State of New Jersey
State Health Ins. Assistance Program
S.H.I.P.
Dept. of Health & Sr. Services
JANUARY 2005

MEDICARE ADVANTAGE HMOs IN NEW JERSEY

GENERAL INFORMATION							PLAN BENEFITS[4]							
COMPANY	COUNTIES WHERE AVAILABLE	PLAN / MONTHLY[1] PREMIUM	ACCEPTS[2] <65 DISABLED	COPAY PCP[3]/ SPECIALIST VISIT	COPAY/DEDUCT. INPATIENT HOSPITAL	COPAY/DEDUCT. SKILLED NURSING FACILITY	EMERGENCY CARE	ROUTINE IMMUNIZATIONS	ROUTINE VISION CARE	ROUTINE HEARING CARE	ROUTINE DENTAL CARE	Rx DRUGS	FOREIGN TRAVEL EMERGENCY	OTHER
AETNA HEALTH, INC. "GOLDEN MEDICARE" 1-800-832-2640 www.aetna.com	BERGEN ESSEX HUDSON MORRIS PASSAIC SUSSEX UNION	OPTION 1 / $0	YES	$10-15 / $20	$750 FOR EACH STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $100/2 YRS. EYEWEAR	$0 COPAY ANNUAL EXAM $500/3 YRS. HEARING AID	NO	NO (see optional supplement package below)	YES	$0 copay/annual mammogram $0 copay / pelvic exam $0 copay / annual prostate screening
		OPTION 2 / $29	YES	$10-15 / $20	$250 FOR EACH STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $100/2 YRS. EYEWEAR	$0 COPAY ANNUAL EXAM $500/3 YRS. HEARING AID	NO	NO (see optional supplement package below)	YES	$0 copay/annual mammogram $0 copay / pelvic exam $0 copay / annual prostate screening
		OPTION 3 / $0	YES	$10-15 / $20	$500 INITIAL DEDUCTIBLE THEN 15% OF COSTS UP TO $3500 MAX./YR.	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $100/2 YRS. EYEWEAR	$0 COPAY ANNUAL EXAM $500/3 YRS. HEARING AID	NO	UNLIMITED GENERIC ONLY $15-30 DAY SUPPLY $30-90 DAY MAIL ORDER SUPPLY	YES	$0 copay/annual mammogram $0 copay / pelvic exam $0 copay / annual prostate screening
		OPTIONAL SUPPLEMENTAL PACKAGE FOR MEMBERS IN PLAN OPTION 1 ABOVE: *Outpatient prescription drugs; additional premium $25/month; unlimited generic drugs; $15 copay/30-day supply; $30 copay/90-day mail order supply.* ***OPTIONAL SUPPLEMENTAL PACKAGE FOR MEMBERS IN PLAN OPTION 2 ABOVE:*** *Outpatient prescription drugs; additional premium $46/month; unlimited generic drugs; $15 copay/30-day supply; $30 copay/90-day mail order supply. $200 quarterly limit for preferred AND non-preferred brand name drugs; $25 copay/30-day preferred brand; $35 copay/non-preferred 30-day supply; $50 copay/preferred 90-day mail order supply; $70 copay/non-preferred 90-day mail order supply.*												
	BURLINGTON CAMDEN GLOUCESTER MERCER	OPTION 1 / $0	YES	$20-25 / $35	$750 FOR EACH STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $100/2 YRS. EYEWEAR	$0 COPAY ANNUAL EXAM $500/3 YRS. HEARING AID	NO	Discounts at Network Pharmacies	YES	$0 copay/annual mammogram $0 copay / pelvic exam $0 copay / annual prostate screening
		OPTION 2 / $35	YES	$15-20 / $25	$750 FOR EACH STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $100/2 YRS. EYEWEAR	$0 COPAY ANNUAL EXAM $500/3 YRS. HEARING AID	NO	UNLIMITED GENERIC ONLY $15/30 DAY SUPPLY $30/90 DAY MAIL ORDER SUPPLY	YES	$0 copay/annual mammogram $0 copay / pelvic exam $0 copay / annual prostate screening
		OPTION 3 / $0	YES	$10-15 / $20	$500 initial deductible then 15% of costs up to $3500 max./yr.	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $100/2 YRS. EYEWEAR	$0 COPAY ANNUAL EXAM $500/3 YRS. HEARING AID	NO	Discounts at Network Pharmacies	YES	$0 copay/annual mammogram $0 copay / pelvic exam $0 copay / annual prostate screening

1. May be billed quarterly.
2. People with end-stage renal disease (ESRD) may only enroll in a Medicare Advantage HMO if they are already in one, and it later terminates or ceases to provide coverage in the service area.
3. Primary Care Physician (PCP).
4. This is only a partial summary of benefits. Contact the HMO for details. This summary only applies to the calendar year indicated.

