



AmeriHealth 65[®]

A Medicare Advantage HMO Plan from AmeriHealth HMO, Inc.

AmeriHealth 65 Prescription Drug Benefits Rider with Medicare Part D An Addendum to your Evidence of Coverage

Effective January 1, 2007
through December 31, 2007

1-800-645-3965
TTY/TDD: 1-888-857-4816
Seven days a week
8 a.m. — 8 p.m.

USING PLAN PHARMACIES TO GET YOUR OUTPATIENT PRESCRIPTION DRUGS COVERED BY US

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- **What is a “network pharmacy?”** A network pharmacy is a pharmacy at which you can get your 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. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.
- **What are “covered drugs?”** “Covered drugs” is the general term we use to mean all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described on page 3.

The pharmacy directory gives you a list of plan network pharmacies.

As a member of our plan you will get a pharmacy directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the pharmacy directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this plan's pharmacy network. In addition, you can find this information on our Web site at www.amerihealth65.com.

What if a pharmacy is no longer a “network pharmacy?”

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another plan network pharmacy. Please refer to your pharmacy directory or call Member Services to find another network pharmacy in your area.

How do I fill a prescription through the plan's network mail-order pharmacy service?

You can use our network mail-order pharmacy service to fill prescriptions for what we call “mail-order drugs.” These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Generally, it takes us 10-14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If we anticipate a delay in shipment of more than 10 days, for any reason, we will call you within 24 hours of receiving and logging the prescription. We will consult with you to help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local pharmacy.

You are not required to use our mail-order services to get an extended supply of mail-order drugs. You can also get an extended supply through some retail network pharmacies. Some retail pharmacies may agree to accept the mail-order copayment for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may provide an extended supply, but charge a higher copayment than our mail-order service. Please call our Member Services Department at 1-800-645-3965 TTY/TDD 1-888-857-4816 seven days a week 8 a.m. - 8 p.m. to find out which retail pharmacies offer an extended supply.

FILLING PRESCRIPTIONS OUTSIDE THE NETWORK

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Section 4 of the Evidence of Coverage booklet). To learn how to submit a paper claim, please refer to the paper claims process described on page 3.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If the prescriptions are related to care for a medical emergency or urgent care.
- If you are unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- Some covered drugs that are administered in your doctor's office.

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described on page 3.

Getting coverage when you travel or are away from the plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need.

If you are traveling within the U.S., but outside of the plan's service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described on page 3.

Before filling your prescription at an out-of-network pharmacy, call our Member Services Department to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Member Services Department may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Other times you can get your prescription covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy, when covered by your plan (these drugs include orphan drugs or other specialty pharmaceuticals).

Before you fill your prescription in either of these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described next.

HOW DO I SUBMIT A PAPER CLAIM?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. When you return home, simply submit a claim form and your receipt to the following address: FutureScripts Secure, P.O. Box 419019, Dept. #0382, Kansas City, MO, 64141. Please call Member Services for more information on paper claims or to request a form.

If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 12 of your Evidence of Coverage to learn more about requesting coverage determinations.

SPECIALTY PHARMACIES

Home infusion pharmacies

The plan will cover home infusion therapy if:

- Your prescription drug is on our plan's formulary or a formulary exception has been granted for your prescription drug,
- Our plan has approved your prescription for home infusion therapy,
- Your prescription is written by an authorized prescriber.

Note that we will cover only the cost of the prescription drugs and not the cost of other services and supplies associated with your home infusion therapy, such as nursing services and supplies.

Please refer to your pharmacy directory to find a home infusion pharmacy in your area. For more information, please contact Member Services.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please refer to your pharmacy directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Member Services.

Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies through the plan's pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g. emergencies). Please refer to your pharmacy directory to find an I/T/U pharmacy in your area. For more information, please contact Member Services.

WHAT DRUGS ARE COVERED BY THIS PLAN?

What is a formulary?

A formulary is a list of the drugs we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail-order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4 of the Evidence of Coverage booklet. As a person with Medicare you are also entitled to coverage of those drugs that are covered under Medicare Part A and B.

The drugs on the formulary are selected by our plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient formula as the 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.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions," on page 7, for more information about the types of drugs that cannot be covered under a Medicare prescription drug plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See page 2 for more information about filling prescriptions at out-of-network pharmacies.

