay in a network hospital.</p> <p>You are covered for 90 days each benefit period.</p>	<p>Skilled Nursing Facility Co-payment: You pay \$0 days 0-5; You pay \$125 per day for days 6-100. Coverage is limited to 100 days per benefit period. No prior hospital stay is required.</p>	<p>There is no copayment for Medicare-covered home health visits.</p>
WellCare HMO WellCare Advance*	<p>For a Medicare Covered stay in a network hospital:</p> <ul style="list-style-type: none"> - You pay \$100 per day for days 1-7 - \$0 for days 8-90 - Cost sharing may vary for each stay according to the hospital at which services are received - There is no copayment for additional days in a network hospital - You are covered for unlimited days each benefit period 	<p>Skilled Nursing Facility Co-payment: You pay \$0 days 0-7; You pay \$50 per day for days 8-100. Coverage is limited to 100 days per benefit period. No prior hospital stay is required.</p>	<p>You pay \$0-\$15 for each Medicare-covered home health visits.</p>

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
<p>WellCare HMO WellCare Choice*</p>	<p>For a Medicare Covered stay in a network hospital:</p> <ul style="list-style-type: none"> - You pay \$150 per day for days 1-7 - \$0 for days 8-90 - Cost sharing may vary for each stay according to the hospital at which services are received - There is no copayment for additional days in a network hospital - You are covered for unlimited days each benefit period 	<p>Skilled Nursing Facility Co-payment: You pay \$0 days 0-7; You pay \$100 per day for days 8-100. Coverage is limited to 100 days per benefit period. No prior hospital stay is required.</p>	<p>You pay \$0-\$30 for each Medicare-covered home health visits.</p>
<p>WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only</p>	<p>For a Medicare Covered stay in a network hospital:</p> <ul style="list-style-type: none"> - You pay 1 initial deductible of \$952 - You pay \$0 per day for days 1-60 - \$228 for days 61-90 - Cost sharing may vary for each stay according to the hospital at which services 	<p>Skilled Nursing Facility Co-payment: You pay \$0 days 1-20; You pay \$114 per day for days 21-100. Coverage is limited to 100 days per benefit period. No prior hospital stay is required.</p>	<p>You pay \$0 for each Medicare-covered home health visits.</p>

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
	<p>are received</p> <ul style="list-style-type: none"> - You pay \$456 for additional days in a network hospital - You are covered for unlimited days each benefit period 		
<p>WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only</p>	<p>For a Medicare Covered stay in a network hospital:</p> <ul style="list-style-type: none"> - You pay \$75 per day for days 1-7 - \$0 for days 8-90 - Cost sharing may vary for each stay according to the hospital at which services are received - There is no copayment for additional days in a network hospital - You are covered for unlimited days each benefit period 	<p>Skilled Nursing Facility Co-payment: You pay \$0 days 0-7; You pay \$50 per day for days 8-100. Coverage is limited to 100 days per benefit period. No prior hospital stay is required.</p>	<p>You pay \$0-\$10 for each Medicare-covered home health visits.</p>

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

PPO Plan Comparison Chart 2006 – Inpatient Care

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
<p>United HealthCare Evercare Choice Plan P*</p>	<p>For a Medicare-covered stay in a network hospital:</p> <ul style="list-style-type: none"> - You pay \$125 per day for days 1-8 - You pay \$0 for days 9-90. - You pay 30% of the cost for each stay at an out of network hospital. - There is no copayment for additional days at a network hospital. <p>You are covered for unlimited days each benefit period.</p>	<ul style="list-style-type: none"> - There is no co-payment for services received at a Medicare certified skilled nursing facility. - You pay 30% of the cost for services at an out of network facility. - No prior hospital stay is required. - You are covered for 100 days per benefit period. 	<p>There is no copayment for Medicare-covered home health visits.</p> <p>You pay 30% for out of network home health visits.</p>
<p>United HealthCare SNP Evercare Choice Plan DP*</p> <p>Special Needs Plan for Dual Eligible Individuals</p>	<p>For a Medicare-covered stay in a network hospital:</p> <ul style="list-style-type: none"> - You pay \$75 per day for days 1-6 - You pay \$0 for days 7-90. - You pay 30% of the cost for each stay at an out of network hospital. - There is no copayment for additional days at a network hospital. 	<p>You pay:</p> <ul style="list-style-type: none"> - \$0 each day for days 1-20 - \$114 each day for days 21-25 - \$0 each day for days 26-100 - You pay 30% of the cost for services at an out of network facility. - No prior hospital stay is required - You are covered for 100 	<p>There is no copayment for Medicare-covered home health visits.</p> <p>You pay 30% for out of network home health visits.</p>

	You are covered for unlimited days each benefit period.	days per benefit period.	
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* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

PFFS Plan Comparison Chart 2006 – Inpatient Care

PLAN NAME	INPATIENT HOSPITAL CARE	SKILLED NURSING FACILITY	HOME HEALTH CARE
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	For a Medicare-covered stay in a hospital: - You pay \$200 per day for days 1-4 - You pay \$0 for days 5-90. - There is no copayment for additional days at a hospital. You are covered for unlimited days each benefit period.	Skilled Nursing Facility Co-payment: You pay \$0 days 0-10; You pay \$115 per day for days 11-100. Coverage is limited to 100 days per benefit period. No prior hospital stay is required.	There is no copayment for Medicare-covered home health visits.

HMO Plan Comparison Chart 2006: Outpatient Care

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
Original Medicare	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts. You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors of other qualified provider. You pay 100% for routine care.	You pay 20% of Medicare-approved amounts. You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.
Health Net HMO SmartChoice Ruby Option I*	You pay \$10 for each primary care doctor office visit for Medicare-covered services. You pay \$15 for each specialist visit for Medicare-covered services.	You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). 50% - 90% of the cost for each visit for services beyond what is covered under original Medicare.	You pay \$15 for each Medicare-covered visit (medically necessary foot care).
Health Net HMO SmartChoice Ruby Option II*	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$25 for each specialist visit for Medicare-covered services.	You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation) & 50% - 90% of the cost for each visit for services beyond what is covered under Medicare.	You pay \$25 for each Medicare-covered visit (medically necessary foot care).

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
Health Net HMO SmartChoice Green Plan*	<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p>	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation) & 50% - 90% of the cost for each visit for services beyond what is covered under Medicare.</p>	<p>You pay \$25 for each Medicare-covered visit (medically necessary foot care).</p>
Health Net POS SmartChoice Navy POS Plan*	<p>You pay \$10 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$15 for each specialist visit for Medicare-covered services.</p>	<p>You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation) & 50% - 90% of the cost for each visit for services beyond what is covered under Medicare.</p>	<p>You pay \$15 for each Medicare-covered visit (medically necessary foot care).</p>
Health Net SNP SmartChoice Amber Plan* Special Needs Plan for Dual Eligible Individuals Only	<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p>	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation) & 50% - 90% of the cost for each visit for services beyond what is covered under Medicare.</p>	<p>You pay \$25 for each Medicare-covered visit (medically necessary foot care).</p>

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
Oxford Health Medicare Advantage*	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$25 for each specialist visit for Medicare-covered services.	You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$25 for each Medicare-covered visit (medically necessary foot care).
WellCare HMO WellCare Advance*	You pay \$5 for each primary care doctor office visit for Medicare-covered services. You pay \$15 for each specialist visit for Medicare-covered services.	You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$15 for each Medicare-covered visit (medically necessary foot care).
WellCare HMO WellCare Choice*	You pay \$10 for each primary care doctor office visit for Medicare-covered services. You pay \$30 for each specialist visit for Medicare-covered services.	You pay \$30 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$30 for each Medicare-covered visit (medically necessary foot care).

