

Unison Health Plan of Pennsylvania Inc. has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, covered services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS's January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

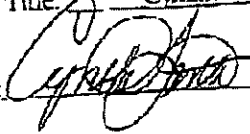
Print Name and Title: Jennifer Kessler, President
Signature/Date: [Handwritten Signature] 1/27/06

Gateway Health Plan, Inc. has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, provider services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, "prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS's January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

* Please note: Gateway Health Plan will meet the requirement to discontinue its prior authorization requirement for services furnished by out-of-network providers as soon as the systems and process changes can be made.

Print Name and Title: Cynthia J. Gentile, Vice President, Strategic Planning

Signature/Date:  01-25-06

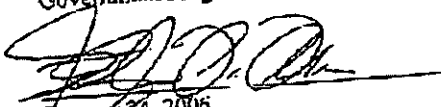


1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

Keystone Health Plan East has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, covered services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS's January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

Name and Title: Steven P. Fera
Vice President Social Mission Programs,
Government Programs

Signature/Date: 
January 24, 2006

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross. Independence is a member of the Blue Cross and Blue Shield Association.

00472 10/99



AmeriHealth HMO, Inc.
Medicare Department
P.O. Box 7576
Philadelphia, PA 19101-7576



AmeriHealth HMO has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, covered services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS's January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

Name and Title:

Steven P. Fera
Vice President Social Mission Programs,
Government Programs

Signature/Date:

January 24, 2006



Health Partners has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, provider services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS's January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

Print Name and Title: JUDY B. HARRINGTON SENIOR VICE PRESIDENT
BUSINESS DEVELOPMENT

Signature/Date: Judy B. Harrington 1/24/06

UPMC Health Plan, Inc. (UPMC for Life) has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, provider services for covered benefits furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS's January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

Print Name and Title: Diane P. Holder, President UPMC Health Plan

Signature/Date: *Diane P. Holder* 1-24-06