



A Medicare Advantage Open Access POS Plan from AmeriHealth HMO, Inc.

# AmeriHealth 65<sup>®</sup> Plus

## Evidence of Coverage Your Member Handbook

Burlington, Camden, Cumberland, Gloucester  
and Salem Counties

**Effective January 1, 2007  
through December 31, 2007**

**1-888-645-3965  
TTY/TDD: 1-888-857-4816  
Seven days a week  
8 a.m. — 8 p.m.**

# Important Information About AmeriHealth 65 Plus

The information in **At A Glance** will be useful when you use your benefits throughout the year. Take some time to review these pages—you may even find out something new about your health care coverage!

## **At A Glance**

### **Page Number**

#### **III Your ID Card**

Your AmeriHealth 65 Plus ID card contains important benefit and provider information. The illustration on Page IV of At A Glance will help you understand the details included on your card.

#### **IV Your AmeriHealth 65 Plus Premium Bill**

The premium bill section will answer any questions you have about your AmeriHealth 65 Plus bill. The graphic shown on Page V will help you if you plan to review your bill each month for accuracy.

#### **V Your Explanation of Benefits**

Your Explanation of Benefits is a statement sent to you after you have medical and drug services. It confirms the services you received, what the provider charged, and what the plan allowance is. We have included a graphic that illustrates the detailed information on your statement. Please note: your ID card may not look exactly like this picture; a few details may be different.

#### **VIII Saving Money on Prescription Drugs**

The rising costs of prescription medication is a real concern for many people. Using generic drugs is one way to combat these costs. Take a look at this section for more details.

#### **IX Healthy Lifestyles<sup>SM</sup>**

Why not take advantage of the many services available to you through our Healthy Lifestyles programs? They can help you make positive changes to your life and your health. Read about our enhanced Connections<sup>SM</sup> Health Management Program, as well as other programs that can help you stop smoking, lose weight, and sleep better.

#### **X Important AmeriHealth 65 Plus Telephone Numbers**

Have a question, a complaint, or a compliment? Call us! Refer to this section when you need to contact Member Services, Member Outreach, or Healthy Lifestyles, or if you need to get more information about Medicare Savings Programs.

## **OTHER AREAS OF INTEREST**

The sections below provide a brief overview of a few important topics that your Evidence of Coverage addresses. This is a quick reference to issues that might concern you, such as how to receive medical care when you are traveling and what services are covered under your plan. Please refer to the page numbers at the left to find the corresponding section (with expanded details) in your Evidence of Coverage.

### **EVIDENCE OF COVERAGE**

#### **15 How Does My AmeriHealth 65 Plus Network Work?**

As an HMO with a Point-of-Service (POS) option, AmeriHealth 65 Plus gives members the opportunity to access care without a referral for most covered services.

#### **16 What Are Plan (In-Network) Providers?**

Providers is the general term we use for doctors, health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and the state to provide health care services.

Providers are considered plan (in-network) providers when they participate in the AmeriHealth 65 Plus network. When we say that plan (in-network) providers participate in the AmeriHealth 65 Plus network, this means that your plan has made an agreement with those providers to coordinate or provide covered services to members of AmeriHealth 65 Plus.

Providers are considered non-plan (out-of-network) providers when they are not part of the AmeriHealth 65 Plus network.

#### **25 How Do I Get Care When I Travel?**

AmeriHealth 65 Plus will cover the cost of urgent or emergency care you receive when you are outside the service area but still within the United States. You will be covered at the in-network benefit level. All you pay is the applicable copayment. If you have a medical emergency, go to the nearest emergency room or call 911 for assistance. An emergency is when you reasonably believe that your health is in serious danger—when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

#### **29 What are Covered Services?**

Covered services is the general term we use in this booklet to mean all of the health care services and supplies that AmeriHealth 65 Plus covers. Covered services are listed in the Benefits Chart in Section 4.

Your plan also provides benefits if you choose to receive health care through a provider who is out-of-network. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. This includes deductibles and coinsurance. See Section 5 for a complete list of exclusions and limitations.

For AmeriHealth 65 Plus members, emergency, urgent and dialysis services outside the United States are covered at the non-plan (out-of-network) benefit level. Any non-emergency or non-urgent care you receive from a non-plan (out-of-network) provider will be covered at the out-of-network benefit level.

**If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.**

## 69-71 How Do I File an Appeal or Grievance?

You can file an appeal with AmeriHealth 65 Plus if you believe that your plan failed to provide or pay for services that you think should have been covered. For more details, please refer to the Appeals and Grievances section of your Evidence of Coverage.


You can file a grievance with AmeriHealth 65 Plus about problems you encountered with one of our providers. You may also file a grievance about problems you experience with AmeriHealth 65 Plus. We encourage you to let us know if you have concerns; we have Member Services Representatives who are available to help you with your questions. Call us at the number listed on the back of your ID card. Or, to file a grievance, review the procedures in this section of your Evidence of Coverage.

## 107 Definitions

This section explains some of the terms used in this booklet and in the Evidence of Coverage. Health care can be confusing—we hope these definitions help you to understand your coverage with AmeriHealth 65 Plus.

## YOUR ID CARD

Your AmeriHealth 65 Plus ID card provides important information about your health care coverage; you should check your card to make sure all the information is correct. On the reverse side of the card, you'll find instructions on how to receive care if you are out of the AmeriHealth 65 Plus service area. You should carry your card with you at all times, and remember to show it at your physician's office when you have an appointment. Call AmeriHealth 65 Plus Member Services if you lose your ID card, or if anything on the card is incorrect. The following illustration should help you understand the components of your ID card. Please note that your ID card may not look exactly like this picture; a few details may be different.



**AmeriHealth 65 Plus**  
A Medicare Advantage Open Access POS Plan from AmeriHealth HMO, Inc.

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RXBIN:004336 RXPCN:ADV RXGRP:MEDDRX  
SAMPLE, JOHN Q  
QIM12345678 00 L  
MARCUS WELBY, MD THX\$25  
215-555-1212 PCP\$15 RX  
ER\$50 SPEC\$25  
IP\$100 OPSURG\$75 AMBL\$50

ISSUER: 80840  
CMS - H3156-001

**MedicareRx**  
Prescription Drug Coverage

**FutureScripts™ Secure** RXBIN:012353 RXPCN:03820000 *Submit paper prescription claims to FutureScripts Secure, P.O. Box 419019, Kansas City, MO 64141.*

**Member:** Present this card to providers when seeking care. Contact your Primary Care Physician first for routine medical care in or out of the area. See your Evidence of Coverage for Self- Referred services that require pre-certification. Medicare charge limitations may apply.

Member Services: **1-800-645-3965**  
Mental Health/Substance Abuse: **1-800-688-1911**  
TTY/TDD: **1-888-857-4816**

Urgent Care In Area: Call your PCP prior to receiving services.  
Urgent Care Out of Area: Call 1-800-313-8564 for assistance in accessing out of area urgent care or you may seek care with another provider.  
In case of emergency, seek appropriate medical care immediately. Contact your PCP for follow-up care within 48 hours.  
Hospital: Must call 1-800-227-3116 for admission notification within 24 hours.

AmeriHealth 65 Plus  
P.O. Box 7820  
Philadelphia, PA 19101-7820

For benefits information, visit our website at [www.amerihhealth65.com](http://www.amerihhealth65.com)

2301 (10/05)



## YOUR EXPLANATION OF BENEFITS (EOB)

Whenever a claim is filed on your behalf, you will receive an Explanation of Benefits (EOB) statement that explains how each claim was processed. Your EOB gives you a personal record of:

You should keep your Explanation of Benefits in case you have questions about benefits or services you have received. Please review the image below for a better understanding of any Explanation of Benefits you may receive in the future.

**Explanation of Benefits**  
**Member Services:**  
**Outside Philadelphia Toll Area Call: 1-800-645-3965**  
**TTY/TDD Service for the Hearing Impaired: 1-888-857-4816**

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<b>MEMBER NAME</b>	<b>ID NUMBER</b>												
JOHN DOE	00000XXXX00												
<b>PATIENT NAME</b>	<b>CLAIM NUMBER</b>	<b>DATE PROCESSED</b>											
JOHN DOE	000000000000	4/14/2006											

PROVIDER NAME	DATES OF SERVICE	DESCRIPTION OF SVC	PROC CODE	NO OF SVCS	PROVIDER CHARGE	ALLOWANCE	NON-COVERED	RMK CODE	DEDUCTIBLE	CO-INSURANCE AMOUNT	COPAY	BENEFIT AMOUNT
MARCUS WELBY, MD	3/02/06	SURGICAL PROCEDURE	00000	1	1,000.00	1,000.00	.00	P80	.00	100.00	.00	900.00
					1,000.00	1,000.00	.00		.00	100.00	.00	900.00

YOUR RESPONSIBILITY                      100.00

REMARK CODES:  
P80    CAP SERVICE BY CAP PROVIDER

### Remark Code Descriptions

If applicable, there will be a separate page describing the Remark Code included with your EOB statement descriptions.

### Member's Responsibility

Please note that you are responsible for any amounts noted in the copay, coinsurance, deductible and not covered columns.

**Any questions? Call the Member Services Department at 1-800-645-3965 (TTY/TDD: 1-888-857-4816), seven days a week, from 8 a.m. to 8 p.m.**

# Questions & Answers

**Question:** What happens to my health care coverage with AmeriHealth 65 Plus if I want to join a Medicare stand-alone prescription drug plan (PDP)?

**Answer:** Medicare regulations dictate that a Medicare beneficiary may not be enrolled with a Medicare Advantage plan (such as AmeriHealth 65 Plus) and a prescription drug plan at the same time. Therefore, if you choose to enroll in a stand-alone prescription drug plan, Medicare requires that we disenroll you from AmeriHealth 65 Plus. As your health care insurer, we urge you to be aware of this regulation, and to call Member Services at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m., if you have questions or concerns.

**Question:** What drugs are covered under Part B (your Medicare benefit), and what drugs are covered under Part D?

**Answer:** This distinction can be confusing for our Medicare beneficiaries, and we want to keep this as simple and straightforward as possible. The following are covered under Part D: prescription drugs, biological products, vaccines, insulin, and the medical supplies that are associated with the injection of insulin (e.g. syringes, needles, alcohol swabs, and gauze). Smoking cessation agents are also covered under Part D.

Drugs that are covered under Part B include:

- Hemophilia factor drugs usually not self-administered by the patient and that are injected while receiving physician services
- Drugs taken using durable medical equipment (e.g. nebulizers)
- Immunosuppressive drugs (if the member had an organ transplant covered by Medicare)
- Injectable osteoporosis drugs (if the member is homebound and cannot self-administer)
- Antigens
- Oral cancer drugs (for which there is an IV equivalent)
- Intravenous immune globulin (IVIG)
- Certain drugs for dialysis, including heparin, Epogen® (epoetin alfa), erythropoietin (EPO), and Aranesp® (darboetin alfa)

Also, please be aware that the Centers for Medicare & Medicaid Services (CMS) require that some drugs be covered under Part B or Part D, depending on the diagnosis or place of service. For example, the Hepatitis B vaccine is covered under Part B if the member is at “high or intermediate risk”; Part D covers all other instances.

Please call Member Services at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. if you have questions about your drug coverage under Medicare Part D.

# Q & A uestions nswers

Question: How are my bills paid in the AmeriHealth 65 Plus plan?

Answer: When you get services covered by AmeriHealth 65 Plus, you will pay your copayment or coinsurance at the time of services and your provider sends the remainder of the bill to AmeriHealth 65 Plus. After AmeriHealth 65 Plus processes the bill, you will get an EOB (Explanation of Benefits) in the mail. Please check the notice to be sure AmeriHealth 65 Plus was not billed for services or supplies that you did not get.

Question: What should I do when I have paid a medical bill from someone other than an AmeriHealth 65 Plus provider?

Answer: Please forward any medical bills that you have already paid (other than your monthly premium from AmeriHealth 65 Plus) to:

AmeriHealth 65 Plus Claims  
P.O. Box 41574  
Philadelphia, PA 19101-1574

## SAVING MONEY ON PRESCRIPTION DRUGS

To help Medicare beneficiaries reduce their pharmaceutical costs, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003. A result of the Medicare Modernization Act was the introduction of Medicare prescription drug coverage, also known as Medicare Part D. Anyone who is entitled to Medicare Part A or enrolled in Medicare Part B is eligible to enroll in the coverage.

Medicare Part D is designed to help Medicare beneficiaries gain access to insurance coverage that includes prescription drugs. It also provides low-income beneficiaries with access to comprehensive coverage with low cost-sharing.

For full prescription drug details, please refer to your outpatient Prescription Drug Rider.

### Generic Drugs

You can also help decrease your health care costs by asking your doctor to prescribe a generic drug in place of a brand-name drug. Generic drugs are sold under generic, often unfamiliar names, yet by law, they must have the same active ingredients and are subject to the same rigorous Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand-name counterparts. Each year more generic drugs are approved and become available for their popular brand-name counterparts.

## RADIOLOGY QUALITY INITIATIVE PROGRAM

Effective January 1, 2006, AmeriHealth implemented a Radiology Quality Initiative for outpatient diagnostic imaging services. Our decision to introduce this initiative was consistent with a recommendation from the American College of Radiology. This organization concluded that there is an immediate need for “nationally accepted, scientifically based appropriateness criteria” to guide radiologists and referring physicians in “making appropriate imaging decisions.”

Over the last few years, health plans throughout the U.S. and many in the Philadelphia area have introduced prior authorization programs for diagnostic imaging as a way to promote appropriate utilization based on evidence-based criteria. Like other programs across the country, our Radiology Quality Initiative program requires prior authorization for certain diagnostic imaging services:

- Computed Tomography (e.g. CT/CTA)
- Magnetic Resonance Imaging (e.g. MRI/MRA)
- Nuclear Cardiology Studies
- Positron Emission Tomography (e.g. PET) (already subject to prior authorization)

If you need one of these outpatient diagnostic imaging services in-network, your AmeriHealth 65 Plus plan (in-network) physician will handle the prior authorization process. This program does not apply to imaging services provided during emergency room visits or inpatient admissions. AmeriHealth 65 Plus has communicated the specifics of this program to our network physicians, who are required to contact American Imaging Management, Inc. (AIM) for requests from network physicians for approval of scheduled services. If you need one of these services out-of-network, we recommend that you obtain prior authorization, or you may be responsible for charges.

**Please note:** The guidelines used in the Radiology Quality Initiative program to assess the appropriateness of diagnostic imaging services are based on recommendations from experts in radiology and medicine. The program is aimed at curbing the use of discretionary scans for diagnostic screening. It is not intended to interfere with scans that are essential in the treatment of critical or life-threatening illnesses.

## HEALTHY LIFESTYLES<sup>SM</sup>

Since you're a member of AmeriHealth 65 Plus, why not take advantage of the services we offer through our Healthy Lifestyles programs? These programs can help you make positive changes to your life, and we'll even reimburse you when you complete any or all of the following:

**Fitness Program\***: Get up to \$150 reimbursement upon completion of 120 visits within a 365 day-period. Some restrictions apply.

**Smoking Cessation\***: If you smoke, quitting is one of the best things you can do for your health. Better yet, when you kick the habit, we'll help you foot the bill! Up to \$200 maximum reimbursement. Members are encouraged to complete the Smoking Cessation Program. However, it is difficult to determine whether the member has missed visits etc. Therefore, reimbursement will be granted as long as there is proof of enrollment and payment of the Smoking Cessation Program.

**Weight Management\***: We'll reimburse you up to \$200 for the cost of Weight Watchers<sup>®1</sup> or any network hospital weight management program.

\*These programs require enrollment.

<sup>1</sup>Weight Watchers<sup>®</sup> is a registered trademark of Weight Watchers International, Inc.

## MAMMOGRAPHY AND PAP TEST SCREENING

When it comes to breast cancer and cervical cancer, early detection is key. That's why we've sent nearly four million educational reminders to our female members that emphasize not only early detection, but also prevention and treatment. You can also request personal reminders for these tests on our Web site.

## STAY HEALTHY!

### Care Management and Coordination

It can be difficult, and even intimidating, to find your way around the health care system. You might be scheduling elective surgery, such as a hip or knee replacement, or trying to manage complex home health care services. If that's the case, call on our staff of registered nurses to work with your health care provider and help coordinate your care.

### Individual Support from the Connections<sup>SM</sup> Health Management Program

If you have a condition such as diabetes, lung or breathing problems, heart conditions, or other recurring health concerns, our Connections program can help you lead a healthier life. Connections can also help if you're facing a significant medical decision such as treatment options for back or joint pain, breast or prostate cancer, or surgery, including weight-loss surgery.

Connections provides:

- Access to a Health Coach to talk to anytime, day or night, 24 hours a day, seven days a week.
- Personalized check-in calls from your Health Coach about your chronic condition or other health concerns.
- Educational materials mailed to your home.
- Health reminders about important tests and information to help you take better control of your health.

- Access to an encyclopedia of health information—our Healthwise® Knowledgebase gives you well-organized health information on the Web, on audiotape, or through the mail in collaboration with your Health Coach.

We offer Connections for free. The program can help you work with your health care provider and get the support you need to manage your health. Call a Connections Health Coach anytime, day or night, 24 hours a day, seven days a week, at **1-800-275-2583 (TTY/TDD: 1-888-857-4816)** and see how we can help you.

## **IMPORTANT AMERIHEALTH 65 PLUS TELEPHONE NUMBERS**

AmeriHealth 65 Plus Member Services 1-800-645-3965 (TTY/TDD: 1-888-857-4816)

If you have questions about your coverage or premium bill, would like to make a change to your benefits, or need to update your address, call Member Services seven days a week, from 8 a.m. to 8 p.m.

AmeriHealth 65 Plus Member Outreach 1-877-393-6729

Healthy Lifestyles 1-800- 275-2583  
(TTY/TDD: 1-888-857-4816)

Take advantage of Healthy Lifestyle reimbursement programs like Weight Watchers®, or call Healthy Lifestyles for help with smoking cessation. Enroll in the Connections Health Management program if you have a condition such as diabetes, lung or breathing problems, heart conditions, or other recurring health concerns. You can reach Healthy Lifestyles Monday–Friday, 8 a.m. to 6 p.m. Talk to a Connections Health Coach anytime, day or night, 24 hours a day, seven days a week.

Medicare Savings Programs 1-877-393-6733

There are state and federally funded assistance programs for which certain members may qualify. To see if you are eligible for these programs, call Managed Care Programs at the number listed above Monday–Friday, 8:30 a.m. to 5 p.m.

# **EVIDENCE OF COVERAGE: Your Medicare Health Benefits and Services as a Member of AmeriHealth 65 Plus**

## **January 1 – December 31, 2007**

This booklet provides the details about your Medicare health coverage and explains how to get the care you need. This booklet and the Letter of Coverage are important legal documents. Please keep it in a safe place.

The Letter of Coverage included with this booklet details your coverage and refers you to the appropriate sections of the Evidence of Coverage relevant to that coverage.

If you need to receive this booklet in a different format (such as Braille, Spanish or audiotapes), please call us so we can send you a copy. Section 1 of this book tells you how to contact us.

### **AMERIHEALTH 65 PLUS MEMBER SERVICES:**

For help or information, please call Member Services seven days a week, 8 a.m. to 8 p.m. Calls to these numbers are free:

**1-800-645-3965**

**TTY/TDD: 1-888-857-4816**

# Welcome to AmeriHealth 65 Plus!

We are pleased that you've chosen AmeriHealth 65 Plus.

## **AmeriHealth 65 Plus is a Health Maintenance Organization (HMO) for people with Medicare.**

Now that you are enrolled in AmeriHealth 65 Plus, you are getting your care through AmeriHealth HMO, Inc. **(AmeriHealth 65 Plus is not a "Medigap" or supplemental Medicare insurance policy.)**

## **This booklet explains how to get your Medicare services through AmeriHealth 65 Plus.**

This booklet, together with your enrollment form, any applicable riders, and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of AmeriHealth 65 Plus. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2007 to December 31, 2007.

You are still covered by Original Medicare, but now you are getting your Medicare services as a member of AmeriHealth 65 Plus. This booklet gives you the details, including:

- What is covered in AmeriHealth 65 Plus and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan and when you get care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave AmeriHealth 65 Plus, including your choices for continuing Medicare if you leave.

If you need to receive this booklet in a different format (such as Spanish, Braille, or audiotapes) please call us so we can send you a copy. Section 1 of this booklet tells how to contact us.

## **Please tell us how we're doing**

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with AmeriHealth 65 Plus. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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### HOW TO CONTACT AMERIHEALTH 65 PLUS MEMBER SERVICES

If you have any questions or concerns, please call or write to AmeriHealth 65 Plus Member Services. We will be happy to help you. Our business hours are seven days a week, 8:00 a.m. until 8:00 p.m.

**CALL 1-800-645-3965.** This number is also on the cover of this booklet for easy reference.

**TTY/TDD: 1-888-857-4816.** This number requires special telephone equipment. This number is also on the cover of this booklet for easy reference.