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	You pay \$0 for each primary care doctor office visit for Medicare-covered services. You pay \$0 for each specialist visit for Medicare- covered services.	You pay \$0 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$0 for each Medicare-covered visit (medically necessary foot care).
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	You pay \$0 for each primary care doctor office visit for Medicare-covered services. You pay \$10 for each specialist visit for Medicare-covered services.	You pay \$10 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$10 for each Medicare-covered visit (medically necessary foot care).

PPO Plan Comparison Chart 2006 – Outpatient Care

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
United HealthCare Evercare Choice Plan P*	- You pay \$0-\$15 for each primary care doctor office visit for Medicare-covered services.	You pay \$0-\$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation)	You pay \$0-\$25 for each Medicare-covered visit (medically necessary foot care).

	<ul style="list-style-type: none"> - You pay 30% for each out of network primary care doctor visit - You pay \$0 -\$25 for each specialist visit for Medicare-covered services. - You pay 30% for each out of network specialist visit. 	You pay 30% for out of network chiropractic services.	<p>You pay \$0-\$25 for each routine visit up to 6 visits per year.</p> <p>You pay 30% of the cost for out of network podiatry services.</p>
<p>United HealthCare SNP Evercare Choice Plan DP*</p> <p>Special Needs Plan for Dual Eligible Individuals</p>	<ul style="list-style-type: none"> - There is no copayment for each primary care doctor office visit for Medicare-covered services. - You pay 30% for each out of network primary care doctor visit - You pay \$25 for each specialist visit for Medicare-covered services. - You pay 30% for each out of network specialist visit. 	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation)</p> <p>You pay 30% for out of network chiropractic services.</p>	<p>You pay \$25 for each Medicare-covered visit (medically necessary foot care).</p> <p>You pay \$0 for each routine visit up to 6 visits per year.</p> <p>You pay 30% of the cost for out of network podiatry services.</p>

PFFS Plan Comparison Chart 2006 – Outpatient Care

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
SecureHorizons Direct PFFS	You pay \$10 for each primary care doctor office visit for Medicare-covered services.	You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to	You pay \$20 for each Medicare-covered visit (medically necessary foot

PLAN NAME	DOCTORS OFFICE VISITS	CHIROPRACTIC SERVICES	PODIATRY SERVICES
SecureHorizons Direct Plan 5*	You pay \$20 for each specialist visit for Medicare- covered services.	correct subluxation).	care).

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006: Outpatient Care

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
Original Medicare	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of Medicare-approved charges.	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts for the doctor. You pay 20% of outpatient facility charges.	You pay 20% of Medicare-approved amounts or applicable fee schedule charge.
Health Net HMO SmartChoice Ruby Option I*	You pay \$25 for each Medicare-covered individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group therapy visit. An additional facility charge may be included in the cost for services.	You pay \$0-\$50 of the cost of each Medicare-covered visit to an ambulatory surgical center. You pay \$0-\$50 of the cost for each Medicare-covered visit to an outpatient hospital facility.	You pay \$50 for Medicare-covered ambulance services.
Health Net HMO SmartChoice Ruby Option II*	You pay \$25 for each Medicare-covered individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group therapy visit. An additional facility charge may be included in the cost for services.	You pay \$0-\$100 of the cost of each Medicare-covered visit to an ambulatory surgical center. And \$0-\$100 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$75 for Medicare-covered ambulance services.

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
Health Net HMO SmartChoice Green Plan*	You pay \$25 for each Medicare-covered individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group therapy visit. An additional facility charge may be included in the cost for services.	You pay \$0-\$100 for each Medicare-covered visit to an ambulatory surgical center. And \$0-\$100 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$75 for Medicare-covered ambulance services.
Health Net POS SmartChoice Navy Plan*	You pay \$25 for each Medicare-covered individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group therapy visit. An additional facility charge may be included in the cost for services.	You pay \$0-\$50 for each Medicare-covered visit to an ambulatory surgical center. And \$0-\$50 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$75 for Medicare-covered ambulance services.
Health Net SNP SmartChoice Amber Plan* Special Needs Plan for Dual Eligible Individuals Only	You pay \$25 for each Medicare-covered individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group therapy visit. An additional facility charge may be included in the cost for services.	You pay \$0-\$100 for each Medicare-covered visit to an ambulatory surgical center. And \$0-\$100 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$75 for Medicare-covered ambulance services.

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
Oxford Health Medicare Advantage*	For Medicare-covered mental health services, you pay 50% of the cost for each individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group visit.	You pay \$300 for each Medicare-covered visit to an ambulatory surgical center. You pay \$300 for each Medicare-covered visit to an outpatient facility.	You pay 20% for Medicare-covered ambulance services.
WellCare HMO WellCare Advance*	You pay \$15 for each Medicare-covered individual therapy visit. You pay \$5 for each Medicare-covered group therapy visit.	You pay \$15 for each Medicare-covered individual visit. You pay \$5 for each Medicare-covered group visit.	You pay \$25 for each Medicare-covered visit to an ambulatory surgical center. And \$50-\$75 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$50 for Medicare-covered ambulance services.
WellCare HMO WellCare Choice*	You pay \$30 for each Medicare-covered individual therapy visit. You pay \$20 for each Medicare-covered group therapy visit.	You pay \$30 for each Medicare-covered individual therapy visit. You pay \$20 for each Medicare-covered group therapy visit.	You pay \$50 of the cost of each Medicare-covered visit to an ambulatory surgical center. And \$100-\$150 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$100 for Medicare-covered ambulance services.

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	You pay 20% of the cost for each Medicare-covered individual therapy visit. You pay 20% of the cost for each Medicare-covered group therapy visit.	You pay 20% of the cost for each Medicare-covered individual visit. You pay 20% of the cost for each Medicare-covered group therapy visit.	You pay 20% of the cost of each Medicare-covered visit to an ambulatory surgical center. And 20% of the cost for each Medicare-covered visit to an outpatient hospital facility.	You pay 20% of the cost for Medicare-covered ambulance services.
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	You pay \$10 for each Medicare-covered individual therapy visit. You pay \$5 for each Medicare-covered group therapy visit.	You pay \$10 for each Medicare-covered individual therapy visit. You pay \$5 for each Medicare-covered group therapy visit.	You pay \$50 of the cost of each Medicare-covered visit to an ambulatory surgical center. And \$50-\$75 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$100 for Medicare-covered ambulance services.

PPO Plan Comparison Chart 2006 – Outpatient Care

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
United HealthCare	For Medicare-covered mental health	For Medicare-covered services, you pay \$35 for	You pay \$25 for each Medicare-covered visit	You pay \$100 for Medicare-covered

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
Evercare Choice Plan P*	<p>services: You pay \$35 for each individual therapy visit; 30% for out of network services</p> <p>You pay \$25 for each group therapy visit; 30% for out of network services</p>	<p>each individual visit</p> <p>For Medicare-covered services, you pay \$25 for each group visit.</p> <p>Additional facility charge may be included in the cost</p> <p>You pay 30% for out of network substance abuse services.</p>	<p>to an ambulatory surgical center; 30% of the cost for out of network services.</p> <p>You pay \$100 for each Medicare-covered visit to an outpatient facility; 30% of the cost for services at an out of network facility.</p>	<p>ambulance services; 30% for out of network ambulance services.</p>
<p>United HealthCare SNP Evercare Choice Plan DP*</p> <p>Special Needs Plan for Dual Eligible Individuals</p>	<p>For Medicare-covered mental health services: You pay \$35 for each individual therapy visit; 30% for out of network services</p> <p>You pay \$25 for each group therapy visit; 30% for out of network services</p>	<p>For Medicare-covered services, you pay \$35 for each individual visit</p> <p>For Medicare-covered services, you pay \$25 for each group visit.</p> <p>Additional facility charge may be included in the cost</p> <p>You pay 30% for out of network substance abuse</p>	<p>You pay \$25 for each Medicare-covered visit to an ambulatory surgical center; 30% of the cost for out of network services.</p> <p>You pay \$50 for each Medicare-covered visit to an outpatient facility; 30% of the cost for services at an out of network facility.</p>	<p>You pay \$100 for Medicare-covered ambulance services; 30% for out of network ambulance services.</p>

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
		services.		