(This information may also be found on our web site at www.state.nj.us/health/senior/ship.shtml)

OVER

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AMERICHOICE OF N.J. "PERSONAL CARE PLUS"[5] 1-877-289-1915 www.americhoice.com	ESSEX HUDSON PASSAIC UNION	$0	YES	$20 / $25	$880 / BENEFIT PERIOD	$0	$50 / ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$25 COPAY ANNUAL EXAM	$20 COPAY ANNUAL EXAM $600/3YRS HEARING AID	NO	NO	YES	$0 COPAY/ANNUAL MAMMOGRAM $0 COPAY / PELVIC EXAM $0 COPAY / ANNUAL PROSTATE CANCER SCREENING
AMERIHEALTH HMO, INC. "AMERIHEALTH 65 STANDARD" 1-800-898-3492 www.amerihealth65.com	SALEM	$145	YES	$15 / $25	$750 ANNUAL DEDUCTIBLE	$0	$40 / ER VISIT	$0 COPAY FLU, PNEUMONIA HEPATITIS B	$25 COPAY EXAM/2 YRS. $100 EYEWEAR / .	$0 COPAY ANNUAL EXAM $700 / 3 YRS. HEARING AID	$10 COPAY 2 EXAMS / YR. 2 CLEANINGS / YR.	$1500 ANNUAL MAXIMUM GENERIC ONLY AT NETWORK PHARMACY $15 / 30 DAY SUPPLY $30 / 90 DAY SUPPLY	NO	$0 COPAY/ANNUAL MAMMOGRAM $25 COPAY / PELVIC EXAM $15 COPAY / ANNUAL PROSTATE CANCER SCREENING
HORIZON HEALTHCARE OF N.J., INC. "MEDICARE BLUE VALUE" 1-800-224-1234 www.horizon-bcbsnj.com	ALL	$33.40	YES	$10 / $10	15% OF ELIGIBLE CHARGES (UP TO ANNUAL OUT-OF-POCKET MAXIMUM OF $3000 FOR ALL PLAN SERVICES)	15% OF ELIGIBLE CHARGES (UP TO ANNUAL OUT-OF-POCKET MAXIMUM OF $3000 FOR ALL PLAN SERVICES)	$50 / ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	$0 COPAY FLU, PNEUMONIA $10 COPAY HEPATITIS B	$20 COPAY ANNUAL EXAM $100 / 2 YRS EYEWEAR	$0 COPAY ANNUAL EXAM $750 / 3 YRS. HEARING AID	NO	$50 ANNUAL DEDUCT-IBLE UNLIMITED GENERIC $10 / 30 DAY SUPPLY $20 / 90 DAY SUPPLY BRAND $500 MAX./ YR. 50% COPAY	YES	$0 COPAY/ANNUAL MAMMOGRAM $0 COPAY / PELVIC EXAM $0 COPAY / ANNUAL PROSTATE CANCER SCREENING

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5. Beginning January 1, 2005, AmeriChoice Personal Care Plus is a special plan for Medicare beneficiaries who also have Medicaid coverage. People already enrolled in AmeriChoice Personal Care Plus may remain in the plan with Medicare only, and will be reponsible for the out-of-pocket costs indicated above. New enrollees must have **both** Medicaid and Medicare. The costs indicated above will be paid by the state's Medicaid program, NOT by the member.

OVER

NOTE: Oxford's Medicare Advantage" plan in Hudson County has an approved maximum limit n enrollment. Call the plan to find out if it is open to new members or if it has a waiting list.