**WRITE** AmeriHealth 65 Plus Member Services  
P.O. Box 7759  
Philadelphia, PA 19101-7759

**VISIT** 1901 Market Street  
1st Floor  
Philadelphia, PA 19103  
Monday - Friday 8:30 a.m. - 4:30 p.m.

### HOW TO CONTACT THE MEDICARE PROGRAM AND THE 1-800-MEDICARE (TTY/TDD 1-877-486-2048) HELPLINE

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & **M**edicaid **S**ervices. CMS contracts with and regulates Medicare health plans (including AmeriHealth HMO, Inc. and Medicare Private Fee-for-Service Organizations).

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE (1-800-633-4227)** to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, seven days a week. The TTY/TDD number is **1-877-486-2048** (you need special telephone equipment to use this number). Calls to these numbers are free.

- Use a computer to look at [www.medicare.gov](http://www.medicare.gov), the official **government Web site for Medicare information**. This Web site gives you a lot of up-to-date information about Medicare, nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare managed care plans and prescription drug plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

## **SHIP—AN ORGANIZATION IN YOUR STATE THAT PROVIDES FREE MEDICARE HELP AND INFORMATION**

“SHIP” stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. SHIPs are state organizations paid by the federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare Advantage Plan like AmeriHealth 65 Plus for the first time. Section 12 has more information about your Medigap guaranteed issues rights.

You can contact the SHIP in your state at:

### **Burlington County**

**RSVP**

**Burlington Co. Community College**

**Route 530**

**Pemberton, NJ 08068**

**1-609-894-9311 ext. 7498**

### **Camden County**

**Camden Co. Div. of Senior  
and Disabled Services**

**The Parkview On The Terrace**

**700 Browning Rd., Suite 11**

**West Collingswood, NJ 08107**

**1-877-222-3737**

### **Cumberland County**

**Cumberland Co. Office on Aging  
& Disabled**

**790 East Commerce St.**

**Bridgeton, NJ 08302**

**1-856-453-8066 Ext. 28**

### **Gloucester County**

**RSVP, Gloucester Co. College**

**14 Tanyard Rd.**

**Sewell, NJ 08080**

**1-856-468-1742**

### **Salem County Office on Aging**

**98 Market Street**

**Salem, NJ 08079**

**Phone: 1-856-935-7510 ext.**

**8465**

You can also find the Web site for your local SHIP at [www.medicare.gov](http://www.medicare.gov) on the Web.

## **QUALITY IMPROVEMENT ORGANIZATION—A GROUP OF DOCTORS AND HEALTH PROFESSIONALS IN YOUR STATE WHO REVIEW MEDICAL CARE AND HANDLE CERTAIN TYPES OF COMPLAINTS FROM PATIENTS WITH MEDICARE**

“QIO” stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The

doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See Section 9 for more information about complaints.

You can contact the QIO in your state at:

**Healthcare Quality Strategies Inc.**  
**557 Cranbury Road, Suite 21**  
**East Brunswick, NJ 08816**  
**Phone: 1-800-624-4557**  
**1-732-238-5570**  
**www.hqsi.org**

## **OTHER ORGANIZATIONS (INCLUDING MEDICAID AND THE SOCIAL SECURITY ADMINISTRATION)**

**Medicaid agency—a state government agency that handles health care programs for people with low incomes**

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

**Division of Medical Assistance and Health Services**  
**Quakerbridge Plaza**  
**P.O. Box 712**  
**Trenton, NJ 08625-0712**  
**Phone: 1-800-356-1561**

### **Social Security Administration**

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration toll free at **1-800-772-1213**. The TTY/TTD number is **1-800-325-0778** (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit [www.ssa.gov](http://www.ssa.gov) on the Web.

### **Railroad Retirement Board**

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or **1-800-808-0772** (calls to this number are free). The TTY/TTD number is **1-312-751-4701** (you need special telephone equipment to use this number). You can also visit [www.rrb.gov](http://www.rrb.gov) on the Web.

### **Employer (or “Group”) Coverage**

If you have coverage through your current or former employer, or your spouse's current or former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.

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### WHAT IS AMERIHEALTH 65 PLUS?


Now that you are enrolled in AmeriHealth 65 Plus, you are getting your Medicare through AmeriHealth HMO, Inc. AmeriHealth 65 Plus is offered through AmeriHealth HMO, Inc., and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of AmeriHealth 65 Plus. AmeriHealth 65 Plus is **not** a Medicare supplement policy. See Section 14 for a definition of Medicare supplement policy. (Medicare supplement policies are sometimes called “Medigap” insurance policies.) AmeriHealth 65 Plus provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. AmeriHealth 65 Plus gives you all of the usual Medicare services that are covered for everyone with Medicare. We also give you some additional services. Please see additional inserts if applicable. Since AmeriHealth 65 Plus is a Medicare HMO, you have the opportunity to receive health care from plan (in-network) providers at low out-of-pocket costs and from non-plan (out-of-network) providers at higher out-of-pockets costs. Of course, if you need emergency or urgently needed services or out-of-area renal dialysis services within the United States, those services will be covered at the in-network benefit level. Emergency, urgent or dialysis services outside the United States are covered at the non-plan (out-of-network) benefit level.

Since AmeriHealth 65 Plus is an HMO, this means that you should get most or all of your health services from the doctors, hospitals, and other health providers that are part of AmeriHealth 65 Plus. You may use non-plan (out-of-network) providers to get covered services. However, if you use non-plan (out-of-network) providers for care that is not emergency care, it may cost you more to use them. See Section 7 for more details on why it may cost less to see plan (in-network) providers.

## USE YOUR PLAN MEMBERSHIP CARD INSTEAD OF YOUR RED, WHITE, AND BLUE MEDICARE CARD

Now that you are a member of AmeriHealth 65 Plus, you have an AmeriHealth 65 Plus membership card. Here is a sample card to show what it looks like:

  
A Medicare Advantage Open Access PPO Plan from AmeriHealth (HMO) Inc.

---

RXBIN:004336 RXPEN:ADV RXGRP:MEDDRX  
SAMPLE, JOHN Q  
QIM12345678 00 L  
MARCUS WELBY, MD THX\$25  
215-555-1212 PCP\$15 RX  
ER\$50 SPEC\$25  
IP\$100 OPSURG\$75 AMBL\$50

ISSUER: 80840  
CMS - H3156-001

**MedicareR**  
Prescription Drug Coverage X

**FutureScripts™ Secure** RXBIN:012353 RXPEN:03820000 *Submit paper prescription claims to FutureScripts Secure, P.O. Box 419019, Kansas City, MO 64141.*

**Member:** Present this card to providers when seeking care. Contact your Primary Care Physician first for routine medical care in or out of the area. See your Evidence of Coverage for Self- Referred services that require pre-certification. Medicare charge limitations may apply.

Member Services: **1-800-645-3965**  
Mental Health/Substance Abuse: **1-800-688-1911**  
TTY/TDD: **1-888-857-4816**

**Urgent Care In Area:** Call your PCP prior to receiving services.  
**Urgent Care Out of Area:** Call 1-800-313-8564 for assistance in accessing out of area urgent care or you may seek care with another provider.  
In case of emergency, seek appropriate medical care immediately. Contact your PCP for follow-up care within 48 hours.  
**Hospital:** Must call 1-800-227-3116 for admission notification within 24 hours.

AmeriHealth 65 Plus  
P.O. Box 7820  
Philadelphia, PA 19101-7820

For benefits information, visit our website at [www.amerhealth65.com](http://www.amerhealth65.com)

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During the time you are a plan member and using plan services, **you must use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get covered services using your red, white, and blue Medicare card instead of your AmeriHealth 65 Plus membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your AmeriHealth 65 Plus membership card with you at all times. You will need to show this card at the doctor's office or emergency room. You will also need it to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

### HELP US KEEP YOUR MEMBERSHIP RECORD UP TO DATE

Member Services has a file of information about you as a plan member. Doctors, hospitals, and other plan (in-network) providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific AmeriHealth 65 Plus coverage and other information. Section 8 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Services know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. Call the number on the cover of this booklet to contact Member Services.

## WHAT IS THE GEOGRAPHIC SERVICE AREA FOR AMERIHEALTH 65 PLUS?

You can enroll in AmeriHealth 65 Plus and get covered services as long as you live in these service areas: Burlington, Camden, Cumberland, Gloucester, and Salem Counties. The service area for members of an employer group health plan may vary.

## USING PLAN (IN-NETWORK) PROVIDERS AND NON-PLAN (OUT-OF-NETWORK) PROVIDERS TO GET YOUR COVERED SERVICES

### Why should you use plan (in-network) providers to get your covered services?

Now that you are a member of AmeriHealth 65 Plus, you can use plan (in-network) and non-plan (out-of-network) providers to get your covered services. Your out-of-pocket costs will usually be lower if you use plan (in-network) providers.

- **What are “plan (in-network) providers?”** “Providers” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services.
  - We call them “plan (in-network) providers” when they participate in the AmeriHealth 65 Plus network. When we say that plan (in-network) providers “participate in the AmeriHealth 65 Plus network,” this means that we have arranged with them to coordinate or provide covered services to members of AmeriHealth 65 Plus.
  - We call them “non-plan (out-of-network) providers” when they are **not** part of the AmeriHealth 65 Plus network.
- **What are “covered services?”** “Covered services” is the general term we use in this booklet to mean all of the health care services and supplies that are covered by AmeriHealth 65 Plus. Covered services are listed in the Benefits Chart in Section 4.

### What if you use non-plan (out-of-network) providers to get your covered services?

Non-plan (out-of-network) providers are providers that are not part of AmeriHealth 65 Plus. You may use non-plan (out-of-network) providers to get your covered services. However, **your out-of-pocket costs may be higher than if you use our plan providers.** The exception is if you use non-plan (out-of-network) providers for emergency care. See Section 7 for more detail on why it costs less to see plan (in-network) providers. Medicare requires that we have or arrange for enough providers to give you all medically necessary plan covered services at the in-network cost-sharing level.

You do not need to get a referral or prior authorization (approval in advance) when you get care from non-plan (out-of-network) providers. However, it is strongly recommended that you obtain prior authorization (approval in advance) from the plan before you get some services from non-plan (out-of-network) providers. When you obtain these out-of-network services without prior authorization, the plan reviews the services to determine whether the services are covered benefits. If the services are covered benefits, the plan then reviews the services to determine whether the services are medically necessary. If the plan determines that the services are not covered benefits or are not medically necessary/medically appropriate for your condition, then **NO BENEFITS ARE PAYABLE AND YOU WILL BE RESPONSIBLE FOR ALL CHARGES UP TO THE MEDICARE ALLOWED AMOUNT SUBJECT TO THE APPEALS PROCESS.** Refer to Section 4 for more information on which services require prior authorization. The provider directory gives you a list of plan (in-network) providers.

## YOUR AMERIHEALTH 65 PLUS NETWORK PLAN

Your AmeriHealth 65 Plus plan provides coverage for the same services provided to beneficiaries in the Original Medicare program based on local and national coverage decisions. AmeriHealth 65 Plus is a program that allows you to maximize your health care benefits by utilizing AmeriHealth 65 Plus plan (in-network) providers.

Plan (in-network) providers are doctors, hospitals and other health care professionals and institutions that are part of the AmeriHealth 65 Plus network. The AmeriHealth 65 Plus network includes hospitals, primary care physicians and specialists, and a wide range of facility and ancillary providers, including suppliers of durable medical equipment and home health agencies, skilled nursing facilities, free-standing dialysis centers and ambulatory surgical centers.

When you receive health care through an AmeriHealth 65 Plus plan (in-network) provider there are virtually no claim forms to fill out. When services are rendered by plan (in-network) providers, you will not be responsible for the cost of services performed that are determined to be medically inappropriate unless you have agreed in advance to be financially responsible for medically inappropriate care.

Benefits are also provided if you choose to receive health care through a provider who is not an AmeriHealth 65 Plus plan (in-network) provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. This includes deductibles and coinsurance. **Even if your doctor recommends or refers you to a provider, you should always check to see if the provider is a plan (in-network) provider to keep your out-of-pocket costs low.**

Some of the services you receive through this AmeriHealth 65 Plus plan require prior authorization (approval in advance) before you receive them, to determine whether they are medically appropriate regardless of whether you go to a plan (in-network) provider or a non-plan (out-of-network) provider. **Failure to get prior authorization (approval in advance) for non-plan (out-of-network) services, when required, may result in you being responsible for all charges up to the Medicare allowed amount.**

You will receive a directory of the plan (in-network) providers who belong to the AmeriHealth 65 Plus network. It will identify the providers who have agreed to become plan (in-network) providers and will also identify the hospitals in the network with which the plan (in-network) providers are affiliated. Also included in the directory is a listing of the ancillary providers affiliated with the network.

**Note:** Not all plan (in-network) providers are authorized by AmeriHealth 65 Plus to provide all your health care services at the plan (in-network) level of benefits. Such services include, but are not limited to, outpatient radiology services and certain outpatient laboratory testing services. For example, a hospital that is listed in your AmeriHealth 65 Plus network directory as a plan (in-network) hospital may not maintain an outpatient radiology department that belongs to the AmeriHealth 65 Plus network.

However, you will not be financially responsible for out-of-network coinsurance and deductibles if:

- (a) a plan (in-network) provider fails to provide written notice to you of the provider's out-of-network status for outpatient radiology or laboratory services, and that provider performs such services; or
- (b) a plan (in-network) provider provides a written order for outpatient radiology or laboratory services to be performed by a plan (in-network) provider that has out-of-network status for those services, and that provider performs such services.

Your AmeriHealth 65 Plus plan covers only care that is medically appropriate/medically necessary. Medically appropriate care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are hospital inpatient care treatment in short procedure units and care in a hospital outpatient department.

**A list of the services that must be prior authorized is located in Section 4 of this booklet.**

### **Claim Forms**

When you receive covered services or prescription drugs from plan (in-network) providers, there are virtually no claim forms to file. Just show your AmeriHealth 65 Plus identification card to the provider. When you receive care from non-plan (out-of-network) providers, you may have to file a claim form. For reimbursement:

- (a) Complete the AmeriHealth 65 Plus claim form (have your provider complete the appropriate section, if necessary).
- (b) Attach all itemized bills for each charge being submitted. Bills should include the name and address of the provider, type of service, date of service, the cost of services and the doctor's certification (for physical therapy, ambulance or medical equipment).
- (c) Return the claim form and itemized bills to:  
  
**AmeriHealth 65 Plus Service Center  
P.O. Box 41574  
Philadelphia, PA 19101-1574**
- (d) If you paid the full amount for your service, we will reimburse you directly. If you paid less than the full amount, payment will be made to your provider.
- (e) For non-plan (out-of-network) pharmacy prescription drugs, please contact Member Services to request the pharmacy reimbursement claim form.

### **Payment of Benefits**

Payment for covered services and supplies, when medically necessary/medically appropriate, will vary depending on whether the covered service was provided by a plan (in-network) or non-plan (out-of-network) provider.

### **REIMBURSEMENT FOR PROVIDERS**

A member or the provider may submit bills directly to AmeriHealth HMO, Inc., and, to the extent that benefits are payable within the terms and conditions of this coverage, reimbursement will be furnished as detailed below. The member's deductibles, coinsurance, benefit maximums and benefits for covered services are based on the rate of reimbursement as defined under "covered expense" in Section 14 of this booklet.

## 1. Facility Providers

### Plan (in-network) facility providers

Plan (in-network) facility providers are members of the AmeriHealth 65 Plus network and have a contractual arrangement with AmeriHealth HMO, Inc. for the provision of services to members. Benefits will be provided as specified in Section 4 (Benefits Chart) for services which have been performed by a plan (in-network) facility provider. AmeriHealth HMO, Inc. will pay plan (in-network) facility providers in accordance with the contracts entered into between such providers and AmeriHealth HMO, Inc. No payment will be made directly to the members for covered services rendered by any plan (in-network) facility provider.

### Non-Plan (out-of-network) Member facility providers

Non-Plan (out-of-network) facility providers include facilities that are not part of the AmeriHealth 65 Plus network. AmeriHealth HMO, Inc. may have a contractual arrangement with a facility even if it is not part of the AmeriHealth 65 Plus network. Non-plan (out-of-network) member facility providers that have contracts with AmeriHealth HMO, Inc. will be compensated in accordance with the contracts entered into between such providers and AmeriHealth HMO, Inc.

**A non-plan (out-of-network) non-member facility provider** is a facility provider that does not belong to the AmeriHealth 65 Plus network, nor does it have a contract with AmeriHealth HMO, Inc. **If the provider participates with Medicare**, AmeriHealth HMO, Inc. will make payment based on the lesser of the actual charges or the Medicare allowed amount. The member will be responsible for coinsurance and deductibles.

**A non-plan (out-of-network) non-member facility provider** is a facility provider that does not belong to the AmeriHealth 65 Plus network, nor does it have a contract with AmeriHealth HMO, Inc. **If the provider does not participate with Medicare**, AmeriHealth HMO, Inc. will make payment based on the lesser of the actual charges or the Medicare allowed amount. The member will be responsible for coinsurance and deductibles.

### General Information about facility providers

AmeriHealth HMO, Inc. will provide benefits for the covered expenses incurred for certain medical services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a plan (in-network) facility provider or a member facility provider, payment shall be made to such facility provider subject to any existing agreement between the facility provider and AmeriHealth HMO, Inc.

If AmeriHealth HMO, Inc. determines that covered services were for emergency care, urgently needed care, or dialysis and the services were provided in the United States, the member will not be subject to coinsurance, deductibles and penalties ordinarily applicable to covered services rendered by non-plan (out-of-network) providers.

Once covered services are rendered by a facility provider, AmeriHealth HMO, Inc. will not honor a member's request not to pay for claims submitted by the facility provider. The member will have no liability to any person because of its rejection of the request.

## 2. Professional Providers

AmeriHealth HMO, Inc. is authorized by the member to make payment directly to the plan (in-network) participating professional providers furnishing covered services for which benefits are provided under this Evidence of Coverage. Plan (in-network) professional providers have agreed to accept the rate of reimbursement determined by contract as payment in full for covered services. Plan (in-network) professional providers will make no additional charge to members for covered services except in the case of certain copayments or coinsurance, deductible and applicable penalties as specified under this program.

### **Non-Plan (out-of-network) Professional Provider Reimbursement**

When covered services are performed by a non-plan (out-of-network) professional provider, AmeriHealth HMO, Inc. will make payment to the member, subject to any coinsurance, deductibles, and applicable penalties on services by non-plan (out-of-network) professional providers.

When a member seeks care from a non-plan (out-of-network) professional provider **that participates** with Medicare, payment will be based on the Medicare allowed amount. The member will be responsible for coinsurance and deductibles.

When a member seeks care from a non-plan (out-of-network) professional provider that **does not participate** with Medicare, payment will be based on the Medicare allowed amount. This means that in New Jersey, providers may not balance bill you for the difference between the provider's charges and the Medicare allowed amount. In some states, providers may bill up to 115% of the Medicare allowed amount. However, we pay the difference. The member will be responsible for coinsurance and deductibles.

If AmeriHealth HMO, Inc. determines that covered services were for emergency care, urgently needed care, or dialysis and the services were provided in the United States, the member will not be subject to the coinsurance, deductible and penalties ordinarily applicable to covered services rendered by non-plan (out-of-network) professional providers.

Once covered services are rendered by a professional provider, AmeriHealth HMO, Inc. will not honor a member's request not to pay for claims submitted by the professional provider. AmeriHealth HMO, Inc. will have no liability to any person because of its rejection of the request.

## 3. Ancillary Providers

### **Plan (in-network) ancillary providers**

Plan (in-network) ancillary providers include members of the AmeriHealth 65 Plus network that have a contractual relationship with AmeriHealth HMO, Inc. for the provision of services or supplies to its members. Benefits will be provided as specified in the Evidence of Coverage for the provision of services or supplies provided to members by plan (in-network) ancillary providers. AmeriHealth HMO, Inc. will compensate plan (in-network) ancillary providers in the AmeriHealth 65 Plus network in accordance with the contracts entered into between such providers and AmeriHealth HMO, Inc. No payment will be made directly to the member for covered services rendered by any plan (in-network) ancillary provider.

### **Non-plan (out-of-network) ancillary providers**

Non-plan (out-of-network) ancillary providers are not members of the AmeriHealth 65 Plus network. Ancillary providers **who participate with Medicare** are paid based on the lesser of actual charges or the Medicare allowed amount. The member is responsible for coinsurance and deductibles.

Non-plan (out-of-network) ancillary providers **who do not participate with Medicare** are paid based on the lesser of actual charges or the Medicare allowed amount, up to 115%. Some states do not allow providers to balance bill. The member is responsible for coinsurance and deductibles.