PFFS Plan Comparison Chart 2006 – Outpatient Care

PLAN NAME	OUTPATIENT MENTAL HEALTH CARE	OUTPATIENT SUBSTANCE ABUSE CARE	OUTPATIENT SURGERY	AMBULANCE SERVICES
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	You pay \$25 for each Medicare-covered individual/group therapy visit.	For Medicare-covered services, you pay \$25 for each individual/group therapy visit.	You pay \$100 for each Medicare-covered visit to an ambulatory surgical center. You pay \$100 for each Medicare-covered visit to an outpatient hospital facility.	You pay \$150 for Medicare-covered ambulance services.

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006: Outpatient Care

PLAN NAME	EMERGENCY CARE	URGENTLY NEEDED CARE	OUTPATIENT REHAB SVCS
Original Medicare	You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within three days of the emergency room visit. You pay 20% of doctor charges. NOT covered outside the U.S. except under limited circumstances.	You pay 20% of Medicare-approved amounts or applicable copayment. NOT covered outside the U.S. except under limited circumstances.	You pay 20% of Medicare approved amounts.
Health Net HMO SmartChoice Ruby Option I*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited circumstances.	You pay \$15 for each Medicare-covered Occupational Therapy visit. You pay \$15 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.
Health Net HMO) SmartChoice Ruby Option II*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.

PLAN NAME	EMERGENCY CARE	URGENTLY NEEDED CARE	OUTPATIENT REHAB SVCS
		U.S. except under limited circumstances.	
Health Net HMO SmartChoice Green Plan*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.
Health Net POS SmartChoice Navy Plan*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.
Health Net SNP SmartChoice Amber Plan* Special Needs	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.

PLAN NAME	EMERGENCY CARE	URGENTLY NEEDED CARE	OUTPATIENT REHAB SVCS
Plan for Dual Eligible Individuals Only		NOT covered outside the U.S. except under limited circumstances.	
Oxford Health Medicare Advantage*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered urgently needed care visit. NOT covered outside the U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered occupational therapy visit. You pay \$25 for each Medicare-covered physical therapy and/or speech/language therapy visit.
WellCare HMO WellCare Advance*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$5-\$50 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited circumstances.	You pay \$15 for each Medicare-covered Occupational Therapy visit. You pay \$15 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.
WellCare HMO WellCare Choice*	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$10-\$50 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited	You pay \$30 for each Medicare-covered Occupational Therapy visit. You pay \$30 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.

PLAN NAME	EMERGENCY CARE	URGENTLY NEEDED CARE	OUTPATIENT REHAB SVCS
		circumstances.	
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	You pay 20% of the cost (up to \$50) for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay 20% of the cost for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	You pay 20% of the cost (up to \$50) for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Worldwide coverage.	You pay \$25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside the U.S. except under limited circumstances.	You pay \$0 for each Medicare-covered Occupational Therapy visit. You pay \$0 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.

PPO Plan Comparison Chart 2006 – Outpatient Care

PLAN NAME	EMERGENCY CARE	URGENTLY NEEDED CARE	OUTPATIENT REHAB SVCS
United	You pay \$35 for each Medicare-	You pay \$25 for each	You pay \$0-\$25 for each

<p>HealthCare Evercare Choice Plan P*</p>	<p>covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside U.S. except under limited circumstances.</p>	<p>Medicare-covered urgently needed care visit (\$50 for out of network urgent care services). NOT covered outside the U.S. except under limited circumstances.</p>	<p>Medicare-covered occupational therapy visit. You pay \$0-\$25 for each Medicare-covered physical therapy and/or speech/language therapy visit.</p> <p>*An additional facility charge may apply.</p> <p>You pay 30% of the cost for all outpatient rehabilitation services received out of network.</p>
<p>United HealthCare SNP Evercare Choice Plan DP*</p> <p>Special Needs Plan for Dual Eligible Individuals</p>	<p>You pay \$35 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. NOT covered outside U.S. except under limited circumstances.</p>	<p>You pay \$35 for each Medicare-covered urgently needed care visit (30% of the cost of care received out of network). NOT covered outside the U.S. except under limited circumstances.</p>	<p>You pay \$10 for each Medicare-covered occupational therapy visit. You pay \$10 for each Medicare-covered physical therapy and/or speech/language therapy visit.</p> <p>*An additional facility charge may apply.</p> <p>You pay 30% of the cost for all outpatient rehabilitation services received out of network.</p>

PFFS Plan Comparison Chart 2006 – Outpatient Care

PLAN NAME	EMERGENCY CARE	URGENTLY NEEDED CARE	OUTPATIENT REHAB SVCS
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	You pay \$50 for each Medicare-covered emergency room visit. Worldwide coverage.	You pay \$40 for each Medicare-covered urgently needed care visit. Worldwide coverage.	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech Language Therapy visit.

*Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006 Outpatient Medical Services and Supplies

PLAN NAME	DURABLE MEDICAL EQUIPMENT	PROSTHETIC DEVICES	DIABETES SELF MONITORING TRAINING & SUPPLIES	DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES
Original Medicare	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts. Additional coverage through the Medicare Rx prescription drug program.	You pay 20% of Medicare approved amounts, except for approved lab services. There is no copayment for Medicare-approved lab services.
Health Net HMO SmartChoice Ruby Option I*	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay \$0 for Medicare-covered Diabetes self-monitoring training. You pay \$0 for each Medicare-covered Diabetes Supply item.	You pay \$0 for each Medicare-covered clinical/diagnostic lab service. \$20 for each Medicare-covered radiation therapy service. \$20-\$75 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.
Health Net HMO SmartChoice Ruby Option II*	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0 for each Medicare-covered clinical/diagnostic lab service. \$20 for each Medicare-covered radiation therapy service. \$20-\$200 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.

PLAN NAME	DURABLE MEDICAL EQUIPMENT	PROSTHETIC DEVICES	DIABETES SELF MONITORING TRAINING & SUPPLIES	DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES
Health Net HMO SmartChoice Green Plan*	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0 for each Medicare-covered clinical/diagnostic lab service. \$20 for each Medicare-covered radiation therapy service. \$20-\$200 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.
Health Net POS SmartChoice Navy Plan*	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay \$0 for Medicare-covered Diabetes self-monitoring training. You pay \$0 for each Medicare-covered Diabetes Supply item.	You pay \$0 for each Medicare-covered clinical/diagnostic lab service. \$20 for each Medicare-covered radiation therapy service. \$20-\$75 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.
Health Net SNP SmartChoice Amber Plan* Special Needs Plan for Dual Eligible	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0 for each Medicare-covered clinical/diagnostic lab service. \$20 for each Medicare-covered radiation therapy service. \$20-\$200 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.

PLAN NAME	DURABLE MEDICAL EQUIPMENT	PROSTHETIC DEVICES	DIABETES SELF MONITORING TRAINING & SUPPLIES	DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES
Individuals Only				
Oxford Health Medicare Advantage*	There is no copayment for Medicare-covered items.	There is no copayment for Medicare-covered items.	There is no copayment for diabetes self-monitoring training. There is no copayment for diabetes supplies.	There is no copayment for the following Medicare-covered services: clinical/diagnostic lab services, radiation therapy. You Pay 20% of the cost for each Medicare covered x-ray
WellCare HMO WellCare Advance*	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0-\$50 for each Medicare-covered clinical/diagnostic lab service. \$15 for each Medicare-covered radiation therapy service. \$0-\$50 for each Medicare covered X-ray visit.
WellCare HMO WellCare Choice*	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0-\$100 for each Medicare-covered clinical/diagnostic lab service. \$30 for each Medicare-covered radiation therapy service. \$0-\$100 for each Medicare covered X-ray visit.