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OXFORD HEALTH PLANS (N.J.), INC. "OXFORD MEDICARE ADVANTAGE"[5] 1-800-303-6720 www.oxfordhealth.com	HUDSON	OXFORD MEDICARE ADVANTAGE $0	YES	$10 / $25	$80 / DAY DAYS 1 - 10 $0 / DAY DAYS 11-90	$0 / DAY DAYS 1-10 $75 / DAY DAYS 11-100	$50 / ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	$0 COPAY FLU PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $0 COPAY EYEWEAR / 2 YRS.	$0 COPAY ANNUAL EXAM $700 3YRS. HEARING AID	$0 COPAY 2 EXAMS / YR. 2 CLEANINGS / YR.	UNLIMITED GENERIC ONLY $15 / 30 DAY SUPPLY $45 / 90 DAY MAIL ORDER SUPPLY	NO	$0 COPAY/ANNUAL MAMMOGRAM $0 COPAY / PELVIC EXAM $0 COPAY / PROSTATE CANCER SCREENING
	MERCER, MIDDLESEX, MONMOUTH, PASSAIC	OXFORD MEDICARE ADVANTAGE BALANCE $0	YES	$10 / $20	PLAN PAYS FIRST $500. YOU THEN PAY ANNUAL DE-DUCTIBLE OF $2000. PLAN THEN COVERS 100%. SEE #5 FOOTNOTE BELOW	PLAN PAYS FIRST $500. YOU THEN PAY ANNUAL DE-DUCTIBLE OF $2000. PLAN THEN COVERS 100%. SEE #5 FOOTNOTE BELOW	$50 / ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	$0 COPAY FLU PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $0 COPAY EYEWEAR / 2 YRS.	$0 COPAY ANNUAL EXAM $700 3YRS. HEARING AID	$0 COPAY 2 EXAMS / YR. 2 CLEANINGS / YR.	UNLIMITED GENERIC ONLY $15 - 30 DAY SUPPLY $30 - 90 DAY MAIL ORDER SUPPLY	YES	$0 COPAY/ANNUAL MAMMOGRAM $0 COPAY / PELVIC EXAM $0 COPAY / PROSTATE CANCER SCREENING
	BERGEN, ESSEX OCEAN, UNION	OXFORD MEDICARE ADVANTAGE BALANCE $0	YES	$10 / $20	PLAN PAYS FIRST $500. YOU THEN PAY ANNUAL DE-DUCTIBLE OF $2000. PLAN THEN COVERS 100%. SEE #5 FOOTNOTE BELOW	PLAN PAYS FIRST $500. YOU THEN PAY ANNUAL DE-DUCTIBLE OF $2000. PLAN THEN COVERS 100%. SEE #5 FOOTNOTE BELOW	$50 / ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	$0 COPAY FLU PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $0 COPAY EYEWEAR / 2 YRS.	$0 COPAY ANNUAL EXAM $700 3YRS. HEARING AID	$0 COPAY 2 EXAMS / YR. 2 CLEANINGS / YR.	UNLIMITED GENERIC $15 / 30 DAY SUPPLY $45 / 90 DAY MAIL ORDER SUPPLY BRAND $600 ANNUAL MAX. GREATER OF: $25 OR 50% 30-DAY PREFERRED $50 OR 50% 30-DAY NON-PREFERRED $75 OR 50% 90-DAY MAIL ORDERED PERFERRED $150 OR 50% 90-DAY MAIL ORDERED NON-PERFERRED	YES	$0 COPAY/ANNUAL MAMMOGRAM $0 COPAY / PELVIC EXAM $0 COPAY / PROSTATE CANCER SCREENING
		OXFORD MEDICARE ADVANTAGE SIGNATURE $0	YES	$10 / $20	$80 / DAY DAYS 1 -10 $0 / DAY DAYS 11- 90	$0/DAY DAYS 1-10 $75/DAY DAYS 11-100	$50 / ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	$0 COPAY FLU PNEUMONIA HEPATITIS B	$0 COPAY ANNUAL EXAM $0 COPAY EYEWEAR / 2 YRS.	$0 COPAY ANNUAL EXAM $700 3YRS. HEARING AID	$0 COPAY 2 EXAMS / YR. 2 CLEANINGS / YR.	UNLIMITED GENERIC ONLY $15 / 30 DAY SUPPLY $45 / 90 DAY MAIL ORDER SUPPLY	YES	$0 COPAY/ANNUAL MAMMOGRAM $0 COPAY / PELVIC EXAM $0 COPAY / PROSTATE CANCER SCREENING

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5. After Oxford Medicare Advantage Balance plan has paid $500 toward the following services, you are responsible for the next $2000 (a deductible) out-of-pocket: inpatient hospital care, inpatient mental healthcare, skilled nursing facility, home healthcare, outpatient services, ambulance services, durable medical equipment, prosthetic devices, partial hospitalization, cardiac rehabilitation services, and renal dialysis. The plan then covers these services 100%. The $2000 deductible is prorated. If the effective date of membership is after June 30, the deductible is $1000 after Oxford Medicare Advantage Balance has paid $250.