How do you find out what drugs are on the formulary?

You may call Member Services to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance/copayment depends on which drug tier your drugs are in. The table on page 10 shows the coinsurance/copayment amount you pay for each tier when you are in your initial coverage level. (See “How much do you pay for drugs covered by this plan?” on page 9 for more information about the initial coverage level.)

You can ask us to make an exception to your drug’s tier placement. See “How can you request an exception to the plan’s formulary?” described on page 6.

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don’t notify you of the change in advance, you will get a 60-day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately.

Immediately after receiving the 60-day notice or 60-day supply, you should work with your physician to either switch to a drug we cover or request an exception (which is a type of coverage determination). If your physician determines that you need the drug that is being removed from our formulary and none of the drugs we cover are medically appropriate for you, you or your physician may request an exception. Similarly, if your physician determines that you are not able to meet a prior authorization, quantity limit, step therapy restriction, or other utilization management requirement for medical necessity reasons, you or your physician may request an exception. (See Section 12 for more information about how to request an exception.)

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Member Services to be sure it is not covered.

If Member Services confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services.
- You can ask us to make an exception for us to cover your drug. See the section, “How can you request an exception to the plan’s formulary?” on page 6 for more information.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by means of an exception request. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 11 of the Evidence of Coverage booklet for more information on how to request an appeal.

If you recently joined this plan and you learn that we do not cover a drug you were taking when you joined our plan, you may be able to get a one-time fill of that prescription. You can get a one-time fill of the non-covered drug if one of the following applies:

- You didn’t know that your drug wasn’t covered by this plan, or
- You knew it wasn’t covered but you didn’t know that you could request an exception to the plan’s formulary.

After your one-time fill, you can ask Member Services if we cover another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment. You can also file a request for an exception to our formulary. See the section, “How can you request an exception to the plan’s formulary?” below for more information.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment.

Transition Process

AmeriHealth 65 will grandfather members who are on a drug requiring prior authorization for 30 days. This should be an adequate time frame for beneficiaries to discuss alternatives with their physicians. Pharmacists will be instructed to contact the Pharmacy Services Department to request a one-time non-preferred copay exception for the member. The Pharmacy Services Department will follow up with the beneficiary’s physician to initiate a non-preferred exception form or offer formulary alternatives.

If you have any questions about our transition policy or need help asking for a formulary exception call member services at 1-800-645-3965.

How can you request an exception to the Plan’s formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a brand-Preferred or brand non-preferred drug, you can ask us to cover it as a generic drug instead. This would lower the copayment amount you must pay for your drug. Please note: if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan’s formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Please go to Section 11 of the Evidence of Coverage booklet, subsection “Detailed information about how to request a coverage determination and an appeal,” to learn more about requesting an exception. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision. Please see Section 11 of the Evidence of Coverage booklet for more information about how to request an appeal.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare drug plans. These drugs or categories of drugs are called “exclusions” and include:

- Non-prescription drugs
- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates
- Benzodiazepines (unless covered by your plan)
- Erectile Dysfunction Drugs

In addition, a prescription drug plan cannot cover a drug that is covered under Medicare Part A or Part B. See “How does your enrollment in this plan affect coverage for drugs covered under Medicare Part A or Part B?” on page 9.

For more information about catastrophic coverage, and out-of-pocket costs, see pages 10-15.

DRUG MANAGEMENT PROGRAMS

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that physicians will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See the section, “How can you request an exception to the plan’s formulary?” described on page 6 for more information.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors.
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition.
- Drugs that are inappropriate because of your age or gender.
- Possible harmful interactions between drugs you are taking.
- Drug allergies.
- Drug dosage errors.

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication Therapy Management Programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We offer a medication therapy management program(s) for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to get the program.

HOW DOES YOUR ENROLLMENT IN THIS PLAN AFFECT COVERAGE FOR THE DRUGS COVERED UNDER MEDICARE PART A OR PART B?

As a person with Medicare, you are entitled to coverage of those drugs that are covered under Medicare Parts A and B, and the drugs that are covered in your Medicare drug plan.

Your enrollment in AmeriHealth 65 does not affect Medicare coverage for drugs. You are entitled to all medically necessary A and B services including drugs that are covered under A and B. In addition, AmeriHealth 65 also covers your Part D benefit.