PLAN NAME	DURABLE MEDICAL EQUIPMENT	PROSTHETIC DEVICES	DIABETES SELF MONITORING TRAINING & SUPPLIES	DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	You pay \$0 for each Medicare-covered item.	You pay \$0 for each Medicare-covered item.	You pay \$0 for Medicare-covered Diabetes self-monitoring training. You pay \$0 for each Medicare-covered Diabetes Supply item.	You pay 0%-20% of the cost for each Medicare-covered clinical/diagnostic lab service. 0% of the cost for each Medicare-covered radiation therapy service. 0% - 20% of the cost for each Medicare covered X-ray visit.
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0 - \$100 for each Medicare-covered clinical/diagnostic lab service. \$10 for each Medicare-covered radiation therapy service. \$0-\$100 for each Medicare covered X-ray visit.

PPO Plan Comparison Chart 2006 – Outpatient Medical Services and Supplies

PLAN NAME	DURABLE MEDICAL EQUIPMENT	PROSTHETIC DEVICES	DIABETES SELF MONITORING TRAINING & SUPPLIES	DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES
United HealthCare Evercare Choice Plan P*	<p>You pay 20% of the cost for each Medicare covered item.</p> <p>You pay 30% of the cost for equipment purchased out of network.</p>	<p>You pay 20% of the cost for each Medicare covered item.</p> <p>You pay 30% of the cost for devices purchased out of network.</p>	<p>There is no copayment for diabetes self-monitoring training. There is no copayment for diabetes supplies.</p> <p>You pay 30% of the cost of supply items purchased out of network.</p>	<p>You pay \$0-\$25 for each Medicare-covered clinical/diagnostic lab service. \$0-\$25 for each Medicare-covered radiation therapy service. \$0-\$25 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.</p> <p>You pay 30% of the costs for services received out of network.</p>
United HealthCare SNP Evercare Choice Plan DP* Special Needs Plan for Dual Eligible Individuals	<p>You pay 20% of the cost for each Medicare covered item.</p> <p>You pay 30% of the cost for equipment purchased out of network.</p>	<p>You pay 20% of the cost for each Medicare covered item.</p> <p>You pay 30% of the cost for devices purchased out of network.</p>	<p>There is no copayment for diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered supply item.</p> <p>You pay 30% of the cost of services and supply items purchased out of network.</p>	<p>You pay \$10 for each Medicare-covered clinical/diagnostic lab service. \$10 for each Medicare-covered radiation therapy service. \$10 for each Medicare covered X-ray visit. *An additional facility charge may be included in the cost for services.</p> <p>You pay 30% of the costs for services received out of network.</p>

PFFS Plan Comparison Chart 2006 – Outpatient Medical Services and Supplies

PLAN NAME	DURABLE MEDICAL EQUIPMENT	PROSTHETIC DEVICES	DIABETES SELF MONITORING TRAINING & SUPPLIES	DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	You pay 30% of the cost for each Medicare-covered item.	You pay 30% of the cost for each Medicare-covered item.	There is no copayment for Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item.	You pay \$0 for each Medicare-covered clinical/diagnostic lab service. 20% of the cost for each Medicare-covered radiation therapy service. \$20 or 20% of the cost for each Medicare covered X-ray visit.

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006: Preventive Services

PLAN NAME	BONE MASS MEASUREMENT <small>FOR PEOPLE WHO ARE AT RISK</small>	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) <small>FOR WOMEN AGE 40 AND OLDER</small>
Original Medicare	You pay 20% of Medicare- approved amounts.	There is no copayment for a Pap smear once every 2 years, annually for beneficiaries at high risk. You pay 20% of Medicare approved amounts for Pelvic Exams.	You pay 20% of Medicare- approved amounts.
Health Net HMO SmartChoice Ruby Option I*	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
Health Net HMO SmartChoice Ruby Option II*	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.

PLAN NAME	BONE MASS MEASUREMENT <small>FOR PEOPLE WHO ARE AT RISK</small>	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) <small>FOR WOMEN AGE 40 AND OLDER</small>
Health Net HMO SmartChoice Green Plan*	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
Health Net POS SmartChoice Navy Plan*	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
Health Net SNP SmartChoice Amber Plan* Special Needs Plan for Dual Eligible Individuals Only	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.

PLAN NAME	BONE MASS MEASUREMENT <small>FOR PEOPLE WHO ARE AT RISK</small>	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) <small>FOR WOMEN AGE 40 AND OLDER</small>
Oxford Health Medicare Advantage*	There is no copayment for each Medicare-covered Bone Mass Measurement.	There is no copayment for: Medicare-covered Pap Smears and Pelvic Exams - additional Pap Smears and Pelvic Exams up to 1 Pap Smear and Pelvic Exam every year.	There is no copayment for Medicare-covered screening mammograms. No referral necessary for Medicare-covered screenings.
WellCare HMO WellCare Advance*	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
WellCare HMO WellCare Choice*	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.

PLAN NAME	BONE MASS MEASUREMENT FOR PEOPLE WHO ARE AT RISK	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) FOR WOMEN AGE 40 AND OLDER
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	You pay \$0 for each Medicare-covered Bone Mass Measurement.	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings.

PPO Plan Comparison Chart 2006 – Preventive Services

PLAN NAME	BONE MASS MEASUREMENT FOR PEOPLE WHO ARE AT RISK	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) FOR WOMEN AGE 40 AND OLDER
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United HealthCare Evercare Choice Plan P*	You pay \$0 for each Medicare-covered Bone Mass Measurement. You pay 30% of the cost for each out of network Bone Mass measurement.	You pay \$0 for each Medicare-covered Pap Smear and Pelvic Exam. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year. You pay 30% of the cost for each out of network pap smear and pelvic exam.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings. You pay 30% of the cost for each out of network mammogram.
United HealthCare SNP Evercare Choice Plan DP* Special Needs Plan for Dual Eligible Individuals	You pay \$0 for each Medicare-covered Bone Mass Measurement. You pay 30% of the cost for each out of network Bone Mass measurement.	You pay \$0 for each Medicare-covered Pap Smear and Pelvic Exam. \$0 for each additional Pap Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year. You pay 30% of the cost for each out of network pap smear and pelvic exam.	You pay \$0 for Medicare covered Screening Mammograms. No referral necessary for Medicare-covered screenings. You pay 30% of the cost for each out of network mammogram.

PFFS Plan Comparison Chart 2006 – Preventive Services

PLAN NAME	BONE MASS MEASUREMENT <small>FOR PEOPLE WHO ARE AT RISK</small>	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) <small>FOR WOMEN AGE 40 AND OLDER</small>
SecureHorizons Direct PFFS	You pay \$0 for each Medicare-covered Bone Mass	You pay \$0 for each Medicare-covered Pap Smears and Pelvic Exams. \$0 for each additional Pap	You pay \$0 for Medicare covered Screening Mammograms. No referral

PLAN NAME	BONE MASS MEASUREMENT <small>FOR PEOPLE WHO ARE AT RISK</small>	PAP SMEARS AND PELVIC EXAMS	MAMMOGRAMS (ANNUAL SCREENING) <small>FOR WOMEN AGE 40 AND OLDER</small>
SecureHorizons Direct Plan 5*	Measurement.	Smear and Pelvic Exam up to 1 Pap Smear and Pelvic Exam every year.	necessary for Medicare-covered screenings.

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006: Preventive Services

PLAN NAME	IMMUNIZATIONS FLU, HEPATITS B VACCINE - FOR PEOPLE WHO ARE AT RISK, PNEUMONIA VACCINES	PROSTATE CANCER SCREENING EXAMS FOR MEN AGE 50 AND OLDER	COLORECTAL SCREENING EXAMS FOR PEOPLE AGE 50 AND OLDER
Original Medicare	There is no copayment for the Pneumonia vaccine and Flu vaccine. You pay 20% of Medicare-approved amounts.	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services.	You pay 20% of Medicare-approved amounts.
Health Net HMO SmartChoice Ruby Option I*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.
Health Net HMO SmartChoice Ruby Option II*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.