## **4. Pharmacies**

### **Plan (in-network) pharmacies**

Plan (in-network) pharmacies include members of the AmeriHealth 65 Plus network that have a contractual relationship with AmeriHealth HMO, Inc. for the provision of services or supplies to the member. Benefits will be provided as specified in the Benefits Chart in Section 4 for the provision of services or supplies provided to members by plan (in-network) pharmacies. AmeriHealth HMO, Inc. will compensate plan (in-network) pharmacies in the AmeriHealth 65 Plus network in accordance with the contracts entered into between the pharmacies and AmeriHealth HMO, Inc. No payment will be made directly to the member for covered services rendered by any plan (in-network) pharmacy.

### **Non-Plan (out-of-network) pharmacies**

Non-Plan (out-of-network) pharmacies are not members of the AmeriHealth 65 Plus network.

### **Assignment of benefits to providers**

The right of a member to receive benefit payments under AmeriHealth 65 Plus is personal to the member and is not assignable in whole or in part to any person, hospital, or other entity, nor may AmeriHealth 65 Plus benefits be transferred, either before or after covered services are rendered.

### **Deductible**

If you choose to utilize a non-plan (out-of-network) provider, you must pay a portion of your covered medical expenses before AmeriHealth 65 Plus begins to pay for benefits. An annual deductible must be met before payment will be made for non-plan (out-of-network) services. See the Benefits Chart in Section 4 for specific deductible amounts.

### **Coinsurance**

Coinsurance is a percentage of the covered expenses that must be paid by all members when covered services are provided. It is applied after the deductible is met. Refer to the Benefits Chart in Section 4 for specific coinsurance amounts.

### **Lifetime Maximum**

There is a lifetime maximum for all non-plan (out-of-network) services. Non-plan (out-of-network) benefits will cease after benefits for non-plan (out-of-network) care exceed the individual lifetime maximum. Covered expenses for prescription drugs do not apply to the lifetime maximum. See the Benefits Chart in Section 4 for the lifetime maximum amount.

## AMERIHEALTH 65 PLUS

### APPLICATION OF DEDUCTIBLES, COPAYMENTS, COINSURANCE AND PENALTIES

#### Example 1: Plan (in-network) provider

The member seeks care from a facility provider in the AmeriHealth 65 Plus network.

#### Charges, Discount, Allowance, Coinsurance and Covered Benefit Amount

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Provider charge	\$30,000
Less AmeriHealth 65 Plus discount*	<u>-\$23,400</u>
Allowance eligible for coinsurance	\$6,600
Less 10% coinsurance paid by member	<u>-\$660</u>
Covered benefit amount	\$5,940

\*The Plan (in-network) reserves the right to change or adjust the AmeriHealth 65 Plus discount.

#### Example 2: Plan (in-network) provider

The member seeks care from a non-facility provider in the AmeriHealth 65 network.

#### Charges, Discount, Allowance, Coinsurance and Covered Benefit Amount

---

Provider charge (allowable)	\$600
Allowance eligible for coinsurance	\$600
Less 10% coinsurance paid by member	<u>-\$60</u>
Covered benefit amount	\$540

#### Example 3: Non-Plan (out-of-network) provider

The member seeks care from a provider that is not in the AmeriHealth 65 network, but is a Medicare participating provider. The member has not met their annual deductible.

#### Charges, Discount, Allowance, Coinsurance and Covered Benefit Amount

---

Provider charge (Medicare Allowed Amount)	\$700
Less deductible	<u>-\$500</u>
Balance eligible for coinsurance	\$200
30% coinsurance paid by member	<u>-\$60</u>
Covered benefit amount	\$140

#### Example 4: Non-Plan (out-of-network) provider

The member seeks care from a provider who is not part of the AmeriHealth 65 network and does not participate with Medicare. You have met your annual deductible.

#### Charges, Discount, Allowance, Coinsurance and Covered Benefit Amount

---

Provider charge (Medicare Allowed Amount)	\$230
Less deductible	(previously met)
Balance eligible for coinsurance	\$230
30% coinsurance paid by member	<u>-\$69</u>
Covered benefit amount	\$161

## **The Provider Directory gives you a list of Plan (in-network) Providers**

If you don't have the provider directory, you can get a copy from Member Services by calling the number on the cover of this booklet. You can also access our provider directory on AmeriHealth 65's Web site at [www.amerihealth65.com](http://www.amerihealth65.com). Member Services can give you the most up-to-date information about changes in plan (in-network) providers.

## **HOSPITAL TIERING**

As a member of AmeriHealth 65 Plus, you have access to all providers that participate in the AmeriHealth 65 network. However, if you obtain care from one of AmeriHealth 65's Tier I hospitals, you can significantly lower your out-of-pocket costs for inpatient hospital stays and outpatient surgery. Although all hospitals in AmeriHealth 65's network deliver the highest quality of care, there are those whose administrative costs are lower, which allows us to pass along our savings to our members. Please contact Member Services for a complete list of AmeriHealth 65 Plus Tier I hospitals.

**Please note that if you are admitted to a Tier I or Tier II hospital due to an emergency, you are responsible for the applicable cost-sharing levels of the hospital.**

## **RADIOLOGY QUALITY INITIATIVE PROGRAM**

Effective January 1, 2006 AmeriHealth HMO, Inc. implemented a new Radiology Quality Initiative for outpatient diagnostic imaging services. Our decision to introduce this initiative was consistent with a recommendation from the American College of Radiology. This organization concluded that there is an immediate need for "nationally accepted, scientifically-based appropriateness criteria" to guide radiologists and referring physicians in "making appropriate imaging decisions."

Over the last few years health plans throughout the U.S. and many in the Philadelphia area have introduced prior authorization programs for diagnostic imaging as a way to promote appropriate utilization based on evidence-based criteria. Like other programs across the country, our Radiology Quality Initiative requires prior authorization for certain diagnostic imaging services. The introductory phase of this program began on October 10, 2005. As of January 1, 2006, our Radiology Quality Initiative required prior authorization for:

- Computed Tomography (e.g. CT/CTA)
- Magnetic Resonance Imaging (e.g. MRI/MRA)
- Nuclear Cardiology Studies
- Positron Emission Tomography (e.g. PET) (already subject to prior authorization)

Should you need one of these outpatient diagnostic imaging services, your AmeriHealth 65 Plus network physician will handle the prior authorization process. This program does not apply to imaging services provided during emergency room visits or inpatient admissions. AmeriHealth 65 Plus has communicated the specifics of this program to our network physicians and American Imaging Management, Inc. (AIM) is currently accepting requests from network physicians for approval of scheduled services.

**Please note:** The guidelines used in the Radiology Quality Initiative program to assess the appropriateness of diagnostic imaging services are based on recommendations from well-respected experts in radiology and medicine. The program is aimed at curbing the use of discretionary scans for diagnostic screening. It is not intended to interfere with scans that are essential in the treatment of critical or life-threatening illnesses.

## **Access to care and information from Plan (in-network) Providers**

You have the right to get timely access to plan (in-network) providers and to all services covered by the plan. (“Timely access” means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 8 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

- Routine women’s health care, which includes breast exams, mammograms, Pap tests, and pelvic exams. You will have to pay more for these services if you do not get them from a plan provider these services do not require a referral.
- Flu shots and pneumonia vaccinations (you will have to pay more if you do not use a plan provider).
- Covered care from non-plan providers.
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan’s service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan’s service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan’s service area.

## **CHOOSING YOUR PCP (PCP MEANS PRIMARY CARE PHYSICIAN)**

### **What is a “PCP”?**

When you become a member of AmeriHealth 65 Plus, you must choose a plan provider to be your PCP. Your PCP is a physician, nurse practitioner, or other health care professional who meets state requirements and is trained to give you basic medical care. However, with AmeriHealth 65 Plus you do not need to see your PCP for routine care or for referrals to specialists.

### **How do you choose a PCP?**

As an AmeriHealth 65 member, you must select a primary care physician (PCP) from the AmeriHealth 65 Plus provider directory. However, with AmeriHealth 65 Plus you have the freedom to obtain care from any physician in-network. When seeking medical care, you can visit any in-network PCP or specialist and pay the applicable copay. A plan member selects a primary care physician (PCP) to coordinate all of the members care. A PCP is usually a family practitioner, general practitioner, or internist. The PCP knows the plan's network and can guide the member to plan specialist when needed. The member always has the option to change to a different PCP.

### **Getting care from your PCP**

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without contacting your PCP first except as we explain below and in Section 4.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

## **WHAT IF YOU NEED MEDICAL CARE WHEN YOUR DOCTOR’S OFFICE IS CLOSED?**

### **What to do if you have a medical emergency or urgent need for care**

In an emergency, you should get care immediately. You do **not** have to contact your provider or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. If the services were performed within the United States, the services will be covered at the plan (in-network) benefit level. If the services were received outside of the United States, the services will be covered at the non-plan (out-of-network) benefit level. Section 3 tells what to do if you have a medical emergency or urgent need for care.

### **What to do if it is not a medical emergency**

If you need to talk with your doctor or get medical care when the doctor’s office is closed, and it is *not* a medical emergency, you can still call your provider. There will always be a provider on call to help you. If necessary, call your plan provider to obtain a TTY/TDD phone number in the event that you require after-hours care for hearing impaired.

See Section 3 for more information about what to do if you have an urgent need for care.

## **GETTING CARE FROM SPECIALISTS**

A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). You may get care from specialists without a referral from another doctor. If you use our plan (in-network) specialists, your costs for covered services will be lower than if you used non-plan (out-of-network) providers.

## **THERE ARE SOME SERVICES YOU CAN GET ON YOUR OWN, WITHOUT A REFERRAL**

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. But there are a few exceptions: you can get the following services on your own, without a referral or approval in advance from your PCP. You still have to pay your cost sharing, as appropriate, co-payment for these services.

- Routine women’s health care, which includes breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from your PCP only if you get it from a plan provider.

- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area.

## **GETTING CARE WHEN YOU TRAVEL OR ARE AWAY FROM THE PLAN'S (IN-NETWORK) SERVICE AREA**

If you need care when you are outside the service area, your coverage at the plan (in-network) level is limited. The only services we cover when you are outside our service area (but within the United States) at the plan (in-network) level is care for a medical emergency, urgently needed care, renal dialysis, and care that AmeriHealth 65 Plus or a plan (in-network) provider has approved in advance. Emergency, urgent and dialysis services outside the United States are covered at the non-plan (out-of-network) benefit level. Any non-emergency or non-urgent care you receive from a non-plan (out-of-network) provider will be covered at the out-of-network benefit level. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number on the cover of this booklet.

## **HOW TO CHANGE YOUR PCP**

You may change your PCP for any reason, at any time. To change your PCP, call Member Services at the number on the cover of this booklet. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

## **WHAT IF YOUR DOCTOR LEAVES AMERIHEALTH 65 PLUS?**

Sometimes a doctor, specialist, clinic or other plan (in-network) provider you are using might leave the plan. If your provider leaves AmeriHealth 65, we will let you know, and help you select another provider so that you can keep getting covered services at an in-network benefit level.

## SECTION 3—Getting care if you have a medical emergency or an urgent need for care

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### WHAT IS A "MEDICAL EMERGENCY"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger**—when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

### WHAT SHOULD YOU DO IF YOU HAVE A MEDICAL EMERGENCY?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your provider.** (Section 2 tells about plan (in-network) providers.)
- Make sure that AmeriHealth 65 Plus or your provider knows about your emergency, because we will need to be involved in following up on your emergency care. You or someone else should call to tell your provider about your emergency care as soon as possible, preferably within 48 hours. The number to call AmeriHealth 65 is located on your AmeriHealth 65 membership card. Please call the Member Services number on the back of your card.
- AmeriHealth 65 Plus or your provider will help manage and follow up on your emergency care. If you are treated for an emergency medical condition while out of the service area, but within the United States, you may return to the service area to receive follow-up care through AmeriHealth 65 Plus plan (in-network) providers. However, we will cover services given out of the service area, but within the United States, at the plan (in-network) benefit level as long as the care you need still meets the definition for either emergency services or urgently needed services.
- AmeriHealth 65 Plus will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan (in-network) providers to take over your care as soon as your medical condition and the circumstances allow.

## WHAT IS COVERED IF YOU HAVE A MEDICAL EMERGENCY?

- You can get covered emergency medical care whenever you need it, anywhere in the United States.
- Ambulance services are covered in situations where other means of transportation in the United States would endanger your health.

If you have had an emergency medical condition anywhere in the United States, we will cover medically necessary services related to the emergency at the plan (in-network) benefit level from the time the non-plan (out-of-network) provider requests authorization from us until:

- A plan (in-network) provider assumes responsibility for your care; or
- We agree with the non-plan (out-of-network) provider on a treatment plan for you; or
- Under certain circumstances until you are discharged.

If you have had an emergency medical condition outside of the United States (except under limited circumstances), we will cover medically necessary services related to the emergency at the non-plan (out-of-network) benefit level.

## WHAT IF IT WASN'T REALLY A MEDICAL EMERGENCY?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong (as long as you thought your health was in serious danger, as explained in “What is a medical emergency?” on the preceding page). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, the amount of the covered additional care that we pay will depend on whether you get the care from plan (in-network) providers. If you get the care from plan (in-network) providers, your costs will usually be lower than if you get the care from non-plan (out-of-network) providers.
- If you get any additional care from a non-plan (out-of-network) provider after the doctor says it was not a medical emergency, it will cost you more to get that care than if you see one of our plan (in-network) providers. You should try to get your additional care from plan (in-network) providers. There is an exception: We will pay for additional care at the plan (in-network) benefit level from a non-plan (out-of-network) provider if you are out of our service area but within the United States, as long as the additional care you get meets the definition of “urgently needed care” that is given below.

## WHAT IS “URGENTLY NEEDED CARE”? (THIS IS DIFFERENT FROM A MEDICAL EMERGENCY)

“Urgently needed care” is **when you need medical attention right away for an unforeseen illness or injury**, and it is not reasonable given the situation for you to get medical care from your plan (in-network) provider. In these cases, your health is not in serious danger. As we explain on the next page, how you get “urgently needed care” depends on whether you need it when you are in the plan (in-network)’s service area, or outside the plan (in-network)’s service area. Section 2 tells about the plan (in-network)’s service area.

## **WHAT IS THE DIFFERENCE BETWEEN A “MEDICAL EMERGENCY” AND “URGENTLY NEEDED CARE”?**

The main difference between an urgent need for care and a medical emergency is in the danger to your health. “Urgently needed care” is if you need medical help immediately, but your health is not in serious danger. A “medical emergency” is if you believe that your health is in serious danger.

### **GETTING URGENTLY NEEDED CARE WHEN YOU ARE IN THE PLAN’S (IN-NETWORK) SERVICE AREA**

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan’s (in-network) service area, please call your provider. There will always be a doctor on call to help you. Keep in mind that if you have an urgent need for care while you are in the plan’s (in-network) service area, we encourage you to get this care from plan (in-network) providers. You can get urgently needed care from a non-plan (out-of-network) provider. However, using our plan (in-network) providers will result in lower costs to you. If necessary, call your plan provider to obtain a TTY/TDD phone number in the event that you require after-hours care, for hearing impaired.

### **GETTING URGENTLY NEEDED CARE WHEN YOU ARE OUTSIDE THE PLAN’S (OUT-OF-NETWORK) SERVICE AREA**

AmeriHealth 65 Plus covers urgently needed care that you get from non-plan (out-of-network) providers when you are outside the plan’s (in-network) service area, but still in the United States, at the plan’s (in-network) benefit level. If you need urgent care while you are outside the plan’s (in-network) service area, we prefer that you call your provider first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your plan (in-network) provider. However, we will cover follow-up care that you get from non-plan (out-of-network) providers outside the plan (in-network)’s service area (but within the United States) at the plan (in-network) benefit level as long as the care you are getting still meets the definition of “urgently needed care.”

As explained in Section 2, we cover renal (kidney) dialysis services that you get when you are temporarily outside the plan’s service area (for up to six months in a row).

Please remember that routine and elective medical services that are provided by non-plan (out-of-network) providers are subject to deductibles and coinsurance. Prior authorization (approval in advance) is also strongly recommended for certain services. If you do not obtain prior authorization (approval in advance), you may be responsible for all charges up to the Medicare allowed amount, if the plan determines that the services are not covered or are not medically necessary.

## SECTION 4—Benefits Chart—A list of the Covered Services you get as a member of AmeriHealth 65 Plus

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### WHAT ARE COVERED SERVICES?

This section describes the medical benefits and coverage you get as a member of AmeriHealth 65 Plus. **“Covered services” means the medical care, services, supplies, and equipment that are covered by AmeriHealth 65 Plus.** This section has a benefits chart that gives a list of your covered services and the Schedule of Copayments and Limitations tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are not covered** (these are called “exclusions”). Section 5 also tells about limitations on certain services.

You can get covered benefits out-of-network from any provider qualified to provide the benefit in question. We urge you to call Member Services at the phone number on the cover of this booklet to ask if a particular out-of-network provider is qualified to provide any of the plan benefits in question. Services you get from a provider that is not qualified to provide the plan benefit in question will not be covered.

### THERE ARE SOME CONDITIONS THAT APPLY TO GETTING COVERED SERVICES

#### Some general requirements apply to all covered services

The “covered services” listed in the benefits chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as “covered services” must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 14 for a definition of “medically necessary.”)
- Covered services provided or furnished by AmeriHealth 65 Plus plan (in-network) providers or authorized by plan (in-network) providers within the United States will be covered at the plan (in-network) benefit level. Covered services provided or furnished by non-plan (out-of-network) providers will be covered at the non-plan (out-of-network) benefit level. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan’s service area but within the United States. These covered services will be covered at the plan (in-network) benefit level.

- Even if your doctor recommends or refers you to a provider, you should always check to see if the provider is a plan (in-network) provider to keep your out-of-pocket cost low. If the provider is a non-plan (out-of-network) provider, your services will be covered at the non-plan (out-of-network) benefit level, subject to the limitations.

### **In addition, some in-network covered services require “prior authorization” (approval in advance) in order to be covered**

Some of the in-network covered services listed in the benefits chart in this section are covered only if your provider gets “prior authorization” (approval in advance) from AmeriHealth 65 Plus. In these cases, you need to have prior authorization (approval in advance) when you see plan (in-network) providers.

The use of plan (in-network) providers will ensure that the prior authorization (approval in advance) process will be initiated on your behalf.

Covered in-network services that need prior authorization (approval in advance) are marked in the benefits chart and include all inpatient hospital admissions, certain outpatient services, psychiatric care, treatment of substance abuse, certain surgical and diagnostic procedures, certain prescription drugs, durable medical equipment, prosthetics and non-emergency ambulance care.

### **Out-of-Network Services—Limitations**

If you decide not to use a plan (in-network) provider, it is your responsibility to obtain prior authorization (approval in advance) for services. The prior authorization (approval in advance) process lets you know in advance if an inpatient admission, service, supply or prescription drug is covered by the plan and limits the possibility that you may be responsible for payment. Services that require prior authorization (approval in advance) and that have not been prior authorized (approval in advance) will not be covered.

#### **A. In-Network Hospital Prior Authorization (approval in advance) Review**

All inpatient hospital admissions must meet the requirements of AmeriHealth HMO, Inc.’s Care Management and Coordination Department. Under the program as described below, any inpatient admission, other than an emergency admission, must receive prior authorization (approval in advance) in accordance with the standards of the plan and the medical appropriateness of the admission. Plan (in-network) hospitals will verify the prior authorization (approval in advance) at or before the time of admission. The plan will not authorize the hospital admission if prior authorization (approval in advance) is required and is not obtained in advance. The plan will hold the member harmless and the member will not be financially responsible for admissions that fail to conform to the prior authorization (approval in advance) requirements unless (1) the hospital provides prior written notice that the admission will not be paid by the plan and (2) the member acknowledges this fact in writing together with a request to be admitted which states that they will assume financial liability for such hospital admission. Please keep in mind you have the right to appeal any decision.

For a non-plan (out-of-network) inpatient admission the member is responsible to have the admission approved in advance as an approved admission:

1. To obtain prior authorization (approval in advance), the member is responsible to contact or have the admitting physician or hospital contact the plan prior to admission to the hospital. The plan will notify the member, admitting physician and hospital of the determination. The member is eligible for inpatient benefits at the non-plan (out-of-network) benefit level shown in the benefits chart if, and only if, prior authorization (approval in advance) of such benefits has been approved in accordance with the plan.
2. If such prior authorization (approval in advance) for a medically appropriate inpatient admission has not been obtained as required under this Evidence of Coverage, the member may be responsible for all charges up to the Medicare allowed amount, if the plan determines that the services are not covered benefits or are not medically necessary.
3. If a member elects to be admitted to the hospital after review and notification that the reason for admission is not approved for a hospital level of care, inpatient benefits will not be provided and the member will be financially liable for non-covered inpatient charges.
4. If pre-admission approval is denied, the member, the physician, or the hospital may appeal the determination and submit information in support of the claim for inpatient benefits. A reconsideration concerning eligibility for inpatient benefits will be made and the member, physician or hospital will be notified. (See Section 10 for information on how to appeal a determination made by the plan in-network).