See your *Medicare & You Handbook* for more information about drugs that are covered by Medicare Part A and Part B.

SOME VACCINES AND DRUGS MAY BE ADMINISTERED IN YOUR DOCTOR'S OFFICE

We cover vaccines that are medically necessary and are covered by our plan but are not already covered by Medicare Part B. In addition, we cover some drugs that may be administered in your doctor's office. (Please see section above, "How does your enrollment in the plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

HOW MUCH DO YOU PAY FOR DRUGS COVERED BY THIS PLAN?

If you qualify for extra help with your Medicare prescription drug coverage your costs for your drugs may be different than those described below. See page 15, "Extra help with drug plan costs for people with limited income and resources" for those who get extra help paying for their prescription drugs.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., deductible, initial coverage level, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are described below.

PRESCRIPTION DRUG OPTION 2

Deductible

You, or others on your behalf, will have a yearly deductible of \$0.

Initial Coverage Level

During the initial coverage level, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the copayment. Your copayment will vary depending on the drug and where the prescription is filled.

Drug Tier	Retail Copayment/Coinsurance (30-day supply)	Retail Copayment/Coinsurance (90-day supply)	Mail-Order Copayment/Coinsurance (30-day supply)	Mail-Order Copayment/Coinsurance (90-day supply)	Out of Network Copayment/Coinsurance*
Generic	\$5 Copayment	\$15 Copayment	\$5 Copayment	\$10 Copayment	\$5 Copayment
Preferred Brand	\$30 Copayment	\$90 Copayment	\$30 Copayment	\$60 Copayment	\$50 Copayment
Non-Preferred Brand	\$50 Copayment	\$150 Copayment	\$50 Copayment	\$100 Copayment	\$50 Copayment

*Please note: If you choose to visit an out-of-network pharmacy when filling prescriptions, you will need to pay the entire cost of the drug and AmeriHealth 65 will reimburse you the full amount minus the applicable copayments.

Once your total drug costs reach \$2,200, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count toward your initial coverage limit.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count toward your initial coverage limit. To find out which drugs are not normally covered in a Medicare drug plan, contact Member Services.

Once your total drug costs reach \$2,200, you will reach the coverage gap.

Coverage Gap (after you reach your initial coverage limit and before you qualify for catastrophic coverage)

After your total drug cost reach \$2,200, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket cost reach \$3,850, and you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare prescription drug plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$3,850 out-of-pocket for the year. When the total amount you have paid toward your deductible (if applicable), copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$3,850, you will qualify for catastrophic coverage. During catastrophic coverage you will pay:

The greater of \$2.15 for generic drugs or preferred brand drugs that are a multi-source drug, and \$5.35 for all other drugs or 5% coinsurance. We will pay the rest.

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare drug plan. The amount you pay when you fill a prescription for these drugs does not count toward your deductible, initial coverage limit, or total out-of-pocket expenditure (that is, the amount you pay does not help you get catastrophic coverage).

HOW IS YOUR OUT-OF-POCKET COST CALCULATED?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy); and otherwise meets our coverage requirements:

- Your annual deductible (if applicable)
- Your coinsurance or copayments; payments you make after the initial coverage limit.

When you have spent a total of \$3,850 for these items, you will reach the catastrophic coverage level. (The amount you pay for your monthly premium does not count toward reaching the catastrophic coverage level.)

Purchases that will not count toward your out-of-pocket costs include:

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by the plan.

WHAT TYPE OF PRESCRIPTION DRUG PAYMENTS COUNT TOWARD YOUR OUT-OF-POCKET COSTS?

The following types of payments for prescription drugs will count toward your out-of-pocket costs:

- Coinsurance or copayments for prescription drugs that are normally covered by a Medicare drug plan.
- Coinsurance or copayments for prescription drugs that were not on our formulary, but were determined to count toward your out-of-pocket costs through the coverage determination, exception, or appeals process.
- Any coinsurance or copayments made at an out-of-network pharmacy in accordance with our out-of-network access rules.

Purchases that will not count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by the plan.
- Certain prescription drugs covered by us, but not normally covered in a Medicare drug plan.

WHO CAN PAY FOR YOUR PRESCRIPTION DRUGS, AND HOW DO THESE PAYMENTS APPLY TO YOUR OUT-OF-POCKET COSTS?