PLAN NAME	IMMUNIZATIONS FLU, HEPATITS B VACCINE - FOR PEOPLE WHO ARE AT RISK, PNEUMONIA VACCINES	PROSTATE CANCER SCREENING EXAMS FOR MEN AGE 50 AND OLDER	COLORECTAL SCREENING EXAMS FOR PEOPLE AGE 50 AND OLDER
Health Net HMO SmartChoice Green plan*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.
Health Net POS SmartChoice Navy plan*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.
Health Net SNP SmartChoice Amber Plan* Special Needs Plan for Dual Eligible Individuals Only	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.

PLAN NAME	IMMUNIZATIONS FLU, HEPATITS B VACCINE - FOR PEOPLE WHO ARE AT RISK, PNEUMONIA VACCINES	PROSTATE CANCER SCREENING EXAMS FOR MEN AGE 50 AND OLDER	COLORECTAL SCREENING EXAMS FOR PEOPLE AGE 50 AND OLDER
Oxford Health Medicare Advantage*	There is no copayment for the pneumonia and flu vaccines. No referral necessary for the Pneumonia and Flu vaccine. There is no copayment for the Hepatitis B vaccine.	There is no copayment for Medicare-covered Prostate Cancer Screening Exams.	You pay \$15-\$25 for each Medicare covered screening exam. You pay \$15-\$25 for each additional screening up to 1 exam per year. An additional facility charge may apply.
WellCare HMO WellCare Advance*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.
WellCare HMO WellCare Choice*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.

PLAN NAME	IMMUNIZATIONS FLU, HEPATITS B VACCINE - FOR PEOPLE WHO ARE AT RISK, PNEUMONIA VACCINES	PROSTATE CANCER SCREENING EXAMS FOR MEN AGE 50 AND OLDER	COLORECTAL SCREENING EXAMS FOR PEOPLE AGE 50 AND OLDER
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare-covered Colorectal Screening Exams.

PPO Plan Comparison Chart 2006 – Preventive Services

PLAN NAME	IMMUNIZATIONS	PROSTATE CANCER	COLORECTAL SCREENING
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	FLU, HEPATITS B VACCINE - FOR PEOPLE WHO ARE AT RISK, PNEUMONIA VACCINES	SCREENING EXAMS FOR MEN AGE 50 AND OLDER	EXAMS FOR PEOPLE AGE 50 AND OLDER
United HealthCare Evercare Choice Plan P*	<p>There is no copayment for the pneumonia and flu vaccines. No referral necessary for the Pneumonia and Flu vaccine.</p> <p>There is no copayment for the Hepatitis B vaccine.</p> <p>You pay 30% of the cost of each out of network immunization.</p>	<p>There is no copayment for Medicare-covered Prostate Cancer Screening Exams.</p> <p>You pay 30% of the cost for screenings received out of network.</p>	<p>There is no copayment for Medicare covered colorectal screening exams.</p> <p>You pay 30% of the cost for each colorectal screening exam received out of network.</p>
United HealthCare SNP Evercare Choice Plan DP* Special Needs Plan for Dual Eligible Individuals	<p>There is no copayment for the pneumonia and flu vaccines. No referral necessary for the Pneumonia and Flu vaccine.</p> <p>There is no copayment for the Hepatitis B vaccine.</p> <p>You pay 30% of the cost of each out of network immunization.</p>	<p>There is no copayment for Medicare-covered Prostate Cancer Screening Exams.</p> <p>You pay 30% of the cost for screenings received out of network.</p>	<p>There is no copayment for Medicare covered colorectal screening exams.</p> <p>You pay 30% of the cost for each colorectal screening exam received out of network.</p>

PFFS Plan Comparison Chart 2006 – Preventive Services

PLAN NAME	IMMUNIZATIONS FLU, HEPATITS B VACCINE - FOR PEOPLE WHO ARE AT RISK, PNEUMONIA VACCINES	PROSTATE CANCER SCREENING EXAMS FOR MEN AGE 50 AND OLDER	COLORECTAL SCREENING EXAMS FOR PEOPLE AGE 50 AND OLDER
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SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for the Pneumonia and Flu vaccines. You pay \$0 for the Hepatitis B vaccine.	You pay \$0 for Medicare-covered Prostate Cancer Screening Exam.	You pay \$0 for Medicare- covered Colorectal Screening Exams.
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* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006: Outpatient Prescription Drugs

PLAN NAME	OUTPATIENT PRESCRIPTION DRUGS
Original Medicare	You pay 100% for most prescription drugs.
HealthNet HMO SmartChoice Ruby Option I*	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the HealthNet Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
HealthNet HMO SmartChoice Ruby Option II*	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the HealthNet Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
Health Net HMO SmartChoice Green Plan*	You pay 100% for most prescription drugs. This plan does not offer Medicare Rx prescription drug coverage.
HealthNet POS SmartChoice Navy Plan	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the HealthNet Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
HealthNet SNP SmartChoice Amber Plan	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the HealthNet Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.

PLAN NAME	OUTPATIENT PRESCRIPTION DRUGS
Oxford Health Medicare Advantage*	You receive outpatient prescription drug coverage for this plan through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
WellCare HMO WellCare Advance*	You pay 100% for most prescription drugs. This plan does not include Medicare Rx prescription drug coverage.
WellCare HMO WellCare Choice*	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the WellCare Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
WellCare SNP WellCare Access*	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the WellCare Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
WellCare SNP WellCare Select*	You receive outpatient prescription drug coverage for these plans through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the WellCare Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.

PPO Plan Comparison Chart 2006 – Outpatient Prescription Drugs

PLAN NAME	OUTPATIENT PRESCRIPTION DRUGS
United HealthCare	You receive outpatient prescription drug coverage for this plan through the new Medicare Rx program. Drug coverage is provided through the Medicare Rx plan that is part of the

Evercare Choice*	Medicare Advantage plan that you select. See the Medicare Rx plan comparison chart on the following pages for detailed drug coverage information.
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* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

PFFS Plan Comparison Chart 2006 – Outpatient Prescription Drugs

PLAN NAME	OUTPATIENT PRESCRIPTION DRUGS	
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	You pay 100% for most prescription drugs. This plan does not offer Medicare Rx prescription drug coverage.	

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

Medicare Rx Plan Comparison Chart 2006: MAPD Outpatient Prescription Drugs

January 1 – December 31, 2006 * Costs for Medicare Rx MA-PDs (1)

COMPANY INFO	PLAN NAME	TELEPHONE	PLAN SERVICE DELIVERY AREA	MONTHLY PREMIUM FOR DRUGS ONLY (2)	TOTAL MONTHLY PREMIUM FOR DRUGS, HOSPITAL AND MEDICAL (2)	ANNUAL DEDUCTIBLE FOR DRUG COVERAGE ONLY	30-DAY SUPPLY CO-PAYS AND CO-INSURANCE (3)				"COVERAGE GAP" COVERAGE	% OF TOP 100 DRUGS INCLUDED IN FORMULARY (4)
							T1	T2	T3	T4		
Health Net of CT	Health Net Smart Choice (021)	(800) 949-2516	Connecticut	\$17.12	\$17.12	\$250	25 %				No	97%
	Health Net Smart Choice (022)	(800) 949-2516	Connecticut	\$17.69	\$20	\$0	\$5	\$27	\$59	25%	No	97%
	Health Net Smart Choice (001)	(800) 949-2516	Connecticut	\$17.69	\$99	\$0	\$5	\$27	\$59	25%	No	97%
	Health Net Smart Choice POS for CT (020)	(800) 949-2516	Connecticut	\$17.69	\$119	\$0	\$5	\$27	\$59	25%	No	97%
							T1	T2	T3	T4		
Oxford Health Plans (CT) Inc.	Oxford Medicare Advantage	(800) 303-6720	New Haven County only	\$0	\$0	\$0	\$3	\$28	\$63	25%	No	97%
							T1	T2	T3	T4		
United HealthCare Insurance Co. (local PPO)	Evercare Plan P	(888) 697-9058	Fairfield, Hartford and New Haven Counties	\$20.39	\$20.39	\$0	\$4	\$28	\$63	25%	No	97%
	Evercare Plan DP	(888) 697-9058	Hartford County	\$30.27	\$30.27	\$0	\$4	\$28	\$62	25%	No	97%