## **B. Emergency Admission Review**

Members are encouraged to notify the plan of a non-plan (out-of-network) emergency admission within two (2) business days of the admission, or as soon as reasonably possible.

If the member elects to remain hospitalized after the plan and the attending physician has determined that a hospital level of care is not medically appropriate, the member will be financially liable for non-covered inpatient charges from the date of notification. The member has the right to appeal the decision as described in Section 10 of this booklet.

## **C. Concurrent Review**

The plan assigns an estimated length of stay for all approved inpatient hospital admissions. It also approves admissions to skilled nursing facilities and other types of care provided by other facility providers and professional providers as provided for in this section. Concurrent review of an approved admission or plan of treatment may result in an approval of a request for an extension of approved care.

## **D. In-Network Prior Authorization (approval in advance) Requirements for Other Than Inpatient Hospital Admissions**

Prior authorization (approval in advance) is required by the plan in advance of an admission in a skilled nursing facility. Prior authorization (approval in advance) is also required in advance for home health care, hospice care, certain surgical and diagnostic services, physical medicine and restorative services and outpatient therapy services which are identified below, non-emergency ambulance services and durable medical equipment and prosthetics exceeding the purchase price of \$500. When a member intends to receive any of these procedures, the plan must review the medical necessity/medical appropriateness for the procedure and grant prior approval of benefits. Surgery, diagnostic, and other listed procedures performed during an emergency, as determined by the plan, do not require prior authorization (approval in advance). However, AmeriHealth 65 Plus encourages members to notify the plan within two (2) business days of emergency services for those procedures listed herein, or as soon as reasonably possible.

**1. Plan (in-network) Care.** Plan (in-network) doctors must contact the plan to initiate prior authorization (approval in advance). The plan will notify the member and the provider of the determination. If such prior authorization (approval in advance) is not obtained and the member undergoes the surgical, diagnostic or other listed procedure, then benefits will be provided for medically necessary/medically appropriate procedures, subject to a provider penalty.

The plan will hold the member harmless and the member will not be financially responsible for this financial penalty due to the plan (in-network) provider's failure to comply with the prior authorization (approval in advance) requirements or determination, unless a member elects to receive the elective surgical, diagnostic or other listed procedure after review and written notification that the procedure is not covered as medically necessary/medically appropriate. In this case, benefits will not be provided and the member will be financially liable for non-covered charges.

If a plan (in-network) provider refers a member for non-plan (out-of-network) services, it is not the member's responsibility to obtain prior authorization (approval in advance) from the plan. In this situation, the provider would be responsible for obtaining prior authorization (approval in advance) from the plan. However, the member is still responsible for out-of-network deductibles and coinsurance unless it is determined by the plan that the services could not be provided in-network.

**REMEMBER, if you obtain out-of-network services without prior authorization no benefits are payable if services are provided that the plan determines were not covered benefits or were not medically necessary/medically appropriate for your condition.**

### **IMPORTANT NOTE**

**If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.**

## 2. Services Requiring Prior Authorization (approval in advance)

### a. Outpatient surgical procedures in-network and out-of-network:

- Bunionectomy
- Cataract Surgery
- Cholecystectomy
- Hemorrhoidectomy
- Herniorrhaphy
- Knee Surgery
- Ligation and Stripping of Varicose Veins
- Submucous Resection (Nasal Surgery)
- Tonsillectomy and/or Adenoidectomy

### b. Non-plan (out-of-network) surgical and diagnostic procedures:

- Prostate Surgery
- Spinal and Vertebral Surgery
- Operative and Diagnostic Endoscopies and Colonoscopies
- MRI
- CAT Scan

All plan (in-network) and non-plan (out-of-network) services listed below must receive prior authorization (approval in advance).

### c. Therapy Services:

- Respiratory Therapy
- Home Infusion Therapy
- Speech Therapy
- Pulmonary Rehabilitation
- Occupational Therapy
- Speech and Language Therapies

### d. Restorative Services

### e. Psychiatric and Alcohol and Drug Abuse Services

### f. Other Facility Services:

- Skilled Nursing Facility
- Home Health Care
- Birth Center

### g. Other Services and Supplies:

- Durable Medical Equipment
- Prosthetics
- Non-Emergency Ambulance Services
- Certain Prescription Drugs

**If you do not receive prior authorization and the services are either not covered or medically necessary, you will be financially responsible for these charges.**

The plan reserves the right to modify the above list of procedures and services that require prior authorization (approval in advance) 60 days after written notice has been given to the member.

### **Your AmeriHealth 65 Plus benefits**

The following describes the benefits available to you under the AmeriHealth 65 Plus network. You are entitled to benefits for covered services when: (1) considered medically necessary and/or medically appropriate and (2) billed for by a provider. All benefit limits, deductibles, coinsurance, and copayment amounts are described in the Schedule of Copayments and Limitations see attached. The benefits chart describes the benefits that will be payable for services and care provided by a plan (in-network) provider, and benefits that will be payable for those services and care that are provided by a non-plan (out-of-network) provider. You will receive a greater level of benefits through plan (in-network) care.

## Benefits Chart—A list of Covered Services

GENERAL INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	
After Deductible Plan Pays (unless otherwise specified)	N/A	30%
Maximum Annual Coinsurance	See the Schedule of Copayments and Limitations.	
Overall Lifetime Maximum	Unlimited	Unlimited

INPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
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<p><b>Inpatient hospital care</b> (<i>requires prior authorization (approval in advance) to be covered</i>)</p>	See the Schedule of Copayments and Limitations.	Covered 70% after deductible is met.
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For more information about hospital care, see Section 6.

Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals, including special diets.
- Regular nursing services.
- Costs of special care units, e.g. intensive or coronary care units.
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services.
- *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal and multivisceral. See Section 6 for more information about transplants.

## Benefits Chart—A list of Covered Services *(continued)*

INPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
<b>Inpatient hospital care</b> <i>(continued)</i>		
<ul style="list-style-type: none"> <li>• Blood.</li> <li>• Physician services.</li> </ul>		
<p><b>Inpatient mental health care</b> <i>(requires prior authorization (approval in advance) to be covered): includes mental health care services that require a hospital stay</i></p> <p>Inpatient psychiatric facility</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p> <p>190-day lifetime maximum (combined with substance abuse days) for all in-network and out-of-network treatment in a Medicare-approved inpatient psychiatric facility.</p>
<p>Inpatient acute care hospital</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>
<p><b>Skilled nursing facility care</b> <i>(requires prior authorization (approval in advance) to be covered)</i></p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after the deductible is met.</p> <p>100 days per Medicare benefit period.</p>
<p>For more information about skilled nursing facility care, see Section 6.</p>		
<p>No prior hospital stay required.</p>		
<p>Covered services include, but are not limited to, the following:</p>		
<ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary).</li> <li>• Meals, including special diets.</li> <li>• Regular nursing services.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Drugs (this includes substances that are naturally present in the body, such as blood clotting factors).</li> <li>• Blood.</li> <li>• Medical and surgical supplies.</li> <li>• Laboratory tests.</li> </ul>		

### Section 4

## Benefits Chart—A list of Covered Services *(continued)*

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### INPATIENT SERVICES

### IN-NETWORK

### OUT-OF-NETWORK

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#### Skilled nursing facility care

*(continued)*

- X-rays and other radiology services.
  - Use of appliances such as wheelchairs.
  - Physician services.
- 

#### **Inpatient services (when the hospital or SNF days are not or are no longer covered)**

*(Requires prior authorization (approval in advance) to be covered)*

See the Schedule of Copayments and Limitations.

70% after deductible is met.

For more information, see Section 6.

- Diagnostic tests (like X-ray or lab tests).
  - Physician services.
  - X-ray, radium, and isotope therapy including technician materials and services.
  - Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
  - Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
  - Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
  - Physical therapy, speech therapy, and occupational therapy.
-

## Benefits Chart—A list of Covered Services *(continued)*

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
<p><b>Home health care</b> <i>(requires prior authorization (approval in advance) to be covered)</i></p> <p>For more information about home health care, see Section 6.</p> <p><b>Home Health Agency Care:</b></p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aide services.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Medical social services.</li> <li>• Medical equipment and supplies.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>
<p><b>Hospice care</b></p> <p>For more information about hospice services, see Section 6.</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare.</li> <li>• Home care.</li> <li>• Hospice consultation services (one time only) for a terminally ill individual who has not yet decided to use hospice care.</li> </ul>	<p>You must receive care from a Medicare-certified hospice.</p> <p>When you enroll in a Medicare-certified hospice, your hospice services are paid by Medicare (see Section 6 for more information about hospice services).</p>	<p>You must receive care from a Medicare-certified hospice.</p> <p>When you enroll in a Medicare-certified hospice, your hospice services are paid by Medicare (see Section 6 for more information about hospice services).</p>
<p><b>Physician services, including doctor's office visits</b></p> <ul style="list-style-type: none"> <li>• Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.</li> <li>• Consultation, diagnosis, and treatment by a specialist.</li> <li>• Second opinion by another plan (in-network) provider prior to surgery. <i>(requires prior authorization (approval in advance) to be covered)</i></li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>

## Benefits Chart—A list of Covered Services *(continued)*

### OUTPATIENT SERVICES

### IN-NETWORK

### OUT-OF-NETWORK

#### Physician services, including doctor's office visits

*(continued)*

- Outpatient hospital services. *(requires prior authorization (approval in advance) to be covered)*
- Non-routine dental care. (Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.)

#### Chiropractic services

- Manual manipulation of the spine to correct subluxation.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met.

#### Podiatry services

- Treatment of injuries and diseases of the feet (such as hammertoe or heel spurs).
- Routine foot care for members with certain medical conditions affecting the lower limbs.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met.

#### Outpatient mental health care

*(requires prior authorization (approval in advance) to be covered)*  
*(including partial hospitalization services)*

Mental health services may be provided by a doctor, clinical psychologist, clinical social practitioner, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.

Partial hospitalization visits

See the Schedule of Copayments and Limitations. *(requires prior authorization (approval in advance) to be covered)*

Covered 70% after deductible is met.

See the Schedule of Copayments and Limitations. *(requires prior authorization (approval in advance) to be covered)*

Covered 70% after deductible is met.

## Benefits Chart—A list of Covered Services *(continued)*

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
<p><b>Outpatient substance abuse services</b> <i>(requires prior authorization (approval in advance) to be covered)</i></p>	<p>See the Schedule of Copayments and Limitations. <i>(requires prior authorization (approval in advance))</i></p>	<p>Covered 70% after deductible is met. 30 visits per year. 30 additional out-of-network full sessions or equivalent partial hospitalization visits are available and may be exchanged on a two-to-one basis to obtain up to 15 additional days of out-of-network or non-hospital residential care.  Lifetime maximum of 120 out-of-network visits.</p>
<p><b>Outpatient surgery services</b> <i>(requires prior authorization (approval in advance) to be covered)</i></p> <ul style="list-style-type: none"> <li>Includes diagnostic/screening tests such as endoscopy and colonoscopy.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>
<p><b>Ambulance services</b></p> <ul style="list-style-type: none"> <li>Includes ambulance services hospital to hospital, and services dispatched through 911, where other means of transportation could endanger your health.</li> <li>Ambulance Services from a hospital to SNF, only if you are bedbound or transportation in any other vehicle would endanger your health. (Require prior authorization/approval in advance) to be covered.</li> <li>Covered if you need to go <u>to</u> a hospital or SNF, only if transportation in any other vehicle could endanger your health (requires prior authorization (approval in advance) to be covered).</li> <li>Air ambulance is covered only in emergency situations.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met if medically necessary.</p>

## Benefits Chart—A list of Covered Services *(continued)*

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
<p><b>Emergency care</b> For more information, see Section 3.</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Services performed within the United States will be covered at the Plan (in-network) benefit level.</p> <p>Services received outside the United States will be covered at the non-plan (out-of-network) benefit level except under limited circumstances, as defined by Medicare.</p>
<p><b>Urgently needed care</b> For more information, see Section 3.</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Services performed within the United States will be covered at the plan (in-network) benefit level.</p> <p>Services received outside the United States will be covered at the non-plan (out-of-network) benefit level.</p>
<p><b>Outpatient rehabilitation services (physical therapy and occupational therapy, cardiac rehabilitation, and speech and language therapy) <i>(requires prior authorization (approval in advance) to be covered)</i></b></p> <p>Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>

## Benefits Chart—A list of Covered Services *(continued)*

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
<p><b>Durable medical equipment and related supplies</b>—such as wheelchairs, crutches, hospital bed, IV infusion pump, insulin pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 14.)</p> <ul style="list-style-type: none"> <li>• All purchased items over \$500 require prior authorization (approval in advance) to be covered.</li> <li>• All rental items regardless of price require prior authorization (approval in advance) to be covered.</li> <li>• Oxygen does not require prior authorization (approval in advance) to be covered.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>
<p><b>Prosthetic devices and related supplies</b> <i>(requires prior authorization (approval in advance) to be covered)</i> (other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also, includes some coverage following cataract removal or cataract surgery. See “Vision Care” on page 47 for more detail.</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>
<p><b>Diabetes self-monitoring, training and supplies</b>—for all people who have diabetes (insulin and non-insulin users).</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.</li> <li>• One pair per calendar year of therapeutic shoes (including fitting of shoes or inserts) for people with diabetes who have severe diabetic foot disease.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>

### Section 4

## Benefits Chart—A list of Covered Services *(continued)*

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
<b>Diabetes self-monitoring, training and supplies</b> <i>(continued)</i>		
<ul style="list-style-type: none"> <li>• Self-management training is covered under certain conditions.</li> <li>• For persons at risk of diabetes: Fasting plasma glucose tests. Contact Member Services for information on how often we will cover these tests.</li> </ul>		
<b>Medical nutrition therapy</b> —for people with diabetes or renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor.	See the Schedule of Copayments and Limitations.	Covered 70% after deductible is met. <i>(requires prior authorization (approval in advance) to be covered).</i>
<b>Outpatient diagnostic tests and therapeutic services and supplies</b>		
<ul style="list-style-type: none"> <li>• X-rays.</li> <li>• Outpatient radiation therapy <i>(requires prior authorization (approval in advance) to be covered)</i>. See the Schedule of Copayments and Limitations.</li> <li>• Surgical supplies, such as dressings <i>(requires prior authorization (approval in advance) to be covered)</i>.</li> <li>• Supplies, such as splints and casts.</li> <li>• Therapeutic shoes for those with diabetic foot disease <i>(requires prior authorization (approval in advance) to be covered)</i>.</li> <li>• Laboratory tests.</li> <li>• Blood.</li> <li>• Positron Emission Tomography (PET scan) <i>(requires prior authorization (approval in advance) to be covered.)</i></li> </ul>		

## Benefits Chart—A list of Covered Services *(continued)*

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### PREVENTIVE CARE AND SCREENING TESTS

### IN-NETWORK

### OUT-OF-NETWORK

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#### Immunizations

- Pneumonia vaccine (as explained in Section 2, you can get this service on your own). One shot may be all you will ever need—ask your doctor.
- Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own.
- *If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.*
- Other vaccines if you are at risk.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met (*requires prior authorization (approval in advance) to be covered*).

(The out-of-network deductible does not apply to pneumococcal and influenza immunizations.)

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#### Mammography screening

- One baseline exam between the ages of 35 and 39.
- One screening every 12 months for women age 40 and older.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met. (*requires prior authorization (approval in advance) to be covered*)

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#### Bone mass measurements

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met (Requires prior authorization (approval in advance) to be covered).

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#### Colorectal screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.
- Fecal occult blood test, every 12 months.

For people at high risk of colorectal cancer, the following are covered:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months.

For people not at high risk of colorectal cancer, the following is covered:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met (Requires prior authorization (approval in advance) to be covered).

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## Benefits Chart—A list of Covered Services *(continued)*

PREVENTIVE CARE AND SCREENING TESTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Pap smears, pelvic exams, and clinical breast exam</b></p> <p>As explained in Section 2, you can get these routine women’s health services on your own. <b>For all women, Pap tests, pelvic exams, and clinical breast exams are covered <u>once</u> per year.</b></p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met. <i>(requires prior authorization (approval in advance) to be covered)</i></p>
<p><b>Prostate cancer screening exam</b></p> <p>For men over age 50, the following are covered once every 12 months (office copays may apply):</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met. <i>(requires prior authorization (approval in advance) to be covered)</i></p>
<p><b>Cardiovascular screening blood tests</b></p> <p>Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease)</p>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met. <i>(requires prior authorization (approval in advance) to be covered)</i></p>
<p><b>Renal dialysis (kidney)</b></p> <ul style="list-style-type: none"> <li>• Outpatient dialysis services (including dialysis services when temporarily out of the service area, as explained in Sections 2 and 3).</li> <li>• Inpatient dialysis treatments (if you are admitted to a hospital for special care).</li> <li>• Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).</li> <li>• Home dialysis equipment and supplies.</li> <li>• Certain home support services (such as, when necessary, visits by trained dialysis workers, to check on your home dialysis, to help in emergencies when needed, and to check your dialysis equipment and water supply).</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met.</p>

## Benefits Chart—A list of Covered Services *(continued)*

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### OTHER SERVICES

### IN-NETWORK

### OUT-OF-NETWORK

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**Drugs that are covered under Original Medicare** (these drugs are covered for everyone with Medicare)

See the Schedule of Copayments and Limitations.

Member is reimbursed 50% of charges.

For more information about plan prescription drug coverage, refer to your Schedule of Copayments and Prescription Drug Limitations.

“Drugs” include substances that are naturally present in the body, such as blood clotting factors.

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services.
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by AmeriHealth 65 Plus. (See Section 14 for a definition of “durable medical equipment”).
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.
- Certain off-label drugs for chemotherapeutic regimen, per Medicare regulations.

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#### Section 4

**Benefits Chart—A list of the Covered Services you get as a member of AmeriHealth 65**

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## Benefits Chart—A list of Covered Services *(continued)*

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
<p><b>AmeriHealth 65 Plus Prescription Drug Benefit</b> (outpatient prescription drugs)</p> <p>“Drugs” include substances that are naturally present in the body.</p>	<p>For more information about additional plan prescription drug coverage (if applicable), refer to the Outpatient Prescription Drug Rider.</p>	<p>For more information about additional plan prescription drug coverage, refer to the Outpatient Prescription Drug Rider.</p>
<p><b>Dental services</b> <i>(requires prior authorization (approval in advance) to be covered)</i></p> <ul style="list-style-type: none"> <li>Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, cardiac surgery, transplants or services that would be covered when provided by a doctor.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met <i>(requires prior authorization (approval in advance) to be covered)</i>.</p>
<p><b>Hearing services</b></p> <ul style="list-style-type: none"> <li>Diagnostic hearing exams.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met <i>(requires prior authorization (approval in advance) to be covered)</i>.</p>
<p><b>Vision care</b></p> <ul style="list-style-type: none"> <li>Outpatient physician services for eye care.</li> <li><i>For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:</i> glaucoma screening once per year.</li> <li>One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> </ul>	<p>See the Schedule of Copayments and Limitations.</p>	<p>Covered 70% after deductible is met <i>(requires prior authorization (approval in advance) to be covered)</i>.</p>
	<p>Covered 100% following cataract surgery.</p>	<p>Member is reimbursed 100% following cataract surgery.</p>

## Benefits Chart—A list of Covered Services *(continued)*

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### OTHER SERVICES

### IN-NETWORK

### OUT-OF-NETWORK

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#### **Routine physical exams**

*For members whose Medicare Part B coverage begins on or after January 1, 2005, and who have not already taken advantage of this benefit in another plan or Original Medicare:* A one-time physical exam within 6 months of your first coverage under Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.

You are covered for one physical exam each calendar year.

See the Schedule of Copayments and Limitations.

Covered 70% after deductible is met.  
1 exam per year.

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#### **Health and wellness education programs**

##### **Health Education Programs**

Programs focused on clinical health conditions such as congestive heart failure and diabetes. AmeriHealth 65 Plus covers a variety of health education programs. For more information, please call Member Services.

Covered, subject to limitations.

Benefits are available out of the network. Please contact Member Services for additional information.

##### **Health Promotion Programs**

Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, and fitness. Please call Member Services for more information.

Covered, subject to limitations.

Benefits are available out of the network. Please contact Member Services for additional information.

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## **WHAT IF YOU HAVE PROBLEMS GETTING SERVICES YOU BELIEVE ARE COVERED FOR YOU?**

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call us at Member Services at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 9 for information about making a complaint.

## **CAN YOUR BENEFITS CHANGE DURING THE YEAR?**

**Generally your benefits will not change during the year. The Medicare program does not allow us to decrease your benefits during the calendar year.** We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any decreases we make in your benefits. We will tell you in advance (in October 2006) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2007.