Except for your premium payments, any payments you make for covered Part D drugs count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group health plans;
- Insurance plans and government-funded health programs; and
- Third-party arrangements that obligate the third party to pay for prescription costs (e.g., TRICARE, workers' compensation).

If you have coverage from a third party that pays part (or all) of your out-of-pocket costs, you must disclose this information to us. An example of third-party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

We are responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf has purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to AmeriHealth 65. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

EXPLANATION OF BENEFITS

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you get during the month, as well as the amount paid for each prescription.
- Information about how to request an exception and appeal our coverage decisions.
- A description of changes to the formulary that will occur at least 60 days in the future.
- A summary of your coverage this year, including information about:
 - Annual Deductible**—the amount you and/or others pay before you start receiving prescription coverage.
 - Amount Paid for Prescriptions**—the amounts paid that count toward your initial coverage limit.
 - Out-Of-Pocket Payments After You Reach the Initial Coverage Limit**—the amount you and/or others make after you reach the initial coverage limit and before you qualify for catastrophic coverage.
 - Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage**—the total amount you and/or others have spent on prescription drugs that count toward your qualifying for catastrophic coverage. This total includes the amounts spent for your deductible, copayments and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy or other excluded parties.)

When will you get an Explanation of Benefits?

You will get an Explanation of Benefits in the mail each month that you use the coverage provided by us.

What should you do if you haven't received an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To obtain a copy, please contact Member Services.

HOW DOES YOUR PRESCRIPTION DRUG COVERAGE WORK IF YOU GO TO A HOSPITAL OR SKILLED NURSING FACILITY?

If you are admitted to a hospital for a Medicare-covered stay, AmeriHealth 65 will provide your prescription drugs under your medical benefit. Once you are released from the hospital, we will provide your prescription drugs under your outpatient drug benefit.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of-network care, and that the drug would not otherwise be covered by Medicare Part B coverage). When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. (Please see Section 13 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.)

IF YOU HAVE OTHER PRESCRIPTION DRUG COVERAGE

We will send you a AmeriHealth 65 Coordination of Benefits (COB) Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call the Member Services Department to update your membership records.

If you have Medicare and Medicaid

On January 1, 2006, your prescription drug coverage changed. AmeriHealth 65, not Medicaid, will pay for most of your prescription drugs.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your premiums, deductibles, and or copayments. Please contact your SPAP to determine what benefits are available to you.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare supplement (Medigap) policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. You cannot use it for out-of-pocket costs under the plan. You cannot change to another Medigap policy while you are in our plan, and if you decide to drop the policy you will not be able to get it back and in no case will you be able to get the prescription drug coverage under the policy. If you do, however, decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. You should have received a letter in the fall of 2006 from your Medigap issuer explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you do not receive this letter, please contact your Medigap issuer.

If you are a member of an employer or union group

If you currently have prescription drug coverage through your employer or union group, you should have received information from your employer or union group indicating whether or not your prescription drug coverage is creditable (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not receive this letter, please contact your benefits administrator to find out how your current prescription drug coverage will work with this plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or union group coverage.

EXTRA HELP WITH DRUG PLAN COSTS FOR PEOPLE WITH LIMITED INCOME AND RESOURCES

What extra help is available?

On January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription copayments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2. You apply and qualify. You may qualify if your yearly income is less than \$14,700 (single) or \$19,800 (married and living with your spouse), and your resources are less than \$11,500 (single) or \$23,000 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2006 and will change in 2007. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call **1-800-772-1213**, visit www.ssa.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will receive a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at **1-800-772-1213**, or visit www.ssa.gov on the Web. TTY/TDD users should call **1-800-325-0778**.

In addition, you can look at the 2007 Medicare & You Handbook, visit www.medicare.gov on the Web, or call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**.

If you have any questions about our plan, please refer to our Member Services numbers listed on the cover of this booklet. Or, visit www.amerihealth65.com.

WHAT IS THE LATE ENROLLMENT PENALTY?

You will have to pay a penalty in addition to your monthly plan premium if you do not enroll in a Medicare drug plan during your initial enrollment period and you do not have creditable coverage for a continuous period of 63 days or more after your initial enrollment period. Creditable prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. However, Medicare helps pay for the penalty for individuals who qualify for the most help. People who qualify for the most help will pay 20% of the penalty for the first 60 months and none of the penalty afterwards.