- (1) MA-PDs are Medicare Advantage Prescription Drug Plans that offer prescription coverage **and** hospital and medical coverage. These plans are options for people who are in (or want to join) a Medicare managed care plan.
- (2) The first premium amount is for prescription drug coverage only. The second premium amount is for prescription, hospital and medical coverage combined.
- (3) The co-pay and co-insurance amounts shown are for the prescription drug coverage only. Contact the plan for the amounts of primary care co-pays and other cost sharing information. Some plans have higher prescription co-pays or co-insurance for using an out-of-network pharmacy.
- (4) The “Top 100” are the drugs most often taken by people who signed up for the Medicare discount drug card. This may or may not reflect the drugs CT beneficiaries take. Medicaid recipients were excluded from the discount cards.

NOTE: All the plans on this page offer mail order.

IMPORTANT! The information in this chart is from Medicare; it is for general comparison purposes only and subject to change. Contact the plan for more details!

CHOICES Hotline! 1-800-994-9422

January 1 – December 31, 2006 * Costs for Medicare Rx MA-PDs (1)

COMPANY INFO	PLAN NAME	TELEPHONE	PLAN SERVICE DELIVERY AREA	MONTHLY PREMIUM FOR DRUGS ONLY (2)	TOTAL MONTHLY PREMIUM FOR DRUGS, HOSPITAL AND MEDICAL (2)	ANNUAL DEDUCTIBLE FOR DRUG COVERAGE ONLY	30-DAY SUPPLY CO-PAYS AND CO-INSURANCE (3)				"COVERAG E GAP" COVERAGE	% OF TOP 100 DRUGS INCLUDED IN FORMULARY (4)
							T1	T2	T3	T4		
WellCare	WellCare Choice	(866) 238-4344	Fairfield County	\$0	\$0	\$0	\$0	\$45	\$100	33%	No	85%
	WellCare Select	(866) 238-4344	Fairfield County	\$7.57	\$7.57	\$250	\$0	38%	43%	25%	No	85%
	WellCare Access	(866) 238-4344	Fairfield County	\$25.64	\$25.64	\$250	25%	25%	25%	25%	No	85%
							T1	T2	T3	T4		
	WellCare Choice	(866) 238-4344	Hartford County	\$0	\$0	\$0	\$0	\$45	\$100	33%	No	85%
	WellCare Select	(866) 238-4344	Hartford County	\$7.57	\$7.57	\$250	\$0	38%	43%	25%	No	85%
	WellCare Access	(866) 238-4344	Hartford County	\$25.61	\$25.61	\$250	25%	25%	25%	25%	No	85%
							T1	T2	T3	T4		
	WellCare Choice	(866) 238-4344	New Haven County	\$0	\$0	\$0	\$0	\$45	\$100	33%	No	85%
	WellCare Select	(866) 238-4344	New Haven County	\$7.57	\$7.57	\$250	\$0	38%	43%	25%	No	85%
	WellCare Access	(866) 238-4344	New Haven County	\$25.64	\$25.64	\$250	25%	25%	25%	25%	No	85%

(1) MA-PDs are Medicare Advantage Prescription Drug Plans that offer prescription coverage and hospital and medical coverage. These plans are options for people who are in (or want to join) a Medicare managed care plan.

- (2) The first premium amount is for prescription drug coverage only. The second premium amount is for prescription, hospital and medical coverage combined.
- (3) The co-pay and co-insurance amounts shown are for the prescription drug coverage only. Contact the plan for the amounts of primary care co-pays and other cost sharing information. Some plans have higher prescription co-pays or co-insurance for using an out-of-network pharmacy.
- (4) The “Top 100” are the drugs most often taken by people who signed up for the Medicare discount drug card. This may or may not reflect the drugs CT beneficiaries take. Medicaid recipients were excluded from the discount cards.

NOTE: All the plans on this page offer mail order.

IMPORTANT! The information in this chart is from Medicare; it is for general comparison purposes only and subject to change. Contact the plan for more details!

HMO Plan Comparison Chart 2006: Additional Benefits

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
Original Medicare	In general, you pay 100% for dental services.	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams.</p>	<p>You pay 100% for routine physical exams.*</p> <p>*You pay \$0 for one routine physical exam within the first 6 months of enrolling in Medicare Part B if your coverage begins on or after January 1, 2005.</p>
Health Net HMO SmartChoice Ruby Option I*	<p>You pay \$0 for cleanings, X-rays, fluoride treatments and oral exams up to 2 per year.</p> <p>You are covered up to \$1,000 for preventive dental services each year.</p>	<p>You pay 100% for hearing aids. You pay \$15 for each Medicare-covered hearing exam (diagnostic hearing exams).</p> <p>You pay \$15 for each routine hearing test up to 1 test every year.</p>	<p>You pay \$0 for each exam. You are covered up to 1 exam(s) every year.</p>

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
Health Net HMO SmartChoice Option II*	In general, you pay 100% for dental services.	You pay 100% for hearing aids. You pay \$25 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$25 for each routine hearing test up to 1 test every year.	You pay \$0 for each exam. You are covered up to 1 exam(s) every year.
Health Net HMO SmartChoice Green Plan*	In general, you pay 100% for dental services.	You pay 100% for hearing aids. You pay \$25 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$25 for each routine hearing test up to 1 test every year.	You pay \$0 for each exam. You are covered up to 1 exam(s) every year.
Health Net POS SmartChoice Navy Plan*	You pay \$0 for cleanings, X-rays, fluoride treatments and oral exams up to 2 per year. You are covered up to \$1,000 for preventive dental services each year.	You pay 100% for hearing aids. You pay \$15 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$15 for each routine hearing test up to 1 test every year.	You pay \$0 for each exam. You are covered up to 1 exam(s) every year.

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
<p>Health Net SNP SmartChoice Amber Plan*</p> <p>Special Needs Plan for Dual Eligible Individuals Only</p>	<p>In general, you pay 100% for dental services.</p>	<p>You pay 100% for hearing aids. You pay \$25 for each Medicare-covered hearing exam (diagnostic hearing exams).</p> <p>You pay \$25 for each routine hearing test up to 1 test every year.</p>	<p>You pay \$0 for each exam. You are covered up to 1 exam(s) every year.</p>
<p>Oxford Health Medicare Advantage*</p>	<p>In general, you pay 100% for dental services.</p>	<p>In general, you pay 100% for routine hearing exams and hearing aids.</p> <p>You pay \$25 for each Medicare-covered hearing exam (diagnostic hearing exams).</p>	<p>There is no copayment for routine physical exams.</p> <p>You are covered up to one exam(s) every year.</p>

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
WellCare HMO WellCare Advance*	In general, you pay 100% for dental services.	You pay: <ul style="list-style-type: none"> - \$25 for each hearing aid up to 1 aid every 3 years. You are covered up to \$400 for hearing aids every 3 years. - \$25 for each fitting-evaluation for a hearing aid up to 1 fitting-evaluation per year - \$25 for each Medicare-covered hearing exam (diagnostic hearing exams) - \$25 for each routine hearing test up to 1 test every year. 	You pay \$0 for each exam. You are covered up to 1 exam(s) every year.
WellCare HMO WellCare Choice*	In general, you pay 100% for dental services.	You pay: <ul style="list-style-type: none"> - \$0 for each hearing aid up to 1 aid every 3 years. You are covered up to \$400 for hearing aids every 3 years. - \$25 for each fitting-evaluation for a hearing aid up to 1 fitting-evaluation per year - \$25 for each Medicare-covered hearing exam (diagnostic hearing exams) - \$25 for each routine hearing test up to 1 test every year. 	You pay \$0 for each exam. You are covered up to 1 exam(s) every year.