**At any time during the year, the Medicare program can change its national coverage.** Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

## **CAN YOUR PRESCRIPTION DRUG FORMULARY LIST CHANGE DURING THE YEAR?**

**The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year.** A formulary is a list of drugs. A change in our drug formulary list could affect which drugs are covered for you. Note that the formulary list applies only to the covered services listed in the benefits chart under the heading that says, “AmeriHealth 65 Plus prescription drug benefit (outpatient prescription drugs).”

## Section 5—Medical care and services that are NOT covered (list of exclusions and limitations)

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### INTRODUCTION

The purpose of this section is to tell you about medical care and services that are not covered (“excluded”) or are limited by AmeriHealth 65 Plus. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

### IF YOU GET SERVICES THAT ARE NOT COVERED, YOU MUST PAY FOR THEM YOURSELF

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless an appeal determines that they are services that we should have paid or covered (appeals are discussed in Sections 10).

### WHAT SERVICES ARE NOT COVERED BY AMERIHEALTH 65 PLUS?

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered by AmeriHealth 65 Plus:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Out-of-network services that you get without prior authorization (approval in advance), when prior authorization (approval in advance) is recommended for getting that service. (Section 4 gives a definition of prior authorization (approval in advance) and tells which services require prior authorization (approval in advance). **If you do not receive prior authorization and the services are either not covered or not medically necessary, you will be financially responsible for charges.**
3. Services that are not reasonable and necessary under Original Medicare program standards, unless otherwise listed as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
4. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency will be paid at the non-plan (out-of-network) benefit level. (See Section 3 for more information about getting care for a medical emergency.)
5. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by AmeriHealth 65 Plus and Original Medicare to not be generally accepted by the medical community. See Section 6 for information about participation in clinical trials while you are a member of AmeriHealth 65 Plus.

6. Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.
7. Private room in a hospital, unless medically necessary.
8. Private duty nurses.
9. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
10. Nursing care on a full-time basis in your home.
11. Custodial care is not covered by AmeriHealth 65 Plus *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
12. Homemaker services.
13. Charges imposed by immediate relatives or members of your household.
14. Meals delivered to your home.
15. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
16. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed is covered, including, surgery and reconstruction of the unaffected breast, to produce a symmetrical appearance.
17. Chiropractic care is generally not covered under the plan (with the exception of manual manipulation of the spine, as outlined in Section 4), and is limited according to Medicare guidelines.
18. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
19. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4 in the Benefits Chart under “Outpatient Medical Services”).
20. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4 in the Benefits Chart under “Outpatient Medical Services”).
21. Radial keratotomy, LASIK surgery, vision therapy and other low-vision aids and services.
22. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmia.

23. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
24. Acupuncture.
25. Naturopaths' services.
26. Services provided to veterans in Veterans' Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under AmeriHealth 65 Plus, we will reimburse veterans for the difference. Members are still responsible for the AmeriHealth 65 Plus cost-sharing amount.
27. Replacement of lost or stolen drugs.
28. Wigs and other items intended to replace hair loss due to male/female pattern baldness, or due to illness or injury including but not limited to traumatic or surgical scalp avulsion, burns or chemotherapy.

## **SECTION 6—Hospital care, skilled nursing facility care, and other services** (this section gives additional information about some of the Covered Services that are listed in the Benefits Chart in Section 4)

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### **HOSPITAL CARE**

If you need hospital care, we will arrange covered services for you in a plan (in-network) hospital.

**If you should receive services in a non-plan (out-of network) hospital you will need to contact AmeriHealth 65 Plus to inform us of your hospital stay prior to your admission in order to obtain authorization.** Covered services are listed in the benefits chart in Section 4 under the heading “Inpatient Hospital Care.” We use “hospital” to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term “hospital” does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

#### **What happens if you join or drop out of AmeriHealth 65 Plus during a hospital stay?**

If you either join or leave AmeriHealth 65 Plus during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to AmeriHealth 65 Plus, if anything, for the periods of your stay when you were and were not a plan member.

### **SKILLED NURSING FACILITY CARE (SNF CARE)**

If you need skilled nursing facility care, AmeriHealth 65 Plus will arrange these services for you in a plan (in-network) SNF. If you should receive services in a non-plan (out-of-network) SNF you will need to contact AmeriHealth 65 Plus to inform us of your SNF stay prior to your admission in order to obtain prior authorization (approval in advance). Please see the Schedule of Copayments and Limitations for the number of inpatient SNF days covered each benefit period. Covered services are listed in the benefits chart in Section 4 under the heading “Skilled Nursing Facility Care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services.** It can be a separate facility, or part of a hospital or other health care facility. A **Skilled Nursing Facility** is called a “SNF” for short. The term “skilled nursing facility” does not include places that mainly provide

custodial care, such as convalescent nursing homes or rest homes. (By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

## **SKILLED NURSING FACILITY CARE**

“Skilled nursing facility care” means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

### **To be covered, the care you get in a SNF must meet certain requirements**

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

### **Stays that provide custodial care only are not covered**

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by AmeriHealth 65 Plus unless it is provided as other care you are getting in *addition to* daily skilled nursing care and/or skilled rehabilitation services.

### **There are benefit period limitations on coverage of skilled nursing facility care**

Coverage for inpatient skilled nursing facility care is limited to a certain amount of days per benefit period. (See the Schedule of Copayments and Limitations for number of days.) A **“benefit period”** begins on the first day you go to a Medicare-covered inpatient hospital or a SNF and ends when you have not received any SNF care or inpatient hospital care for 60 days in a row. If you go to a hospital or SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the benefits chart in Section 4 under the heading “Inpatient Services (when the hospital or SNF days are not or are no longer covered).”

### **In some situations, you may be able to get care in a SNF that is not a plan (in-network) provider**

Generally, you will get your skilled nursing facility care from SNFs that are plan (in-network) providers for AmeriHealth 65 Plus. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan (in-network) provider at the in-network benefit level. One of the conditions is that the SNF that is not a plan (in-network) provider must be willing to accept AmeriHealth 65 Plus’ rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a “Home SNF”):

- A nursing home or continuing care retirement community where you were living right before you went into the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

AmeriHealth HMO, Inc. cannot assure the quality of services that members will receive from a non-plan (out-of-network) skilled nursing facility.

### **What happens if AmeriHealth 65 Plus did not authorize my care?**

Except in cases of medical emergencies, we must give you prior authorization (approval in advance) for your hospital stay. See Section 4 for more detail of prior authorization (approval in advance) requirements.

### **What happens if you join or drop out of AmeriHealth 65 Plus during a SNF stay?**

If you either join or leave AmeriHealth 65 Plus during a SNF stay, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to AmeriHealth HMO, Inc., if anything, for the periods of your stay when you were and were not a plan member.

## **HOME HEALTH AGENCY CARE**

Home health agency care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the benefits chart in Section 4 under the heading “Home Health Care.” If you need home health care services, we will arrange these services for you if the requirements described below are met.

### **What are the requirements for getting home health agency services?**

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **homebound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by the state or accredited to furnish adult day care services in the state.
  - Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.
  - Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. “Supportive devices” include crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person.
2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.

#### 4. You must need *at least one of the following types of skilled care*:

- Skilled nursing care on an “intermittent” (not full-time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
- Physical therapy, which includes exercise to regain the movement and strength of an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheelchair or bathtub.
- Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
- Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

#### **Home health care can include services from a home health aide, as long as you are also getting skilled care**

As long as some qualifying skilled services are *also* included, the home health agency care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

#### **What are “part-time” and “intermittent” home health care services?**

If you meet the requirements given above for getting covered home health services, you may be eligible for “part-time” or “intermittent” skilled nursing services and home health aide services.

- **“Part-time” or “Intermittent”** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

#### **HOSPICE CARE FOR PEOPLE WHO ARE TERMINALLY ILL**

“Hospice” is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of AmeriHealth 65 Plus, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)** 24 hours a day, seven days a week. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Member Services to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than AmeriHealth 65 Plus) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan (in-network) provider or a non-plan (out-of-network) provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through AmeriHealth 65 Plus.

The Medicare program has written a booklet called *Medicare Hospice Benefits*. To get a free copy call **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)** 24 hours a day, seven days a week, which is the national Medicare help line, or visit the Medicare Web site at [www.medicare.gov](http://www.medicare.gov). Section 1 tells more about how to contact the Medicare program and about the Web site.

See below for more information on clinical trials.

## ORGAN TRANSPLANTS

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

## PARTICIPATING IN A CLINICAL TRIAL

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren’t in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not AmeriHealth 65 Plus) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in AmeriHealth 65 Plus and continue to get the rest of your care that is unrelated to the clinical trial through AmeriHealth 65 Plus.

You will have to pay the Original Medicare coinsurance for the clinical trial services. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in Amerihealth 65 Plus. For instance, you will be responsible for Part B co-insurance – generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called “*Medicare & You*.” To get a free copy, call **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)** 24 hours a day, seven days a week, or visit [www.medicare.gov](http://www.medicare.gov) on the Web.

The Medicare program has written a booklet called *Medicare and Clinical Trials*. To get a free copy, call **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)** 24 hours a day, seven days a week, or visit [www.medicare.gov](http://www.medicare.gov) on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's Web site.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan (in-network) providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and what coinsurance and copayments you will have to pay. If you participate in a clinical trial, you may stay enrolled in AmeriHealth 65 Plus and continue to get the rest of your care (subject to plan rules) that is unrelated to the clinical trial through AmeriHealth 65 Plus unless you are out of the area for more than six (6) months.

## **CARE IN RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS**

Care in a Medicare-certified Religious Non-Medical Health Care Institution (RNHCI) is covered by AmeriHealth 65 Plus under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCI. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval in advance) from AmeriHealth 65 Plus, or your stay in the RNHCI may not be covered.

## **NON-EMERGENCY AMBULANCE TRANSPORT**

Non-emergency ambulance services are covered if they meet medical necessity and origin/destination requirements.

### **What are the requirements for getting non-emergency ambulance transport?**

- **Medical necessity requirements.** Non-emergency transportation by ambulance is covered if you are bed-confined, and it is documented that other methods of transportation would be dangerous to your condition; or, if your medical condition, whether or not you are bed-confined requires transportation by ambulance.
- **Origin and destination requirements.** We cover the following non-emergency ambulance transport:
  - (1) From any point of origin to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for your illness or injury.
  - (2) From a hospital, CAH, or SNF to your home.
  - (3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where you are a resident, including the return trip.
  - (4) From your home to the nearest facility that furnishes renal dialysis, including the return trip, if you are receiving renal dialysis for treatment of ESRD.

# SECTION 7—What you must pay for your Medicare health plan coverage and for the care you receive

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## PAYING THE PLAN PREMIUM FOR YOUR COVERAGE AS A MEMBER OF AMERIHEALTH 65 PLUS

To be a member of AmeriHealth 65 Plus, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. You also have AmeriHealth 65 Plus premiums that you must pay.

### How do you pay your monthly plan premium?

**In AmeriHealth 65 Plus, you must pay any applicable premium each month.** This monthly premium covers your plan benefits. AmeriHealth 65 Plus offers two methods for paying your monthly premiums. You can use one of these methods to pay your plan premium for AmeriHealth 65 Plus. These methods for paying your premiums are:

- **ZipCheck®**—a fully automatic, computerized way to have your premium payment deducted directly from your bank account, or
- **Direct Pay**—Your monthly premium bill is sent to your home, you write the check and send it directly to us.

If you are interested in the ZipCheck option simply call the Member Services telephone number listed on the front of this booklet for an application.

If you have any questions about your plan premiums or the payment programs you can use, please call Member Services at the number on the cover of this booklet. If you are enrolled in a plan that charges a monthly premium you should be aware of the following:

- You will receive a bill around the 15th of every month.
- Your premium due date is noted on your bill.
- The bank may apply a penalty to your account if your check should bounce due to insufficient funds.
- **Please do not write any correspondence to us on your premium bill. Send all correspondence to P.O. Box 7759, Philadelphia, PA 19101-7759.**

## **What happens if you don't pay your plan premiums, or don't pay them on time?**

If your plan premiums are past due, we will tell you in writing when a 90-day grace period begins. If you do not pay your past-due plan premiums within the 90-day grace period, we will disenroll you. Disenrolling you ends your membership in AmeriHealth 65 Plus. You will then have Original Medicare coverage. (Section 12 explains about disenrollment and Original Medicare coverage). **Should you decide later to re-enroll in AmeriHealth 65 Plus, or to enroll in another plan offered by AmeriHealth HMO, Inc., you will have to pay any past-due premiums that you still owe from your previous enrollment in AmeriHealth 65 Plus.**

## **Can your plan premiums change during the year?**

We are allowed to *decrease* your premium at any time during the calendar year, but we are not allowed to increase it (the current calendar year is the period from January 1 to December 31, 2007). If we decide to decrease your plan premium during the calendar year, we will let you know in writing. **Increases in your plan premium are only allowed at the beginning of each calendar year, and must be approved by Medicare.** We will tell you in advance (in October 2007) if there will be any changes for the next calendar year in your premiums or in the amounts you will have to pay when you get covered services. If there are any changes for the next calendar year, they will take effect on January 1, 2008.

## **PAYING YOUR SHARE OF THE COST WHEN YOU GET COVERED SERVICES**

### **What are “deductibles,” “copayments” and “coinsurance”?**

- The **“deductible”** is the amount you must pay for the health care services you receive from non-plan (out-of-network) providers, before AmeriHealth 65 Plus begins to pay its share of your covered services.
- A **“copayment”** is a payment you make for your share of the cost of certain covered services you receive from plan (in-network) providers. A copayment is **a set amount per service**. You pay it when you get the service. The Schedule of Copayments and Limitations gives your copayments for covered services.
- **“Coinsurance”** is the percentage of covered expenses for services for which you are responsible to pay. (See page 20 for examples on how coinsurance is applied.)

## **YOU MUST PAY THE FULL COST OF SERVICES THAT ARE NOT COVERED**

You are personally responsible to pay for care and services that are not covered by AmeriHealth 65 Plus. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member. For covered services that have a benefit limitation, you must pay the full cost of any services you get after you have used up your benefit for that type of covered service. With few exceptions, you must pay deductibles and coinsurance for services you receive from providers who are not part of AmeriHealth 65 Plus. The exceptions are care for a medical emergency, urgently needed care, and out-of-area renal (kidney) dialysis services received within the United States. (Sections 2 and 3 explain about using plan (in-network) providers and the exceptions that apply.)

## **YOU MAY PAY MORE TO SEE NON-PLAN (OUT-OF-NETWORK) PROVIDERS**

Your out-of-pocket costs may be higher if you use non-plan (out-of-network) providers than if you use plan (in-network) providers. We will pay for covered care that you get from non-plan providers. However, you may pay more for that care if it was not emergency care, because non-plan providers do not have agreements with us to accept a certain amount as payment in full for your care. As a result, you will have to pay any difference between the amount the non-plan provider charges and the amount we pay (up to the Medicare limiting charge), in addition to any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for non-covered services.

There are situations where the plan may not pay for out-of-network services and you will be financially responsible for payment up to the Medicare limiting charge. The plan will not pay for the services if they are not covered or determined by the plan to be not medically necessary. You can reduce the risk of non-payment by obtaining prior authorization (approval in advance) for services, which are listed in your benefits chart as requiring prior authorization (See Section 4.)

You will pay less to see our plan providers because these providers have agreed to accept a specific negotiated amount as payment in full for services provided to you. There are a lot of doctors, hospitals, and other health care providers who are AmeriHealth 65 Plus providers. If you do not have a list of our plan providers (called the “provider directory”) and would like to have one, please call Member Services at the telephone number on the cover of this booklet.

## **PLEASE KEEP US UP TO DATE ON ANY OTHER HEALTH INSURANCE COVERAGE YOU HAVE**

### **Using all of your insurance coverage**

If you have other health insurance coverage besides AmeriHealth 65 Plus, it is important to use this other coverage *in combination* with your coverage as a member to pay for the care you receive. This is called “coordination of benefits” because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

### **Let us know if you have additional insurance**

You must tell us if you have any other health insurance coverage besides AmeriHealth 65 Plus, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer’s group health insurance for *employees or retirees*, either through yourself or your spouse. If you are age 65 or older and have coverage under an employer group plan of an employer of twenty (20) or more employees, either based on your own current employment or the current employment of a spouse, you must use the benefits under that plan. Similarly, if Medicare based on disability is covered under an employer group plan of an employer of 100 or more employees (or a multiple employer plan that includes an employer of 100 or more employees) either through your own current employment or that of a family member, you must use the benefits under that plan. In such cases, you will only receive benefits not covered by your employer group plan through our contract with Medicare. A special rule applies if you have or developed End Stage Renal Disease (ESRD).

- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- If any no-fault or liability insurance (or payment from a liable third party) is available to you, then benefits under that plan (or from that liable third party) must be applied to the cost of health care covered by this plan where we have provided benefits and a judgement or settlement has been made with a no-fault or liability insurer (or liable third party) and you must reimburse us. However, a share of procurement cost (e.g., attorney fees and cost) may reduce our reimbursement. Workers' compensation for treatment of a work-related illness or injury should also be applied to covered health care cost by this plan.
- Coverage you have through Medicaid.
- Coverage you have through the "Tricare for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA. (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

### **Who pays first when you have additional insurance?**

When you have additional insurance coverage, how we coordinate your benefits as a member of AmeriHealth 65 Plus with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through AmeriHealth 65 Plus, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by AmeriHealth 65 Plus, you may get your care outside of AmeriHealth 65 Plus.

In general, the insurance company that pays its share of your bills *first* is called the **"primary payer."** Then the other company or companies that are involved—called the **"secondary payers"**—each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second—or at all—depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Member Services at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You can get a copy by calling **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)**, 24 hours a day, seven days a week or by visiting the [www.medicare.gov](http://www.medicare.gov) Web site.

## **WHAT SHOULD YOU DO IF YOU HAVE BILLS FROM NON-PLAN (OUT-OF-NETWORK) PROVIDERS THAT YOU THINK WE SHOULD PAY?**

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan (out-of-network) providers at the in-network benefit level. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan's service area but within the United States and care that has been approved in advance by AmeriHealth 65 Plus. If a non-plan (out-of-network) provider asks you to pay for covered services you get in these situations, please contact us at AmeriHealth 65 Plus Claims Department, P.O. Box 41574, Philadelphia, PA 19101-1574. It is best to ask a non-plan (out-of-network) provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, and paid for those services, you can send the bill to us. We will pay your doctor for our share of the bill and let you know what, if anything, you must pay. A non-plan (out-of-network) provider will not be paid any more than what he or she would have received if you had been covered with Original Medicare.

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### INTRODUCTION ABOUT YOUR RIGHTS AND PROTECTIONS

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of AmeriHealth 65 Plus as well as the right to receive information about the organization’s rights and responsibilities. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)**. You can call 24 hours a day, seven days a week.

### YOUR RIGHT TO BE TREATED WITH FAIRNESS AND RESPECT

You have the right to be treated with dignity, respect, and fairness at all times. AmeriHealth 65 Plus must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race, color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number on the cover of this booklet. Member Services can also help if you need to file a complaint about access (such as wheelchair access).

### YOUR RIGHT TO THE PRIVACY OF YOUR MEDICAL RECORDS AND PERSONAL HEALTH INFORMATION

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your

health information to anyone who is not providing your care or paying for your care. There are a few exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask providers to make additions or corrections to your medical records (if you ask a provider to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number on the cover of this booklet.

### **YOUR RIGHT TO SEE PLAN (IN-NETWORK) AND NON-PLAN (OUT-OF-NETWORK) PROVIDERS AND GET COVERED SERVICES WITHIN A REASONABLE PERIOD OF TIME**

As explained in this booklet, you can get most or all of your care from plan (in-network) providers; that is, from doctors and other health care providers who are part of AmeriHealth 65 Plus. You can also get most or all of your care from non-plan (out-of-network) providers; that is, from doctors and other health providers who are not part of AmeriHealth 65 Plus. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. “Timely access” means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan (in-network) providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

### **YOUR RIGHT TO KNOW YOUR TREATMENT CHOICES AND PARTICIPATE IN DECISIONS ABOUT YOUR HEALTH CARE**

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by AmeriHealth 65 Plus. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. “Initial decisions” are discussed in Section 10.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave this includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

## **YOUR RIGHT TO USE ADVANCE DIRECTIVES (SUCH AS A LIVING WILL OR A POWER OF ATTORNEY)**

You have the right to ask someone, such as a family member or friend, to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called **“advance directives.”** There are different types of advance directives and different names for them. Documents called **“living will”** and **“power of attorney for health care”** are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram). Section 1 of this booklet tells how to contact your SHIP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with:

**Department of Health  
State of New Jersey  
Division of Health Facilities Evaluation  
and Licensing Complaint Center, CN 367  
Trenton, NJ 08625  
1-800-792-9770**

## **YOUR RIGHT TO MAKE COMPLAINTS**

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Section 10, and grievances are discussed in Section 9.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* AmeriHealth 65 Plus in the past. To get this information, call Member Services at the phone number on the cover of this booklet.

