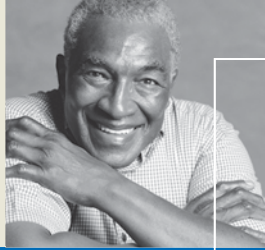


2007



See for yourself why AmeriHealth 65 Plus is a great way to get more from the Medicare benefits you have coming to you.

Summary of Benefits

Burlington, Camden, Cumberland, Gloucester, and Salem Counties

H3156

Effective January 1, 2007
through December 31, 2007

Introduction to the Summary of Benefits for AmeriHealth 65 Plus

January 1, 2007 - December 31, 2007

Burlington, Camden, Cumberland, Gloucester, and Salem Counties

Thank you for your interest in AmeriHealth 65 Plus. Our plan is offered by AmeriHealth HMO Inc, a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call AmeriHealth 65 and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like AmeriHealth 65 Plus. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call AmeriHealth 65 at the number listed at the end of this introduction or **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare AmeriHealth 65 Plus and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS AMERIHEALTH 65 PLUS AVAILABLE?

The service area for this plan includes the following counties: Burlington, Camden, Cumberland, Gloucester, and Salem, NJ. You must live in one of these places to join the plan. There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Member Services for more information.

WHO IS ELIGIBLE TO JOIN AMERIHEALTH 65 PLUS?

You can join AmeriHealth 65 Plus if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are not eligible to enroll in AmeriHealth 65 Plus.

CAN I CHOOSE MY DOCTORS?

AmeriHealth 65 Plus has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at www.amerihealth65.com. Our Member Services number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in- and/or out-of-network. For more information, please call the Member Services number at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

AmeriHealth 65 Plus Rx Option II plan covers both Medicare Part B and Part D prescription drugs. However, AmeriHealth 65 Plus medical only plan does not cover Medicare Part D drugs.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact AmeriHealth 65 for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs through DME.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

AmeriHealth 65 Plus has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at www.amerihealth65.com. Our Member Services number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

AmeriHealth 65 Plus uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.amerihealth65.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirement or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join AmeriHealth 65 Plus, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling **1-800-MEDICARE (1-800-633-4227)**, TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of AmeriHealth 65 Plus, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact AmeriHealth 65 for more details.

Please call AmeriHealth 65 Plus for more information about this plan.

Visit us at www.amerhealth65.com or, call us:

Member Services Hours

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m.
Eastern Standard Time

Current members should call **1-800-645-3965** for questions related to the Medicare Advantage program. **(TTY/TDD 1-888-857-4816)**

Prospective members should call **1-800-898-3492** for questions related to the Medicare Advantage program. **(TTY/TDD 1-877-219-5457)**

Current members should call **1-800-645-3965** for questions related to the Medicare Part D Prescription Drug program. **(TTY/TDD 1-888-857-4816)**

Prospective members should call **1-800-898-3492** for questions related to the Medicare Part D Prescription Drug program. **(TTY/TDD 1-877-219-5457)**

For more information about Medicare, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**.

TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the Web.

If you have special needs, this document may be available in other formats.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
------------------	-------------------	----------------------------------	----------------------------------

Important Information

Premium and Other Important Information

You pay the Medicare Part B premium of \$93.50 each month.

You pay \$86.00 each month for your plan benefits. You also continue to pay the Medicare Part B premium of \$93.50 each month.

You pay \$124.80 each month for your plan benefits. You also continue to pay the Medicare Part B premium of \$93.50 each month.

Most people will pay the standard monthly Part B premium. However, starting January 1, 2007, some people will have to pay a higher premium because of their yearly income (over \$80,000 for singles, \$160,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Most people will pay the standard monthly Part B premium. However, starting January 1, 2007, some people will have to pay a higher premium because of their yearly income (over \$80,000 for singles, \$160,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

There is a \$3,000 maximum out-of-pocket limit every year for the following plan services:

- Durable Medical Equipment
- Prosthetic Devices

There is a \$3,000 maximum out-of-pocket limit every year for the following plan services:

- Durable Medical Equipment
- Prosthetic Devices

Doctor and Hospital Choice (For more information, see Emergency and Urgently Needed Care.)

You may go to any doctor, specialist or hospital that accepts Medicare.

You do NOT need a referral to go to network doctors, specialists, and hospitals. A separate doctor office visit copayment may apply for certain services.

You do NOT need a referral to go to network doctors, specialists, and hospitals. A separate doctor office visit copayment may apply for certain services.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>You pay for each benefit period (3):</p> <ul style="list-style-type: none"> • Days 1-60: an initial deductible of \$992. • Days 61-90: \$248 each day. • Days 91-150: \$496 each lifetime reserve day. (4) <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (3)(4)</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$200 each day for day(s) 1 - 5 • \$0 each day for day(s) 6 - 90 for a Medicare-covered stay at a network hospital. <p>Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.</p> <p>There is a \$1000 maximum out of pocket limit every stay.</p> <p>You are covered for unlimited days each benefit period.</p> <p>Except in an emergency, your provider must obtain authorization from AmeriHealth 65.</p> <p>See page 24 for additional information on Inpatient Hospital Care and page 28 for more information on Hospital Tiering.</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$200 each day for day(s) 1 - 5 • \$0 each day for day(s) 6 - 90 for a Medicare-covered stay at a network hospital. <p>Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.</p> <p>There is a \$1000 maximum out of pocket limit every stay.</p> <p>You are covered for unlimited days each benefit period.</p> <p>Except in an emergency, your provider must obtain authorization from AmeriHealth 65.</p> <p>See page 24 for additional information on Inpatient Hospital Care and page 28 for more information on Hospital Tiering.</p>