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
<p>WellCare SNP WellCare Access*</p> <p>Special Needs Plan for Dual Eligible Individuals Only</p>	<p>In general, you pay 100% for dental services.</p>	<p>You pay 100% for hearing aids. You pay \$0 for each Medicare-covered hearing exam (diagnostic hearing exams).</p> <p>You pay 100% of the cost for each routine hearing test up to 1 test every year.</p>	<p>You pay \$0 for each exam. You are covered up to 1 exam(s) every year.</p>
<p>WellCare SNP WellCare Select*</p> <p>Special Needs Plan for Dual Eligible Individuals Only</p>	<p>In general, you pay 100% for dental services.</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$0 for each hearing aid up to 1 aid every 3 years. You are covered up to \$400 for hearing aids every 3 years. - \$25 for each fitting-evaluation for a hearing aid up to 1 fitting-evaluation per year - \$25 for each Medicare-covered hearing exam (diagnostic hearing exams) - \$25 for each routine hearing test up to 1 test every year. 	<p>You pay \$0 for each exam. You are covered up to 1 exam(s) every year.</p>

*Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

PPO Plan Comparison Chart 2006 – Additional Benefits

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
United HealthCare Evercare Choice Plan P*	In general, you pay 100% for dental services.	In general, you pay 100% for routine hearing exams and hearing aids. You pay \$20 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$0-\$20 for each routine hearing test up to 1 test per year. You pay 30% of the cost for out of network hearing exams.	You pay \$10 for each physical exam. You are covered up to one exam per year. You pay 30% of the cost for physical exams received out of network.
United HealthCare SNP Evercare Choice Plan DP* Special Needs Plan for Dual Eligible Individuals	In general, you pay 100% for dental services.	In general, you pay 100% for routine hearing exams and hearing aids. You pay \$0 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$0for each routine hearing test up to 1 test per year. You pay 30% of the cost for out of network hearing exams.	You pay 100% for each routine physical exam.

*Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

PFFS Plan Comparison Chart 2006 – Additional Benefits

PLAN NAME	DENTAL SERVICES	HEARING SERVICES	ROUTINE PHYSICAL EXAMS
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	In general you pay 100% for dental services.	You pay 100% for hearing aids and routine hearing exams. You pay \$10 for each Medicare-covered hearing exam (diagnostic hearing exams).	You pay \$0 for each exam. You are covered up to 1 exam(s) every year.

*Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly

HMO Plan Comparison Chart 2006: Additional Benefits

PLAN NAME	VISION SERVICES	HEALTH/WELLNESS EDUC.
Original Medicare	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. For people with Medicare who are at risk, you are covered for annual glaucoma screenings. You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. You pay 100% for routine eye exams and glasses.</p>	<p>You pay 100%</p>
<p>Health Net HMO SmartChoice Ruby Option I*</p>	<p>There is no copayment for the following items: -Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair(s) of glasses every 2 years. Contacts limited to 1 pair(s) of contacts every 2 years. You pay: \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). \$15 for each routine eye exam, limited to 1 exam(s) every year. You are covered up to \$100 for eye wear every 2 years.</p>	<p>You are covered for the following: -Congestive Heart Program -Nursing Hotline -Disease Management* -Up to 2 fitness classes per week -24 hour access to health coaches - Some alternative medicine program * Co-pays may apply</p>
<p>Health Net HMO SmartChoice Ruby Option II*</p>	<p>There is no copayment for the following items: -Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair(s) of glasses every 2 years. Contacts limited to 1 pair(s) of contacts every 2 years. You pay: \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of</p>	<p>You are covered for the following: -Congestive Heart Program -Nursing Hotline -Disease Management* -Up to 2 fitness classes per week</p>

PLAN NAME	VISION SERVICES	HEALTH/WELLNESS EDUC.
	<p>the eye). \$25 for each routine eye exam, limited to 1 exam(s) every year. You are covered up to \$40 for eye wear every 2 years.</p>	<p>-24 hour access to health coaches - Some alternative medicine program * Co-pays may apply</p>
<p>Health Net HMO SmartChoice Green Plan*</p>	<p>There is no copayment for the following items: -Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair(s) of glasses every 2 years. Contacts limited to 1 pair(s) of contacts every 2 years. You pay: \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). \$25 for each routine eye exam, limited to 1 exam(s) every year. You are covered up to \$40 for eye wear every 2 years.</p>	<p>You are covered for the following: -Congestive Heart Program -Nursing Hotline -Disease Management* -Up to 2 fitness classes per week -24 hour access to health coaches - Some alternative medicine program * Co-pays may apply</p>
<p>Health Net HMO SmartChoice Navy Plan*</p>	<p>There is no copayment for the following items: -Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair(s) of glasses every 2 years. Contacts limited to 1 pair(s) of contacts every 2 years. You pay: \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). \$15 for each routine eye exam, limited to 1 exam(s) every year. You are covered up to \$100 for eye</p>	<p>You are covered for the following: -Congestive Heart Program -Nursing Hotline -Disease Management* -Up to 2 fitness classes per week -24 hour access to health coaches</p>

PLAN NAME	VISION SERVICES	HEALTH/WELLNESS EDUC.
	wear every 2 years.	<ul style="list-style-type: none"> - Some alternative medicine program * Co-pays may apply
<p>Health Net SNP SmartChoice Amber Plan*</p> <p>Special Needs Plan for Dual Eligible Individuals Only</p>	<p>There is no copayment for the following items: -Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair(s) of glasses every 2 years. Contacts limited to 1 pair(s) of contacts every 2 years. You pay: \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). \$25 for each routine eye exam, limited to 1 exam(s) every year. You are covered up to \$100 for eye wear every 2 years.</p>	<p>You are covered for the following:</p> <ul style="list-style-type: none"> -Congestive Heart Program -Nursing Hotline -Disease Management* -Up to 2 fitness classes per week -24 hour access to health coaches - Some alternative medicine program * Co-pays may apply
<p>Oxford Health Medicare Advantage*</p>	<p>You pay 100% for non-Medicare covered eye exams and glasses. There is no copayment for Medicare- covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). You pay \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</p>	<p>There is no copayment for the following:</p> <ul style="list-style-type: none"> -Health Education Classes -Newsletters -Congestive Heart Program -Nursing Hotline -Disease Management

PLAN NAME	VISION SERVICES	HEALTH/WELLNESS EDUC.
WellCare HMO WellCare Advance*	You pay: <ul style="list-style-type: none"> - \$25 for Medicare-covered eye-wear (1 pair of eyeglasses or contact lenses after each cataract surgery) - \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases & conditions of the eye) - \$25 for each routine eye exam, 1 per year - \$25 for frames, 1 frame every 2 years - You are covered up to \$100 for eyewear every 2 years 	You are covered for the following: <ul style="list-style-type: none"> - Health Education Classes - Newsletters - Nutritional Training - Smoking Cessation - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management
WellCare HMO WellCare Choice*	You pay: <ul style="list-style-type: none"> - \$25 for Medicare-covered eye-wear (1 pair of eyeglasses or contact lenses after each cataract surgery) - \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases & conditions of the eye) - \$25 for each routine eye exam, 1 per year - \$25 for frames, 1 frame every 2 years - You are covered up to \$100 for eyewear every 2 years 	You are covered for the following: <ul style="list-style-type: none"> - Health Education Classes - Newsletters - Nutritional Training - Smoking Cessation - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management