## **YOUR RIGHT TO GET INFORMATION ABOUT YOUR HEALTH CARE COVERAGE AND COSTS**

This booklet and any applicable rider tell you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Member Services at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by AmeriHealth 65 Plus. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 9-11 for more information about filing an appeal.

## **YOUR RIGHT TO GET INFORMATION ABOUT AMERIHEALTH 65 PLUS AND PLAN (IN-NETWORK) PROVIDERS**

You have the right to get information from us about AmeriHealth 65 Plus. This includes information about our financial condition, about our health care providers and their qualifications, and about how AmeriHealth 65 Plus compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number on the cover of this booklet.

## **YOU HAVE THE RIGHT TO MAKE RECOMMENDATIONS ABOUT AMERIHEALTH 65'S MEMBER RIGHTS AND RESPONSIBILITIES**

You have the right to be informed about AmeriHealth 65's Rights and Responsibilities. If you have any recommendations, call Member Services at the phone number listed on the cover.

## **HOW TO GET MORE INFORMATION ABOUT YOUR RIGHTS**

If you have questions or concerns about your rights and protections, please call Member Services at the number on the cover of this booklet. You can also get free help and information from your **State Health Insurance Assistance Program**, (SHIP). (Section 1 tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call **1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048)**. You can call 24 hours a day, 7 days a week. Or you can visit the Medicare Web site at [www.medicare.gov](http://www.medicare.gov) to order this booklet or print it directly from your computer.

## **WHAT CAN YOU DO IF YOU THINK YOU HAVE BEEN TREATED UNFAIRLY OR YOUR RIGHTS ARE NOT BEING RESPECTED?**

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

If you think you have been treated unfairly due to your race, color, age, religion, national origin or any mental or physical disability, please let us know. Or you can call the Office for Civil Rights in your area at **1-212-264-3313** or **1-800-368-1019, TTY/TDD 1-212-264-2355** or **1-800-537-7697**.

For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number on the cover of this booklet. You can also get help from your **S**tate **H**ealth **I**nsurance Assistance **P**rogram, (SHIP). (Section 1 tells how to contact the SHIP in your state).

### **WHAT ARE YOUR RESPONSIBILITIES AS A MEMBER OF AMERIHEALTH 65 PLUS?**

Along with the rights you have as a member of AmeriHealth 65 Plus, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number on the cover of this booklet if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any copayments you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 7 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number on the cover of this booklet.

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### WHAT IS A GRIEVANCE?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal as described in Section 10 and Section 11 of this manual because grievances do not involve problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation (CORF) services ending too soon.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, you must follow the rules outlined in Section 10.

If you have a problem about our failure to cover or pay for a Part D prescription drug, you must follow the rules outlined in Section 11.

### WHAT TYPES OF PROBLEMS MIGHT LEAD TO YOU FILING A GRIEVANCE?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) AmeriHealth 65 Plus.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.

- Failure by the plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 10.

## **FILING A GRIEVANCE WITH AMERIHEALTH 65 PLUS**

**If you have a complaint, we encourage you to first call Member Services at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone.**

If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.** We call this The grievance complaint process. To use this formal grievance/complaint procedure, submit your grievance in writing to: AmeriHealth 65 Plus Medicare Member Appeals Unit, 1901 Market street, P.O. Box 13652, Philadelphia PA 19101-3652. We will write you to let you know that we have received and investigated your concern within 30 days of receiving your grievance. Be sure to describe expedited grievance timeframes for grievances about decisions to not conduct expedited organizational determinations or reconsiderations or to take extensions on initial decisions or appeals. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

## **FOR QUALITY OF CARE PROBLEMS, YOU MAY ALSO COMPLAIN TO THE QIO**

Complaints concerning the quality of care received under Medicare, including care during a hospital stay, may be acted upon by the plan sponsor under the grievance process, by an independent organization called the QIO, or by both. For any complaint filed with the QIO, the plan sponsor must cooperate with the QIO in resolving the complaint. See Section 1 for more information about the QIO.

## **HOW TO FILE A QUALITY OF CARE COMPLAINT WITH THE QIO**

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See page 11 of the introduction for more information about how to file a quality of care complaint with the QIO.

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## INTRODUCTION

This section gives the rules for making complaints about Part C services and payments in different types of situations. **Note: please see Section 11 for complaints about prescription drugs (Part D).** Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from AmeriHealth 65 Plus or penalized in any way if you make a complaint.

Please refer to Original Medicare in Section 8 of your 2007 *Medicare and You Handbook* for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare and You Handbook*, please call **1-800 MEDICARE** to get a copy.

## HOW TO MAKE COMPLAINTS IN DIFFERENT SITUATIONS

This section tells you how to complain about services or payment in each of the following situations:

- Part 1. Complaints about what benefit or service we will provide you or what we will pay for (cover).**
- Part 2. Complaints if you think you are being discharged from the hospital too soon.**
- Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.**

If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. **For more information about grievances, including how to file a grievance, see Section 9.**

### **PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE AMERIHEALTH 65 WILL PROVIDE YOU OR WHAT AMERIHEALTH 65 WILL PAY FOR (COVER)**

#### **WHAT ARE “COMPLAINTS ABOUT YOUR SERVICES OR PAYMENT FOR YOUR CARE?”**

If you are not getting the care you want, and you believe that this care is covered by AmeriHealth 65 Plus.

- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by AmeriHealth 65 Plus.

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by AmeriHealth 65 Plus, but we have refused to pay for this care because we say it is not covered.

## **WHAT IS AN ORGANIZATION DETERMINATION?**

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received. If our initial decision is to deny your request, you can **appeal** the decision by going on to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

**When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of AmeriHealth 65 Plus apply to your specific situation.** This booklet and any amendments you may receive describe the benefits and services covered by AmeriHealth 65 Plus, including any limitations that may apply to these services. This booklet also lists exclusions (services that are “not covered” by AmeriHealth 65 Plus).

## **WHO MAY ASK FOR AN “INITIAL DECISION” ABOUT YOUR MEDICAL CARE OR PAYMENT?**

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at AmeriHealth 65 Plus, P.O. Box 7759, Philadelphia, PA 19101-87759. You can call us at **(1-800-645-3965; TTY/TDD 1-888-857-4816)** to learn how to name your representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact the New Jersey Bar Association at **1-888-541-1900**.

## **DO YOU HAVE A REQUEST FOR MEDICAL CARE THAT NEEDS TO BE DECIDED MORE QUICKLY THAN THE STANDARD TIME FRAME?**

A decision about whether we will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours). A fast decision is sometimes called an “expedited organization determination.”

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

## **ASKING FOR A STANDARD DECISION**

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the following address: AmeriHealth 65 Plus, Members Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.

## ASKING FOR A FAST DECISION

You, any doctor, or your representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us at 1-800-645-3965 (for TTY/TDD, call 1-888-857-4816). Or, you can deliver a written request to AmeriHealth 65 Plus, Members Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652, or fax it to 1-888-289-3008. Be sure to ask for a “fast” or “72-hour” review.

If any doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” decision, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 9.

## WHAT HAPPENS NEXT WHEN YOU REQUEST AN INITIAL DECISION?

1. *For a decision about payment for care you already received.*

We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the timeframe for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a “reconsideration.”)

2. *For a standard initial decision about medical care.*

We have 14 days to make a decision after we have received your request. However, we can take up to 14 more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance” (see Section 9).

If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision.

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. *For a fast initial decision about medical care.*

If you receive a “fast” decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any additional days, you can file a fast grievance.

We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

**APPEAL LEVEL 1: IF WE DENY ANY PART OF YOUR REQUEST FOR COVERAGE OR PAYMENT OF A SERVICE, YOU MAY ASK US TO RECONSIDER OUR DECISION. THIS IS CALLED AN “APPEAL” OR A “REQUEST FOR RECONSIDERATION.”**

Please call us at 1-800-645-3965 (TTY/TDD 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m., if you need help in filing your appeal. We give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” appeal are the same as those described for a “standard” or “fast” initial decision.

**GETTING INFORMATION TO SUPPORT YOUR APPEAL**

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor’s records or the doctor’s opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to AmeriHealth 65 Plus, Members Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.
- By fax, at 1-888-289-3008.
- By telephone – if it is a “fast appeal” – at 1-800-645-3965.
- In person, at 1901 Market Street, Philadelphia, PA 19101-3652.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-645-3965, AmeriHealth 65 Plus, Members Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652. We are allowed to charge a fee for copying and sending this information to you.

**HOW DO YOU FILE YOUR APPEAL OF THE INITIAL DECISION?**

The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the instructions under “Who may ask for an ‘initial decision’ about medical care or payment?” However, providers who do not have a contract with AmeriHealth 65 Plus must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

## HOW SOON MUST YOU FILE YOUR APPEAL?

You need to file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at AmeriHealth 65 Plus, Members Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.

## WHAT IF YOU WANT A “FAST” APPEAL?

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” initial decision.

## HOW SOON MUST WE DECIDE ON YOUR APPEAL?

1. For a decision about payment for care you already received.

After we receive your appeal, we have 60 days to make a decision. If we do not decide within 60 days, your appeal *automatically* goes to Appeal Level 2.

2. For a standard decision about medical care.

After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

3. For a fast decision about medical care.

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

## WHAT HAPPENS NEXT IF WE DECIDE COMPLETELY IN YOUR FAVOR?

1. For a decision about payment for care you already received.

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision.

2. For a standard decision about medical care.

We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

## WHAT HAPPENS NEXT IF WE DENY YOUR APPEAL?

If we deny any part of your appeal, your appeal *automatically* goes on to Appeal Level 2 where an independent review organization will review your case. This organization contracts with the federal government and is not part of AmeriHealth 65 Plus. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. *For a decision about payment for care you already received.*

We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

2. *For a standard decision about medical care.*

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. *For a fast decision about medical care.*

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

## APPEAL LEVEL 2: IF WE DENY ANY PART OF YOUR LEVEL 1 APPEAL, YOUR APPEAL WILL AUTOMATICALLY BE REVIEWED BY A GOVERNMENT-CONTRACTED INDEPENDENT REVIEW ORGANIZATION

At the second level of appeal, your case is given a new review by an outside, independent review organization that has a contract with CMS (**C**enters for **M**edicare & **M**edicaid **S**ervices), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

## HOW SOON MUST THE INDEPENDENT REVIEW ORGANIZATION DECIDE?

1. *For an appeal about payment for care, the independent review organization has up to 60 days to make a decision.*
2. *For a standard appeal about medical care, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.*
3. *For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.*

## **IF THE INDEPENDENT REVIEW ORGANIZATION DECIDES COMPLETELY IN YOUR FAVOR:**

The independent review organization will tell you in writing about its decision and the reasons for it.

1. *For an appeal about payment for care,*

We must pay within 30 days after receiving the decision.

2. *For a standard appeal about medical care,*

We must authorize the care you have asked for within 72 hours after receiving notice of the decision, or provide the care no later than 14 days after receiving the decision.

3. *For a fast appeal about medical care,*

We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

## **APPEAL LEVEL 3: IF THE ORGANIZATION THAT REVIEWS YOUR CASE IN APPEAL LEVEL 2 DOES NOT RULE COMPLETELY IN YOUR FAVOR, YOU MAY ASK FOR A REVIEW BY AN ADMINISTRATIVE LAW JUDGE**

You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

### **HOW SOON DOES THE JUDGE MAKE A DECISION?**

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

### **IF THE JUDGE DECIDES IN YOUR FAVOR**

We must pay for, authorize, or provide the service you have asked for within 60 days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

### **IF THE JUDGE RULES AGAINST YOU**

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

## **APPEAL LEVEL 4: YOUR CASE MAY BE REVIEWED BY THE MEDICARE APPEALS COUNCIL**

### **THIS COUNCIL WILL FIRST DECIDE WHETHER TO REVIEW YOUR CASE**

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or AmeriHealth HMO, Inc. may request a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

### **HOW SOON WILL THE COUNCIL MAKE A DECISION?**

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

### **IF THE COUNCIL DECIDES IN YOUR FAVOR**

We must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

### **IF THE COUNCIL DECIDES AGAINST YOU**

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

## **APPEAL LEVEL 5: YOUR CASE MAY GO TO A FEDERAL COURT**

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we may ask a Federal Court Judge to review the case.

### **HOW SOON WILL THE JUDGE MAKE A DECISION?**

The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

## **PART 2. COMPLAINTS (APPEALS) IF YOU THINK YOU ARE BEING DISCHARGED FROM THE HOSPITAL TOO SOON**

When you are hospitalized, you have the right to get all the hospital care covered by AmeriHealth 65 Plus that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

### **INFORMATION YOU SHOULD RECEIVE DURING YOUR HOSPITAL STAY**

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

### **REVIEW OF YOUR HOSPITAL DISCHARGE BY THE QUALITY IMPROVEMENT ORGANIZATION**

If you think that you are being discharged too soon, ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or your representative) may be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

### **WHAT IS THE “QUALITY IMPROVEMENT ORGANIZATION”?**

“QIO” stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of AmeriHealth 65 Plus or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

## GETTING A QIO REVIEW OF YOUR HOSPITAL DISCHARGE

If you want to have your discharge reviewed, you must quickly contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **“fast review”** of whether you are ready to leave the hospital. This “fast review” is also called an “immediate review.”
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

### WHAT HAPPENS IF THE QIO DECIDES IN YOUR FAVOR?

- If the QIO agrees with you, we will continue to cover your hospital stay for as long as it is medically necessary.

### WHAT HAPPENS IF THE QIO DENIES YOUR REQUEST?

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision.

### WHAT IF YOU DO NOT ASK THE QIO FOR A REVIEW BY THE DEADLINE?

***You still have another option: asking AmeriHealth 65 Plus for a “fast appeal” of your discharge***

If you do not ask the QIO for a fast review of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date (unless the independent review organization overturns our decision).

### **PART 3. COMPLAINTS (APPEALS) IF YOU THINK YOUR COVERAGE FOR SNF, HOME HEALTH OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES IS ENDING TOO SOON**

When you are a patient in a SNF, **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by AmeriHealth 65 Plus that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon.

#### **INFORMATION YOU WILL RECEIVE DURING YOUR SNF, HHA OR CORF STAY**

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or your representative) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

#### **HOW TO GET A REVIEW OF YOUR COVERAGE BY THE QUALITY IMPROVEMENT ORGANIZATION**

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the **Q**uality **I**mprovement **O**rganization (the “QIO”) to do an independent review of whether it is medically appropriate to terminate your coverage.

#### **HOW SOON DO YOU HAVE TO ASK THE QIO TO REVIEW YOUR COVERAGE?**

If you want to appeal the termination of your coverage, you must quickly contact the QIO. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, you must make your request **no later than noon** of the day before the date that your Medicare coverage ends.

#### **WHAT WILL HAPPEN DURING THE REVIEW?**

The QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why we believe that your services should end.

After reviewing all the information, the QIO will decide whether it is medically appropriate to terminate your coverage on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

## **WHAT HAPPENS IF THE QIO DECIDES IN YOUR FAVOR?**

If the QIO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

## **WHAT HAPPENS IF THE QIO DENIES YOUR REQUEST?**

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor AmeriHealth 65 Plus will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

## **WHAT IF YOU DO NOT ASK THE QIO FOR A REVIEW BY THE DEADLINE?**

You still have another option: asking AmeriHealth 65 Plus for a “fast appeal” of your discharge.

If you do not ask the QIO for a fast appeal of your coverage termination by the deadline, you can ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.

# SECTION 11—Appeals and Grievances: What to do if you have complaints about your Part D prescription drug benefits

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## WHAT TO DO IF YOU HAVE COMPLAINTS

### Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Member Services at the number on the cover of this booklet.

Please note that Section 11 addresses complaints about your Part D prescription drug benefits. If you have complaints about your Medicare Advantage benefits, you must follow the rules outlined in Sections 9 and 10.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from AmeriHealth 65 Plus or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations, and appeals.

## **WHAT IS A GRIEVANCE?**

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with AmeriHealth 65 Plus or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

## **WHAT IS A COVERAGE DETERMINATION?**

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an “exception” if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower copayment. If you request an exception, your physician must provide a statement to support your request.

**You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.**

## **WHAT IS AN APPEAL?**

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

## **HOW TO FILE A GRIEVANCE**

**This part of Section 11 explains how to file a grievance.** A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits. (Concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below.)

## What types of problems might lead to you filing a grievance?

- You feel that you are being encouraged to leave (disenroll from) AmeriHealth 65 Plus.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required time frame.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required time frame.
- Failure by the plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

**If you have a grievance, we encourage you to first call Member Services at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance Process.** As a member you can file an expedited grievance with AmeriHealth 65 Plus for the following reasons:

- AmeriHealth 65 Plus’ decision to invoke an extension to the organization determination or reconsideration time frames.
- AmeriHealth 65 Plus’ refusal to grant a member’s request for an expedited organization determination or reconsideration.

AmeriHealth 65 Plus must respond within 24 hours of receiving your expedited grievance request. To file an expedited grievance, please call 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. or mail a written request to Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

## **FOR QUALITY OF CARE COMPLAINTS, YOU MAY ALSO COMPLAIN TO THE QUALITY IMPROVEMENT ORGANIZATION (QIO)**

Complaints concerning the quality of care received under Medicare may be acted upon by the plan sponsor under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, the Plan sponsor must cooperate with the QIO in resolving the complaint.

### **How to file a quality of care complaint with the QIO**

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See Section 1 for more information about how to file a quality of care complaint with the QIO.

## **HOW TO REQUEST A COVERAGE DETERMINATION**

**This part of Section 11 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination.** We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that AmeriHealth 65 Plus will not cover a prescription drug, you should contact us and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by AmeriHealth 65 Plus.
- If you have received a Part D prescription drug you believe may be covered by AmeriHealth 65 Plus while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a “formulary”). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the copayment we require you to pay for a drug.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting.

- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a coverage determination is discussed in greater detail below in the section titled “Detailed information about how to request a coverage determination and an appeal.”

## **HOW TO REQUEST AN APPEAL**

**This part of Section 11 explains what you can do if you disagree with our coverage determination.** If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

### **What kinds of decisions can be appealed?**

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request you can appeal. A coverage determination, which includes those described on page 98, may be appealed if you disagree with our decision.

**Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the copayment we require you to pay for the drug.**

### **How does the appeals process work?**

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination.

Each appeal level is discussed in greater detail below in the section titled “Detailed information about how to request a coverage determination and an appeal.”

## **DETAILED INFORMATION ABOUT HOW TO REQUEST A COVERAGE DETERMINATION AND AN APPEAL**

### **What is the purpose of this section?**

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

## **COVERAGE DETERMINATIONS: AMERIHEALTH 65 PLUS MAKES A COVERAGE DETERMINATION ABOUT YOUR PART D PRESCRIPTION DRUG, OR ABOUT PAYING FOR A PART D PRESCRIPTION DRUG YOU HAVE ALREADY RECEIVED**

### **What is a coverage determination?**

The coverage determination made by AmeriHealth 65 Plus is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact AmeriHealth 65 Plus and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. to get help in making this request.
- You ask for a Part D drug that is not on your plan’s list of covered drugs (called a “formulary”). This is a request for a “formulary exception.” You can call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. to ask for this type of decision.
- You ask for an exception to our plan’s utilization management tools - such as dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You can call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. to ask for this type of decision.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a “tiering exception.” You can call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. to ask for this type of decision.
- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician’s office, will be covered by the plan. You can call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician’s office.

**When we make a coverage determination, we are giving our interpretation of how the Part D**

**prescription drug benefits that are covered for members of AmeriHealth 65 Plus apply to your specific situation.** This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by AmeriHealth 65 Plus, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are “not covered” by AmeriHealth 65 Plus).

### **Who may ask for a coverage determination?**

You can ask us for a coverage determination yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652. You can call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816), seven days a week, from 8 a.m. to 8 p.m. to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

### **ASKING FOR A “STANDARD” OR “FAST” COVERAGE DETERMINATION**

#### **Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?**

A decision about whether we will cover a Part D prescription drug can be a “standard” coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a “fast” coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an “expedited coverage determination.”

You can ask for a fast decision **only** if you or your doctor believes that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

#### **Asking for a standard decision**

To ask for a standard decision, you, your doctor, or your appointed representative should call us at 1-800-645-3965 (for TTY/TDD, call 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. Or, you can deliver a written request to AmeriHealth 65 Plus, Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652, or fax it to 1-888-289-3008.

## Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at 1-800-645-3965 (for TTY/TDD, call 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. Or, you can deliver a written request to AmeriHealth 65 Plus, Medicare Members Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652, or fax it to 1-888-289-3008. Be sure to ask for a “fast,” “expedited,” or “24-hour” review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard time frame.

## What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

### 1. For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.

Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules — such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we have received your physician’s “supporting statement,” which explains why the drug you are asking for is medically necessary. If you are requesting an exception, you should submit your prescribing physician’s supporting statement with the request, if possible.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section “Appeal Level 1” explains how to file this appeal.

If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

### 2. For a fast coverage determination about a Part D drug that you have not received.

If you receive a fast review, we will give you our decision within 24 hours after you or your doctor asks for a fast review — sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician’s “supporting statement,” which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section “Appeal Level 1” explains how to file this appeal.

If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your physician’s request for a fast review, we will give you our decision within the standard 72-hour time frame discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor’s support for a fast review.

### **What happens if we decide completely in your favor?**

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

#### **1. For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician’s “supporting statement.” If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

#### **2. For a fast decision about a Part D drug that you have not received.**

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician’s “supporting statement.”

### **What happens if we deny your request?**

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).

**APPEAL LEVEL 1: IF WE DENY PART OR ALL OF YOUR REQUEST IN OUR COVERAGE DETERMINATION, YOU MAY ASK US TO RECONSIDER OUR DECISION. THIS IS CALLED AN “APPEAL” OR “REQUEST FOR REDETERMINATION.”**

Please call us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under “Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?” and “Asking for a fast decision.”

**Getting information to support your appeal**

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor’s records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to  
**Medicare Member Appeals Unit,  
1901 Market Street,  
P.O. Box 13652,  
Philadelphia, PA 19101-3652.**
- By fax, at **1-888-289-3008**.
- By telephone — if it is a fast appeal — at **1-800-645-3965**.(TTY/TDD: 1-888-857-4816)
- In person, at  
**1901 Market Street  
1st Floor  
Philadelphia, PA 19103**

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m., Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.

## **Who may file your appeal of the coverage determination?**

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

## **How soon must you file your appeal?**

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652. To file a standard appeal, you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at the address above.

## **What if you want a fast appeal?**

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at 1-800-645-3965 (TTY/TDD: 1-888-857-4816) seven days a week, from 8 a.m. to 8 p.m. Or, you can deliver a written request to Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652, or fax it to 1-888-289-3008. Be sure to ask for a “fast,” “expedited,” or “72-hour” review. Remember that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.

## **How soon must we decide on your appeal?**

How quickly we decide on your appeal depends on the type of appeal:

- 1. For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.**

After we receive your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent organization will review your case.

- 2. For a fast decision about a Part D drug that you have not received.**

After we receive your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

## **What happens next if we decide completely in your favor?**

### **1. For a decision about reimbursement for a Part D drug you already paid for and received.**

We must send payment to you no later than 30 calendar days after we receive your request to reconsider our coverage determination.

### **2. For a standard decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

### **3. For a fast decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long.

## **What happens next if we deny your appeal?**

If we deny any part of your appeal, you or your appointed representative has the right to ask an independent organization to review your case. This independent review organization contracts with the federal government and is not part of AmeriHealth 65 Plus.

## **APPEAL LEVEL 2: IF WE DENY ANY PART OF YOUR FIRST APPEAL, YOU MAY ASK FOR A REVIEW BY A GOVERNMENT-CONTRACTED INDEPENDENT REVIEW ORGANIZATION**

### **What independent review organization does this review?**

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

### **How soon must you file your appeal?**

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination you receive from AmeriHealth 65 Plus.

### **What if you want a fast appeal?**

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing physician cannot file the request for you — only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under “Asking for a fast decision.” Remember, if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, the IRO will automatically treat you as eligible for a fast appeal.

## How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to give you a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to give you a decision.

## If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**

We must pay within 30 calendar days from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by its decision.

2. **For a standard decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by its decision.

3. **For a fast decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by its decision.

## What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is **\$110** or more.

## **APPEAL LEVEL 3: IF THE ORGANIZATION THAT REVIEWS YOUR CASE IN APPEAL LEVEL 2 DOES NOT RULE COMPLETELY IN YOUR FAVOR, YOU MAY ASK FOR A REVIEW BY AN ADMINISTRATIVE LAW JUDGE**

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to Maximus Federal Services, 50 Square Drive, Suite 210, Victor, NY 14564.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than **\$110**. If the dollar value is less than **\$110**, you may not appeal any further.

### **How is the dollar value (the “amount remaining in controversy”) calculated?**

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures paid by other entities.

### **You may also combine multiple Part D claims to meet the dollar value if:**

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

### **How soon does the Judge make a decision?**

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

### **If the Judge decides in your favor:**

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.**

We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

### **If the Judge rules against you:**

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

## **APPEAL LEVEL 4: YOUR CASE MAY BE REVIEWED BY THE MEDICARE APPEALS COUNCIL**

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If it decides not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

### **How soon will the Council make a decision?**

If the Medicare Appeals Council reviews your case, it will make its decision as soon as possible.

### **If the Council decides in your favor:**

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

#### **1. For a decision about payment for a Part D drug you already received.**

We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

#### **2. For a standard decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

#### **3. For a fast decision about a Part D drug you have not received.**

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

### **If the Council decides against you:**

If the amount involved is **\$1,090** or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than **\$1,090**, the Council's decision is final and you may not take the appeal any further.

## **APPEAL LEVEL 5: YOUR CASE MAY GO TO A FEDERAL COURT**

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is **\$1,090** or more, you may ask a Federal Court Judge to review the case.

### **How soon will the Judge make a decision?**

The federal judiciary is in control of the timing of any decision.

**If the Judge decides in your favor:**

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. For a decision about payment for a Part D drug you already received.

We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

**If the Judge decides against you:**

The Judge's decision is final and you may not take the appeal any further.

## SECTION 12—Leaving AmeriHealth 65 Plus and your choices for continuing Medicare after you leave

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### WHAT IS DISENROLLMENT?

“Disenrollment” from AmeriHealth 65 Plus means **ending your membership** in AmeriHealth 65 Plus. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave AmeriHealth 65 Plus because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to when you may leave and how often you can make changes, what your other choices are for receiving Medicare services, and how you can make changes.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave AmeriHealth 65 Plus if you move permanently out of our geographic service area or if AmeriHealth 65 Plus leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

### UNTIL YOUR MEMBERSHIP ENDS, YOU MUST KEEP GETTING YOUR MEDICARE SERVICES THROUGH AMERIHEALTH 65 PLUS OR YOU WILL HAVE TO PAY FOR THEM YOURSELF.

If you leave AmeriHealth 65 Plus, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through AmeriHealth 65 Plus.

If you get services from doctors or other medical providers who are not plan providers before your membership in AmeriHealth 65 Plus ends, neither AmeriHealth HMO, Inc. nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception: if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services at the number on the cover of this booklet to find out if your hospital care will be covered by AmeriHealth 65 Plus. If you have any questions about leaving AmeriHealth 65 Plus, please call us at Member Services.

## WHAT SHOULD I DO IF I DECIDE TO LEAVE AMERIHEALTH 65 PLUS?

If you want to leave AmeriHealth 65 Plus:

- The first step is to **be sure that the type of change you want to make and when you want to make it fit with the new rules** explained below about changing how you get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.
- Then, what you must do to leave AmeriHealth 65 Plus depends on whether you want to switch to Original Medicare or to one of your other choices.

## WHEN AND HOW OFTEN CAN I CHANGE MY MEDICARE CHOICES?

In general, there are only certain times during the year when you can change the way you get Medicare.

Here are the rules:

1. From November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1. During the AEP, you are **not limited** in the type of change you may make to your coverage. See "What are my choices, and how do I make changes, if I leave AmeriHealth 65 Plus between November 15 and December 31?" see next page for details.
2. From January 1 until March 31, during the Medicare Advantage Open Enrollment Period (OEP), anyone eligible for Medicare Advantage has another chance to review the coverage they have and make one change. Your new enrollment will be effective the first day of the month that comes after the month we receive your request to leave. However, with this chance, you **are limited** in the type of plan you may join. ***You may not use this chance to add or drop Medicare prescription drug coverage.*** See "What are my choices, and how do I make changes, if I leave AmeriHealth 65 Plus between January 1 and March 31?" see next page for details.

Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Contact us for information.

## WHAT ARE MY CHOICES, AND HOW DO I MAKE CHANGES, IF I LEAVE AMERIHEALTH 65 PLUS BETWEEN NOVEMBER 15 AND DECEMBER 31?

If you leave AmeriHealth 65 Plus between November 15 and December 31 (during the AEP), you have a number of choices for how you receive your Medicare after you leave. If they are available in your area, and if they are accepting new members, you can switch to any of the following types of plans:

- **Other Medicare Advantage Plans** (including HMOs such as AmeriHealth 65 Plus, PPOs, and Private Fee-for-Service plans) are available in some parts of the country. In HMOs and PPOs, you generally get all your Medicare-covered Part A and Part B health care through the plan. Medicare Advantage Plans **may include prescription drug coverage** as part of the Medicare Prescription Drug (Part D) benefit. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use their services. AmeriHealth 65 Plus is a Medicare Advantage Plan offered by AmeriHealth HMO, Inc.
- **Original Medicare** is available throughout the country. Original Medicare is a Fee-for-Service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- **Medicare Prescription Drug Plans** (PDPs) are stand-alone drug plans that only cover prescription drugs, not other benefits or services. If you choose Original Medicare and want to receive Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.
- **Other Medicare Health Plans** (including Medicare Cost Plans, Programs of All-Inclusive Care for the Elderly (PACE), and Demonstrations) may be available. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage **may include prescription drug coverage**.

**Note:** For more information about your choices, please refer to the “Medicare & You” handbook you received in the fall. You may also call **1-800-MEDICARE** (1-800-633-4227), or visit [www.medicare.gov](http://www.medicare.gov) to learn more about your choices.

## **HOW DO I SWITCH FROM AMERIHEALTH 65 PLUS TO ANOTHER MEDICARE ADVANTAGE PLAN OR OTHER MEDICARE HEALTH PLAN BETWEEN NOVEMBER 15 AND DECEMBER 31?**

If you want to change from AmeriHealth 65 Plus to a different Medicare Advantage Plan or other Medicare health plan, here is what to do:

1. Contact the new plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit.
2. Your new plan will tell you the date when your membership in that plan begins, and your membership in AmeriHealth 65 Plus will end on that same day (this will be your “disenrollment date”). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through AmeriHealth 65 Plus until the date your membership ends.

## **WHAT IF I WANT TO SWITCH (DISENROLL) FROM AMERIHEALTH 65 PLUS TO ORIGINAL MEDICARE BETWEEN NOVEMBER 15 AND DECEMBER 31?**

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from AmeriHealth 65 Plus to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan.

To get information about Prescription Drug Plans that you can join, you can call **1-800-MEDICARE (1-800-633-4227)**, which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

- If you want Original Medicare and Medicare prescription drug coverage, simply enroll in a stand-alone Medicare Prescription Drug Plan (PDP). That will automatically disenroll you from AmeriHealth 65 Plus.
- If you want Original Medicare and do not want Medicare prescription drug coverage, simply tell us or Medicare that you want to leave AmeriHealth 65 Plus. You do not have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave AmeriHealth 65 Plus.
  - **To tell us** that you want to leave AmeriHealth 65 Plus.
    - You can write, fax a letter to us or fill out a disenrollment form and send it to Member Services address on page 9 or to our fax number 1-888-289-3029. Be sure to sign and date your letter or form. To get a disenrollment form, call us at the Member Services telephone number on the cover of this booklet. Please do not write your request on your bill.
  - **To tell Medicare** you want to leave AmeriHealth 65 Plus, you can call **1-800-MEDICARE (1-800-633-4227)**, which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Whether you tell us or Medicare that you want to leave AmeriHealth 65 Plus, you will receive a letter telling you when your membership will end. This is your disenrollment date – the day you officially leave AmeriHealth 65 Plus. Your disenrollment date will be January 1. Remember, until January 1, you are still a member of AmeriHealth 65 Plus and must continue to get your medical care as usual through AmeriHealth 65 Plus.

Effective January 1, your membership in AmeriHealth 65 Plus ends and you should use your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will automatically be in Original Medicare when you leave AmeriHealth 65 Plus. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

## **WHAT ARE MY CHOICES, AND HOW DO I MAKE CHANGES, IF I LEAVE AMERIHEALTH 65 PLUS BETWEEN JANUARY 1 AND MARCH 31?**

Between January 1 and March 31 of every year, individuals who are enrolled in (or eligible for) Medicare Advantage Plans can make certain changes to their coverage. During this period, individuals are limited in the changes they can make. This period may not be used to add or drop Medicare prescription drug coverage. If plans are available in your area, and if they are accepting new members, you can make the following changes:

After March 31, you generally cannot change plans or discontinue your membership.

- As a member of a Medicare Advantage Plan with prescription drug coverage (MA-PD), between January 1 and March 31, you can only:
  - A. Switch to another Medicare Advantage Plan with prescription drug coverage (MA-PD) by enrolling in the new MA-PD plan; or
  - B. Switch to Original Medicare and a Prescription Drug Plan (PDP) by enrolling in the PDP.

- As a member of a Medicare Advantage Plan with no prescription drug coverage (MA-only), between January 1 and March 31, you can only:
  - A. Switch to another Medicare Advantage Plan with no prescription drug coverage (MA-only) by enrolling in the new MA-only plan; or
  - B. Switch to Original Medicare only by disenrolling from the MA-only plan. You cannot enroll in a PDP.

## **DO I NEED TO BUY A MEDIGAP (MEDICARE SUPPLEMENT INSURANCE) POLICY?**

If you want to change from AmeriHealth 65 Plus to Original Medicare, you should think about whether you want to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact the SHIP in your state (the phone number is in Section 1). You can ask the SHIP about how and when to buy a Medigap policy if you need one. The SHIP can tell you if you have a guaranteed right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, a Medigap insurer cannot refuse to sell you any policy you choose, or impose limits based on your health. You might also have a **“guaranteed issue right.”** This means that in certain circumstances, and for a limited period of time, a Medigap insurer must sell you a Medigap policy, even if you have health problems. In general, you do not have a guaranteed issue right if you simply decide to disenroll from AmeriHealth 65 Plus. However, for example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period. You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join AmeriHealth 65 Plus or another Medicare health plan for the first time; or (2) joined AmeriHealth 65 Plus or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. You may also have a guaranteed issue right if you move out of our service area. The SHIP can tell you about other situations where you may have guaranteed issue rights. If you do want to buy a Medigap policy, you have to follow the instructions below for changing from AmeriHealth 65 Plus to Original Medicare. (Buying a Medigap policy does not switch you from AmeriHealth 65 Plus to Original Medicare. In fact, while you are still enrolled in AmeriHealth 65 Plus it is against the law for a Medigap insurance company to sell you a policy. A Medigap salesperson or insurance agent cannot cancel your AmeriHealth 65 Plus membership and put you in Original Medicare.)

## **WHAT HAPPENS TO YOU IF AMERIHEALTH HMO, INC. LEAVES THE MEDICARE PROGRAM OR AMERIHEALTH 65 PLUS LEAVES THE AREA WHERE I LIVE?**

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in AmeriHealth 65 Plus will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through AmeriHealth 65 Plus until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another AmeriHealth HMO, Inc. plan, another Medicare Advantage Plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from AmeriHealth 65 Plus to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a “guaranteed issue right” and it is explained earlier in this section under the heading, “Do you need to buy a Medigap (Medicare supplement insurance) policy?”

AmeriHealth HMO, Inc. has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either AmeriHealth HMO, Inc. or CMS can decide to end it. You will get 90 days, advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

## **UNDER CERTAIN CONDITIONS AMERIHEALTH HMO, INC. CAN END YOUR MEMBERSHIP AND MAKE YOU LEAVE THE PLAN.**

### **Generally, we cannot ask you to leave the plan because of your health.**

Unless you are a member of a Medicare Advantage Special Needs Plan (SNP) for chronic conditions, we cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave AmeriHealth 65 Plus because of your health, you should call **1-800-MEDICARE (1-800-633-4227)**, which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

### **We can ask you to leave the plan under certain special conditions.**

If any of the following situations occur, we will end your membership in AmeriHealth HMO, Inc..

- **If you move out of the service area or are away from the service area for more than six months in a row.**
- If you do not stay continuously enrolled in both Medicare Part A and Medicare Part B.
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in AmeriHealth 65 Plus.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of AmeriHealth 65 Plus. We cannot make you leave AmeriHealth 65 Plus for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the inspector general for additional investigation.
- If you do not pay the plan premiums, we will tell you in writing that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave AmeriHealth 65 Plus.

## **YOU HAVE THE RIGHT TO MAKE A COMPLAINT IF WE ASK YOU TO LEAVE AMERIHEALTH HMO, INC.**

If we ask you to leave AmeriHealth 65 Plus, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

## SECTION 13—Legal Notices

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### **NOTICE ABOUT GOVERNING LAW**

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of New Jersey may apply.

### **NOTICE ABOUT NON-DISCRIMINATION**

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Managed Care Plans, like AmeriHealth 65 Plus, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

## SECTION 14—Definitions of some words used in this booklet

**FOR THE TERMS LISTED BELOW, THIS SECTION EITHER GIVES A DEFINITION OR DIRECTS YOU TO A PLACE IN THIS BOOKLET THAT EXPLAINS THE TERM**

**Ambulatory Surgical Facility**—A facility provider, with an organized staff of physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the carrier and which:

- A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an outpatient basis;
- B. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;
- C. does not provide inpatient accommodations; and
- D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional provider.

**AmeriHealth 65 Plus Provider Network**—A group of health care providers under contract with AmeriHealth HMO, Inc. that is licensed and/or certified by Medicare with the purpose of delivering or furnishing health care services.

**Ancillary Provider**—An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, durable medical equipment and ambulance services), for which benefits are provided under the plan.

**Annual Election Period**—November 15th to December 31st of every year is the annual election period for the following year. Organizations offering Medicare Advantage Plans in January of the following year must provide open enrollment to Medicare beneficiaries in November. During the annual election period, an individual eligible to enroll in a Medicare Advantage Plan may change his or her election from a Medicare Advantage Plan to Original Medicare, to a different Medicare Advantage Plan, or from Original Medicare to a Medicare Advantage Plan.

**Appeal**—A type of complaint you can make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Section 10 explain about appeals, including the process involved in making an appeal.

**Balance Billing**—Means charging or collecting from a Medicare beneficiary an amount in excess of the reimbursement rate for Medicare-Covered Services or supplies provided to a Medicare beneficiary except when Medicare is the secondary insurer. “Balance billing” does not include charging or collecting deductibles or coinsurance required by the plan.

**Basic Benefits**—All health care services that are covered under the Medicare Part A and Part B programs except hospice services and additional services that AmeriHealth HMO, Inc. uses Medicare funds to cover, and other services for which the member is required to pay a premium. All members of AmeriHealth 65 Plus receive all Basic Benefits.

**Benefit Period**—For both AmeriHealth 65 Plus and Original Medicare, a benefit period is used to

determine coverage for inpatient stays in skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or Skilled Nursing Facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 6 tells what is meant by skilled care.)
- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

**Brand-Name Drug**—A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand-name drug has expired.

**Calendar Year**—The period that begins on January 1 and ends twelve (12) consecutive months later, on December 31.

**Center for Health Dispute Resolution (CHDR)**—An independent CMS contractor that reviews appeals by members of Medicare Managed Care Plans, including AmeriHealth 65 Plus.

**Centers for Medicare & Medicaid Services (CMS)**—The federal agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

**Coinsurance**—A type of cost-share in which the member pays a percentage of the covered expense for covered services.

**Contract**—The agreement between AmeriHealth HMO, Inc. and the member, including the Evidence of Coverage and Disclosure Information, election form, schedules, riders and/or amendments, if any, and applicable premiums.

**Coordination of Benefits (COB)**—A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans or by Medicare, providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, that plan does not have to pay benefits first.

**Copayment**—A set amount that the member is responsible for on each office visit and is applied to a specific covered service. Copayments, if any, are identified in the Schedule of Copayments and Limitations.

**Cost Share**—A set amount that the member is responsible for on each office visit and is applied to a specific Covered Service. Cost shares, if any, are identified in the Schedule of Copayments and Limitations applicable to your current coverage.

**Coverage Determination**—The plan sponsor has made a coverage determination when it makes a decision about the prescription drug benefits you can receive under the plan, and the amount that you must pay for a drug.

**Covered Expense**—Refers to the basis on which a member's deductibles, coinsurance, benefit maximums and benefits are calculated.