PLAN NAME	VISION SERVICES	HEALTH/WELLNESS EDUC.
WellCare SNP WellCare Access* Special Needs Plan for Dual Eligible Individuals Only	You pay 100% for non-Medicare-covered eye exams and glasses. You pay: <ul style="list-style-type: none"> - \$0 for Medicare-covered eye-wear (1 pair of eyeglasses or contact lenses after each cataract surgery) - \$0 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). 	You are covered for the following: <ul style="list-style-type: none"> - Health Education Classes - Newsletters - Nutritional Training - Smoking Cessation - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management
WellCare SNP WellCare Select* Special Needs Plan for Dual Eligible Individuals Only	You pay: <ul style="list-style-type: none"> - \$25 for Medicare-covered eye-wear (1 pair of eyeglasses or contact lenses after each cataract surgery) - \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases & conditions of the eye) - \$25 for each routine eye exam, 1 per year - \$25 for frames, 1 frame every 2 years - You are covered up to \$100 for eyewear every 2 years 	You are covered for the following: <ul style="list-style-type: none"> - Health Education Classes - Newsletters - Nutritional Training - Smoking Cessation - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management

PPO Plan Comparison Chart 2006 – Additional Benefits

PLAN NAME	VISION SERVICES	ADDITIONAL BENEFITS
United	There is no copayment for the following items: -Medicare-covered eye wear (one pair of eyeglasses or contact	Routine Transportation: There is no co-payment for each round trip

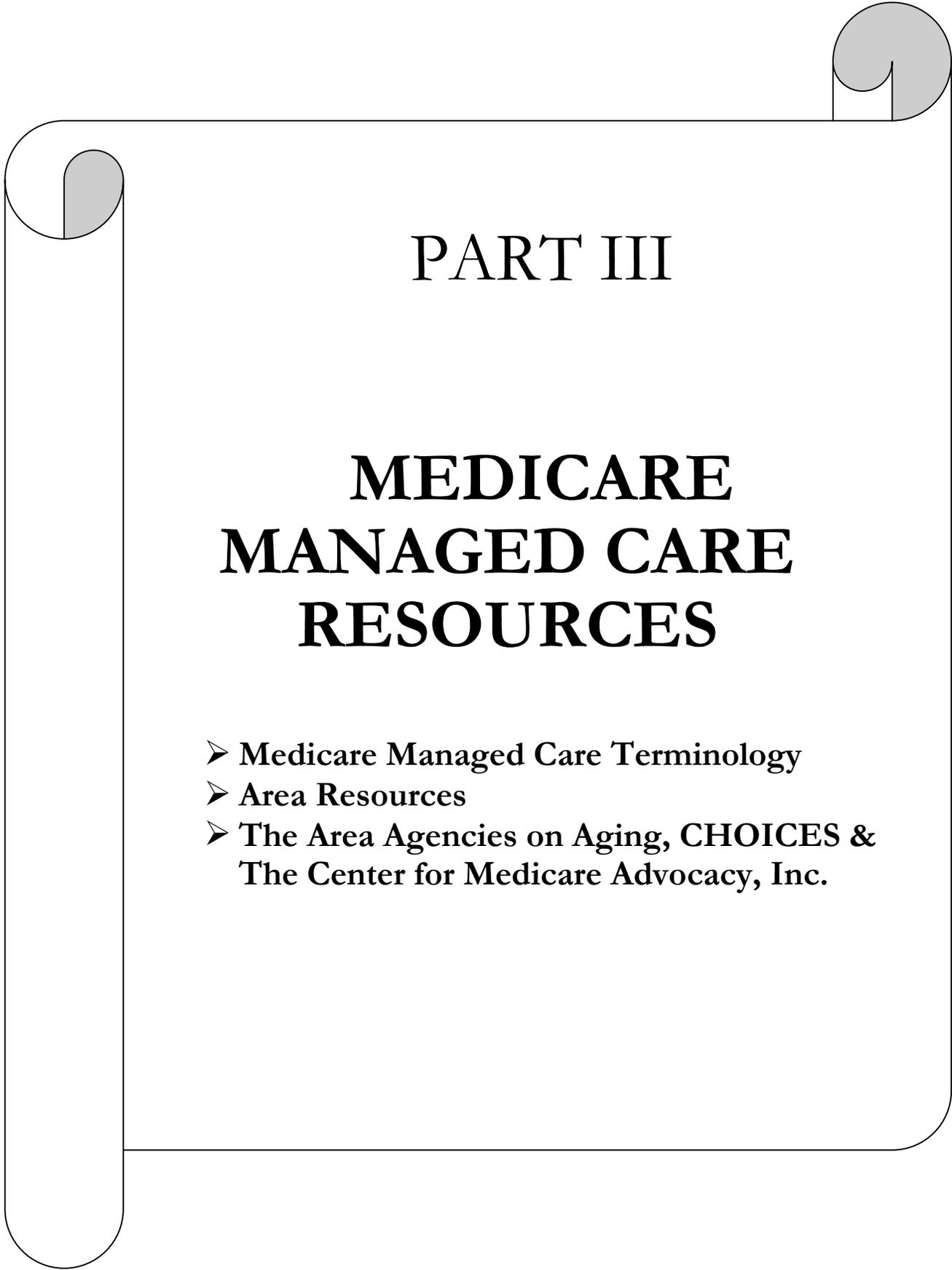
HealthCare Evercare Choice Plan P*	lenses after each cataract surgery). You pay: \$0-\$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). \$0- \$25 for each routine eye exam, limited to 1 exam per year. You pay 30% of the cost for out of network eye exams.	up to 6 trips to plan-approved locations every year.
United HealthCare Evercare Choice Plan DP*	There is no copayment for the following items: - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). - Glasses/contact lenses, up to one pair per year - Each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - Each routine eye exam, limited to 1 exam per year. You pay 30% of the cost for out of network eye exams.	Routine Transportation: There is no co-payment for each round trip up to 20 trips to plan-approved locations every year.

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly.

PFFS Plan Comparison Chart 2006 – Additional Benefits

PLAN NAME	VISION SERVICES	ADDITIONAL BENEFITS
SecureHorizons Direct PFFS SecureHorizons Direct Plan 5*	You pay 100% for non-Medicare-covered eye exams and glasses. You pay: - \$30 for Medicare-covered eye-wear (1 pair of eyeglasses or contact lenses after each cataract surgery) - \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).	There are no additional benefits offered under this plan.

* Information from www.medicare.gov. Please refer to this site for more plan details or contact the plan directly.

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PART III

MEDICARE MANAGED CARE RESOURCES

- Medicare Managed Care 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 managed care plan unless they have been affected by an HMO non-renewal.

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 Managed Care: 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 managed care 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 Managed Care 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)

Medicare Managed Care Plans in CT

Oxford Health Plan 1-800-303-6720

HealthNet (formerly Physicians Health Services) 1-800-977-7524 or
1-888-747-2424 (TTY)

United HealthCare (PPO) 1-800-393-0993 or 1-888-685-8480 (TTY)

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

*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

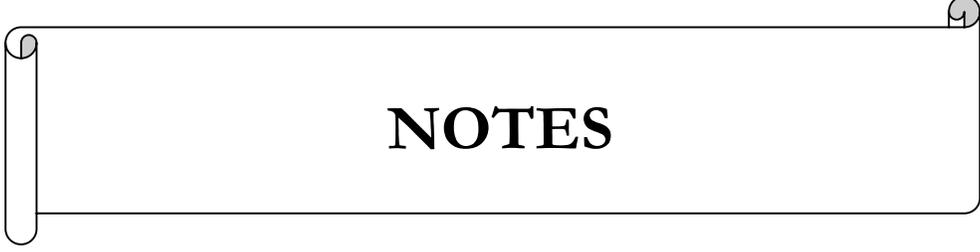
**Agency on Aging of South Central
Connecticut**
One Long Wharf Drive
New Haven, CT 06511; 203-785-8533
www.agencyonaging-scc.org

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

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)



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