- (a) For services rendered by a facility provider, the term “Covered Expense” may not refer to the actual amount(s) paid by AmeriHealth HMO, Inc. to the provider(s). Under AmeriHealth HMO, Inc. contracts, AmeriHealth HMO, Inc. pays facility providers using bulk purchasing arrangements that permit it to pay less for services and enable it to offer the plan-wide discount to all of its members and the AmeriHealth 65 Plus discount to its AmeriHealth 65 Plus members. The amount AmeriHealth HMO, Inc. pays at the time of any given claim may be more and it may be less than the amount used to calculate the member's liability. Rather, “covered expense” means the following:
- i. For services rendered by a plan (in-network) facility provider, “covered expense” means the facility provider's allowable charges for the covered services reduced by the AmeriHealth 65 Plus discount in effect at the time that the services are provided;
  - ii. For services provided by a non-plan (out-of-network) member facility provider that has a direct contractual arrangement with AmeriHealth HMO, Inc., “covered expense” means the facility provider's charges for the covered services reduced by the plan-wide discount in effect at the time that the services are rendered;
  - iii. For services rendered by non-plan (out-of-network) facility providers that have no contractual arrangement with AmeriHealth HMO, Inc., “covered expense” means the lesser of the: (1) facility provider's charges; (2) Medicare Allowed Amount; or (3) Reasonable and Customary charge for the covered services.
- (b) For services rendered by a professional provider, “covered expense” means the following:
- i. For a plan (in-network) professional provider—the rate of reimbursement for covered services the professional provider has agreed to accept as set forth by contract with the AmeriHealth 65 Plus network, or the charge, whichever is less;
  - ii. For a non-plan (out-of-network) professional provider that participates with Medicare—the lesser of actual charges or the Medicare Allowed Amount;
  - iii. For a non-plan (out-of-network) professional provider that does not participate with Medicare—the lesser of actual charges or the Medicare Allowed Amount, up to 115%.
- (c) For services rendered by ancillary providers, “covered expense” means the following:
- i. For services rendered by a plan (in-network) provider, “covered expense” means the amount that AmeriHealth HMO, Inc. has negotiated with the plan (in-network) provider as total reimbursement for the covered services;

- ii. For services rendered by a non-plan (out-of-network) Provider, “covered expense” means the lesser of the: (1) Provider’s charges; (2) Medicare Allowed Amount; or (3) Reasonable and Customary charge for the covered services.

(d) For services provided by pharmacies, “covered expense” means the following:

- i. For covered services provided by a plan (in-network) pharmacy means the amount that AmeriHealth HMO, Inc. has negotiated with the plan provider as total reimbursement for the covered prescription drug;
- ii. For covered services provided by a non-plan (out-of-network) pharmacy means the lesser of the non-plan pharmacy’s billed charges, or 150% of the average wholesale price for the same covered prescription drug.

**Covered Services**—The general term we use in this booklet to mean all of the health care services and supplies that are covered by AmeriHealth 65 Plus. Covered services are listed in the Benefits Chart in Section 4.

**Creditable Coverage**—Coverage that is at least as good as the standard Medicare prescription drug coverage.

**Custodial Care**—Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by AmeriHealth 65 Plus or Original Medicare unless provided with skilled nursing care and/or skilled rehabilitation services.

**Detoxification**—The process whereby an alcohol or drug intoxicated, or alcohol or drug dependent person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

**Dialysis**—Treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

**Disenroll or Disenrollment**—The process of ending your membership in AmeriHealth 65 Plus. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 12 tells about disenrollment.

**Durable Medical Equipment**—is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

**Effective Date of Coverage**—The date coverage begins for a member under this contract. All coverage begins at 12:01 A.M. on the date reflected on the records of AmeriHealth 65 Plus. The member will receive written notification of the effective date from AmeriHealth 65 Plus upon receipt of confirmation of eligibility from CMS.

**Emergency Care**—Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

**Emergency Medical Condition**—A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in: 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

**Evidence of Coverage**—This document, along with your enrollment form and any applicable riders, which explains the covered services, defines our obligations, and explains your rights and responsibilities as a member of AmeriHealth 65 Plus.

**Exception**—A type of coverage determination that, if approved, allows you to obtain a drug that is not on our formulary (a formulary exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if we require you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Exclusion**—Items or services that AmeriHealth 65 Plus does not cover. You are responsible for paying for excluded items or services as specified in Section 5.

**Experimental Procedures and Items**—Items and procedures determined by Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, AmeriHealth HMO, Inc. will follow the Centers for Medicare & Medicaid Services' manuals or will follow decisions already made by Medicare. With the exception of procedures and items under clinical trials, experimental procedures and items are not covered under this Evidence of Coverage.

**Facility Provider**—An institution or entity licensed, where required, to provide care.

Such facilities include:

- Ambulatory Surgical Facility
- Birthing Center
- Free-Standing Dialysis Facility
- Free-Standing Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Non-Hospital Facility
- Psychiatric Hospital
- Rehabilitation Hospital

- Residential Treatment Facility
- Short Procedure Unit

**Formulary**—A list of covered drugs provided by the plan.

**Generic Drug**—A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

**Grievance**—A type of complaint you make when your complaint would not be an appeal but you have any other type of problem either with us or with one of our plan providers. Section 9 explains about grievances.

**Home Health Agency**—A Medicare-certified agency that provides skilled nursing care and other therapeutic services in your home when medically necessary.

**Hospice**—A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

**Hospital**—A duly licensed Medicare-certified institution that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides custodial care, including training in routines of daily living.

**Hospital Services**—(Except as limited or excluded herein) Acute-care covered services furnished by a hospital which are prior authorized (approved in advance) by AmeriHealth HMO, Inc. and set forth in Section 4 (Benefits Chart).

**Identification Card**—The currently effective card issued to the member by AmeriHealth HMO, Inc. which must be presented when a covered service is requested.

**Incurred**—A charge shall be considered incurred on the date a covered person receives the service or supply for which the charge is made.

**Independent Practice Association (IPA)**—A partnership, association, or corporation that delivers or arranges for the delivery of health services and which has entered into a contract with health professionals, a majority of whom are licensed to practice medicine or osteopathy.

**Initial Decision**—In general, a decision by AmeriHealth 65 Plus or a person acting on behalf of AmeriHealth 65 Plus, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

**Inpatient Care**—Health care that you get when you are admitted to a hospital.

**Late Enrollment Penalty**—An amount added to your monthly premium for Medicare drug coverage if you don’t join a plan when you’re first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

**Letter of Coverage**—The document, that indicated the benefit Plan you have selected.

**Lifetime Maximum**—The maximum amount AmeriHealth HMO, Inc. will pay during the member’s lifetime for all periods of enrollment with AmeriHealth 65 Plus. This amount is measured by the actual amount AmeriHealth HMO, Inc. pays to the provider for covered expenses. It is not measured by the provider’s billed charges. Only actual amounts paid by AmeriHealth HMO, Inc. are applied to the Lifetime Maximum.

**Example:**

Lifetime Maximum on a Covered Service is	\$150.00
Billed Charges	\$100.00
Actual amount Paid to Provider	\$ 75.00

The member has used \$75.00 toward his Lifetime Maximum.

**Maximum**—A limit on the amount of covered services that a member may receive. The maximum may apply to all covered services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the covered expenses, less deductibles, coinsurance and copayment amounts paid by the member for the services to which the maximum applies. The maximum may not be measured by the actual amounts paid by AmeriHealth HMO, Inc. to the providers. A maximum may also be expressed in number of days or number of services for a specified period of time.

- A. Benefit Maximum—the greatest amount of a specific covered service that a member may receive in a Benefit Period.
- B. Lifetime Maximum—the greatest amount of covered services that a member may receive in the member’s lifetime.

**Medicaid**—A joint federal/state medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medicaid. Medicaid, unlike Medicare, can cover long-term care, such as custodial nursing home care. Medicaid can cover all or part of your Medicare premiums and/or deductibles and coinsurance, if your income and resources are low enough. You should inquire about Medicaid and related programs—Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, Qualified Individual—at your local Department of Social Services.

**Medically Necessary (Medical Necessity)**—The requirement that a covered service is recommended by the primary care physician or other participating provider, as applicable, and Independence’s Medical Director or physician designee determines that it is all of the following:

- A. It is a “health intervention.” A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a “medical condition” or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; or biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
- B. It is the most appropriate supply or level of service, considering the potential benefits and harms to the Beneficiary.

- C. It is known to be “effective” in improving health outcomes. Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status.
- D. It is cost effective for this condition compared to alternative interventions, including no intervention. Cost effective does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual beneficiary, the characteristics of the individual beneficiary shall be determinative.

An intervention may be medically indicated yet not be a covered service or meet this definition of medical necessity. An intervention is covered if: (a) it is a covered service: (b) it is not an excluded service, and (c) it is medically necessary.

**Medicare**—The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Organization**—A public or private organization licensed by the state as a risk-bearing entity that is under contract with CMS to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. AmeriHealth 65 Plus is a Medicare Advantage Organization.

**Medicare Advantage Plan**—A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the plan. A Medicare Advantage Organization may offer more than one plan in the same service area. AmeriHealth 65 Plus is a Medicare Advantage Plan.

**Medicare Part A**—Hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

**Medicare Part A Premium**—Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If you are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state, or local government employment to be insured, you do not have to pay a monthly premium. If you do not qualify for premium-free Part A Benefits, you may buy the coverage from Social Security if you are at least 65 years old and meet certain other requirements.

**Medicare Part B**—Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

**Medicare Part B Premium**—A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. The member must continue to pay this premium to Medicare to receive covered services whether you are covered by a Medicare Advantage Plan or by Original Medicare.

**Medicare Part D**—The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

**Medicare Prescription Drug Coverage**—Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies.

**“Medigap” (Medicare Supplement Insurance) Policy**—Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

**Member (Member of AmeriHealth 65 Plus, or “Plan Member”)**—A person with Medicare who is eligible to get covered services, who has enrolled in AmeriHealth 65 Plus, and whose enrollment has been confirmed by CMS.

**Member Facility Provider**—A facility provider that is not part of the AmeriHealth 65 Plus network but is approved by and has a contractual relationship with AmeriHealth HMO, Inc. for the provision of services to the member.

**Member Services**—A department within AmeriHealth 65 Plus responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

**Non-Hospital Facility**—A facility provider, licensed by the Department of Health for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities. Non-Hospital Facilities shall include, but not be limited to, residential treatment facilities and free-standing ambulatory care facilities for partial hospitalization Programs.

**Network Pharmacy**—A network pharmacy is a pharmacy where members of our plan can receive covered prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Non-Hospital Residential Treatment**—The provision of medical, nursing, counseling, or therapeutic services to patients suffering from substance abuse or dependency in a residential environment, according to individualized treatment plans.

**Non-Medicare Participating Provider**—A provider who does not participate with Medicare and therefore does not accept Medicare’s fee as payment in full.

**Non-Member Facility Provider**—A facility provider that does not have a contractual relationship with AmeriHealth HMO, Inc. for the provision of services to the member.

**Non-Plan Pharmacy**—A pharmacy that has not entered into a written agreement with or an agent of AmeriHealth HMO, Inc. to render covered services to members.

**Non-Plan (out-of-network) Provider or Non-Plan (out-of-network) Facility**—Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state or Medicare to deliver or furnish health care services. This type of provider is not employed, owned, operated by, or under contract with AmeriHealth HMO, Inc. to deliver covered services to you. As explained in this booklet, you may pay more if you see non-plan providers unless it is for an emergency. The organization will make a payment based on the lesser of the actual charges or the Medicare Allowed Amount.

**Non-Preferred Drug**—A drug that is included on our formulary, but not at the best possible cost sharing.

**Non-Preferred Network Pharmacy**—A network pharmacy that offers covered drugs to members of our plan at higher cost sharing levels than apply at a preferred network pharmacy.

**Occupational Therapy**—Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions that have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational therapy also includes medically prescribed treatment concerned with improving the subscriber's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed toward the improvement of vocational skills and social functioning.

**Office Visit**—A visit for covered services to a physician, specialist, or other Provider.

**Open Enrollment Period (OEP)**—A certain period of time when you can join a Medicare health plan. The plan must be open and accepting new members. If a health plan chooses to be open, it must allow all eligible beneficiaries to join.

**Organization Determination**—The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

**Original Medicare**—A plan that is available everywhere in the United States. Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *that accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).

**Out-of-Network Pharmacy**—A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Pocket Limit**—A specified dollar amount of coinsurance incurred by a member for covered services in a calendar year. Such expense does not include any deductible, penalties, inpatient or outpatient psychiatric care services, or copayment amounts. When the coinsurance out-of-pocket limit is reached, the level of benefits is increased to 100% for the remainder of the calendar year.

**Part D Drugs**—Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug.

**Plan (in-network) Hospital**—A hospital that has a contract with AmeriHealth HMO, Inc. to provide you covered services and/or supplies.

**Plan Mail-Order Pharmacy**—A pharmacy that is a member of the AmeriHealth 65 Plus network and has agreed to a rate of reimbursement determined by contract to provide members with mail-order prescription drug services.

**Plan (in-network) Medical Group**—Physicians organized as a legal entity to provide medical care. The plan medical group has an agreement with AmeriHealth HMO, Inc. to provide medical services to you.

**Plan Pharmacy**—A pharmacy that has an agreement to provide you the medication(s) prescribed by your provider.

**Plan Premium**—The monthly payment to AmeriHealth HMO, Inc. that entitles you to the covered services outlined in this Evidence of Coverage. (Note: To qualify for the services outlined in this EOC, you must also pay the monthly Medicare Part B Premium and, if applicable, Medicare Part A Premiums.)

**Plan (in-network ) Provider or Plan (in-network) Facility Provider**—“**Provider**” is the general term we use for doctors, other health care professionals, hospitals, and other Facility Providers that are licensed or certified by Medicare and by the state to provide health care services. We call them “**Plan (in-network) Providers**” when they are part of AmeriHealth 65 Plus. When we say that Plan (in-network) Providers are “part of AmeriHealth 65 Plus,” this means that we have arranged with them to coordinate or provide Covered Services to members of AmeriHealth 65 Plus. AmeriHealth 65 Plus pays Plan (in-network) Providers based on the contracts it has with the providers.

**Plan-Wide Discount**—AmeriHealth 65 Plus Plan-Wide Discount (“Plan-Wide Discount”)—The percentage reduction from allowable facility charges for covered services that AmeriHealth 65 Plus passes on to its AmeriHealth 65 Plus customers as a share of the savings AmeriHealth 65 Plus is expected to realize from its negotiated facility contracts with Plan (in-network) Facility Providers. The amount of the plan-wide discount prospectively may be changed from time to time.

**Preferred Network Pharmacy**—A network pharmacy that offers covered drugs to members of our plan at lower cost-sharing levels than apply at another network pharmacy.

**Prescription Drug**—Means drugs or medications:

1. which by law require a prescription order to dispense;
2. which are approved by the plan and approved for distribution by the federal government;
3. for which medical appropriateness/medical necessity exists; and
4. which have been approved by the Federal Food and Drug Administration and only for those uses for which they have specifically been approved by the Federal Food and Drug Administration.

**Prescription Drug Benefit Manager**—Companies that contract with Medicare Advantage Organizations to manage pharmacy services.

**Prescription Unit**—The maximum amount (quantity) of medication that may be dispensed per prescription for a single copayment. For most oral medications, the prescription unit represents a thirty (30)-day supply of medication. The prescription unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the prescription unit is set at a smaller quantity for your protection and safety.

**Primary Care Provider**—A health care professional who is trained to give you basic care. Your Provider is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about providers.

**Primary Care Services**—All medical care provided by providers as listed in the AmeriHealth 65 Plus Network directory under “primary care providers” (general practice or internal medicine), “obstetricians/gynecologists” and “pediatricians.”

**Prior Authorization (approval in advance)**—Approval in advance to get services. Some in-network services are covered only if your doctor or other plan provider gets “prior authorization” from AmeriHealth 65 Plus. Covered services that need prior authorization are marked in the Benefits Chart. Prior authorization is not required for out-of-network services. You do not need prior authorization to obtain out-of-network services. However, you may want to check with your plan before obtaining services out-of-network to confirm that the service is covered by your plan and what your cost share responsibility is. If your plan offers Part D drugs, certain drugs may require prior authorization. Check with your plan.

**Professional Provider**—A person or practitioner licensed where required and who performs services within the scope of such licensure. The professional providers are:

- Audiologist
- Certified Registered Nurse
- Chiropractor
- Clinical Laboratory
- Dentist
- Nurse Midwife
- Optometrist
- Osteopath
- Physical Therapist
- Physician
- Podiatrist
- Speech-Language Pathologist
- Teacher of the Hearing Impaired

**Quality Improvement Organization (QIO)**—Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 9 for information about making complaints (appeals or grievances) to the QIO.

**Reasonable and Customary**—Means the amount that is the usual or customary charge for the service or supply as determined by AmeriHealth HMO, Inc. The chosen standard is an amount that is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, AmeriHealth HMO, Inc. determines what is reasonable by the severity and/or complexity of the patient’s condition for which the service or supply is provided.

**Rehabilitation Hospital**—A licensed facility certified by Medicare that is primarily engaged in providing rehabilitation care on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

**Rehabilitation Services**—These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 6 for more information.

**Respiratory Therapy**—Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

**Rider**—A legal document that modifies the protection of this contract, either by expanding or defining benefits, or adding certain coverage or services to this contract.

**Service Area**—Section 2 tells about AmeriHealth 65 Plus' service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare health plan. This is the area within which you generally must get non-emergency and urgently needed services other than dialysis.

**Special Election Period (SEP)**—Special periods of time in which an enrollee can elect or discontinue enrollment in a Medicare Advantage Plan and change his/her enrollment to another Medicare Advantage Plan or return to Original Medicare. In the event of the following circumstances, a special election period is warranted: the Medicare Advantage Plan in which the member is enrolled is terminated; the enrollee moves out of the service area or continuation area of the Medicare Advantage Plan; the Medicare Advantage Organization offering the plan violated a material provision of its contract with the enrollee; or the enrollee meets such other material conditions as CMS may provide.

**Specialist**—A doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

**Speech Therapy**—Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

**State**—The State of New Jersey is responsible for licensing the managed care organization.

**Substance Abuse**—Any use of alcohol or other drugs that produces a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical intolerance of withdrawal.

**Substance Abuse Treatment Facility**—Facility licensed by the Department of Health that is primarily engaged in providing detoxification and rehabilitation treatment for substance abuse.

**Urgently Needed Care**—Section 3 explains about urgently needed services. These are different from emergency services.

## Section 15—Provider Reimbursement Information

### PAYMENT OF PROVIDERS

#### Network Provider Reimbursement

AmeriHealth 65 Plus reimbursement programs for plan (in-network) providers are intended to encourage the provision of quality, cost-effective care for AmeriHealth 65 Plus members. Set forth below is a general description of AmeriHealth 65 Plus' reimbursement programs, by type of plan (in-network) provider.

Please note that these programs may change from time to time, and the arrangements with particular plan (in-network) providers may be modified as new contracts are negotiated. If after reading this material you have any questions about how your health care provider is compensated, please speak with them directly or contact Member Services.

#### PHYSICIANS

AmeriHealth 65 Plus Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to our AmeriHealth 65 Plus fee schedule for the specific medical services that the physician performs.

#### INSTITUTIONAL PROVIDERS

**Hospitals:** For most inpatient medical and surgical services, hospitals are paid per diem rates, which are specific amounts paid for each day a covered person is in the hospital. These rates usually vary according to the intensity of the covered services provided. Some hospitals are also paid case rates, which are set dollar amounts paid for a complete hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most outpatient and emergency covered services and procedures, most hospitals are paid specific rates based on the type of covered service performed. Hospitals may also be paid a global rate for certain outpatient services (e.g., lab and radiology) that includes both the facility and the physician payment. For a few covered services, hospitals are paid based on a percentage of billed charges. Most hospitals are paid through a combination of the above payment mechanisms for various services.

Some hospitals participate in a quality incentive program. The program provides increased reimbursement to these hospitals when they meet specific quality and other criteria, including “patient safety measures.” Such patient safety measures are consistent with recommendations by The Leap Frog Group, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ) and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic submissions. This new incentive program is expected to evolve over time.

**Skilled Nursing Homes, Rehabilitation Hospitals, and Other Care Facilities:** Most skilled nursing facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a covered person is in the facility. These amounts may vary according to the intensity of the covered services provided.

**Ambulatory Surgical Centers (ASCs):** Most ASCs are paid specific rates based on the type of covered service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

## **PHYSICIAN GROUP PRACTICES, PHYSICIAN ASSOCIATIONS AND INTEGRATED DELIVERY SYSTEMS**

Certain physician group practices, Independent Physician Associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with individual physicians to provide medical services. These physician groups are paid on a fee-for-service basis for physician services. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

## **ANCILLARY SERVICE PROVIDERS**

Ancillary service providers, such as durable medical equipment providers, home health care agencies, mental health/substance abuse (“behavioral health”), and laboratories are paid on the basis of fee-for-service payments according to our AmeriHealth 65 Plus fee schedule for the specific Covered Services performed. In some cases, such as for behavioral health, one vendor arranges for all such services through a contracted network of providers. The contracted providers of these ancillary service vendors are then paid on a fee-for-service basis. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters. A subsidiary of AmeriHealth HMO, Inc. has a less than one percent ownership interest in this behavioral health management company.

## **PHARMACY**

A pharmacy benefits management company (PBM), which is an affiliate of the Plan, administers our HMO pharmacy benefits, provides a network of Plan Pharmacies and processes pharmacy claims. The PBM is paid an administrative fee for processing each pharmacy claim and providing other pharmacy related services. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. These rebates and discounts reduce the overall cost of pharmacy benefits.

## NOTES

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AmeriHealth HMO, Inc.