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<p>Inpatient Mental Health Care</p>	<p>You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. (3)(4)</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$100 each day for day(s) 1 - 5 • \$0 each day for day(s) 6 - 90 for a Medicare-covered stay at a network hospital. <p>Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.</p> <p>There is a \$500 maximum out of pocket limit every stay.</p> <p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your provider must obtain authorization from AmeriHealth 65.</p> <p>See page 24 for additional information about Inpatient Mental Health Care.</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$100 each day for day(s) 1 - 5 • \$0 each day for day(s) 6 - 90 for a Medicare-covered stay at a network hospital. <p>Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.</p> <p>There is a \$500 maximum out of pocket limit every stay.</p> <p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your provider must obtain authorization from AmeriHealth 65.</p> <p>See page 24 for additional information about Inpatient Mental Health Care.</p>

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<p>Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 for each day. • Days 21 - 100: \$124 for each day. <p>There is a limit of 100 days for each benefit period. (3)(4)</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$25 each day for day(s) 1 - 100 for a stay at a Skilled Nursing Facility. <p>No prior hospital stay is required.</p> <p>You are covered for 100 days each benefit period. (3)</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$25 each day for day(s) 1 - 100 for a stay at a Skilled Nursing Facility. <p>No prior hospital stay is required.</p> <p>You are covered for 100 days each benefit period. (3)</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>
<p>Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>There is no copayment for all covered home health visits.</p>	<p>There is no copayment for Medicare-covered home health visits.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>	<p>There is no copayment for Medicare-covered home health visits.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Hospice	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must receive care from a Medicare-certified hospice.</p>	<p>You must receive care from a Medicare-certified hospice.</p>	<p>You must receive care from a Medicare-certified hospice.</p>
Outpatient Care			
Doctor Office Visits	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p> <p>See Physical Exams for more information.</p>	<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p> <p>See Physical Exams for more information.</p>
Chiropractic Services	<p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p>	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Podiatry Services	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>You pay \$25 for each Medicare-covered visit (medically necessary foot care).</p>	<p>You pay \$25 for each Medicare-covered visit (medically necessary foot care).</p>
Outpatient Mental Health Care	<p>You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)</p>	<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>	<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>
Outpatient Substance Abuse Care	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>For Medicare-covered services, you pay \$25 for each individual/group visit.</p> <p>Except in an emergency, your provider must obtain authorization from AmeriHealth 65.</p>	<p>For Medicare-covered services, you pay \$25 for each individual/group visit.</p> <p>Except in an emergency, your provider must obtain authorization from AmeriHealth 65.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Outpatient Services/ Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p>	<p>You pay \$75 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$150 for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>	<p>You pay \$75 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$150 for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>
Ambulance Services (medically necessary ambulance services)	<p>You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)</p>	<p>You pay \$50 for Medicare-covered ambulance services.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>	<p>You pay \$50 for Medicare-covered ambulance services.</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2)</p> <p>You pay 20% of doctor charges. (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> <p>See page 24 for additional information about Emergency Care.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> <p>See page 24 for additional information about Emergency Care.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<p>Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>You pay 20% of Medicare-approved amounts or applicable copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.</p>	<p>You pay \$15 to \$25 for each Medicare-covered urgently needed care visit. NOT covered outside the U.S. except under limited circumstances. See page 24 for additional information about Urgently Needed Care.</p>	<p>You pay \$15 to \$25 for each Medicare-covered urgently needed care visit. NOT covered outside the U.S. except under limited circumstances. See page 24 for additional information about Urgently Needed Care.</p>
<p>Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. Authorization rules may apply for services. Contact plan for details. See page 24 for additional information about Outpatient Rehabilitation Services.</p>	<p>You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. Authorization rules may apply for services. Contact plan for details. See page 24 for additional information about Outpatient Rehabilitation Services.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Outpatient Medical Services and Supplies			
Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.
Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.
Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Diabetes Self-Monitoring Training. There is no copayment for Diabetes supplies.	There is no copayment for Diabetes Self-Monitoring Training. There is no copayment for Diabetes supplies.
Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no copayment for Medicare-approved lab services.	There is no copayment for the following Medicare-covered service(s): <ul style="list-style-type: none">• clinical/diagnostic lab services• radiation therapy	There is no copayment for the following Medicare-covered service(s): <ul style="list-style-type: none">• clinical/diagnostic lab services• radiation therapy

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Diagnostic Tests, X-Rays, and Lab Services (continued)		You pay: • \$25 to \$50 for each Medicare-covered X-ray visit. Authorization rules may apply for services. Contact plan for details.	You pay: • \$25 to \$50 for each Medicare-covered X-ray visit. Authorization rules may apply for services. Contact plan for details.

Preventive Services

Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement. Authorization rules may apply for services. Contact plan for details.	There is no copayment for each Medicare-covered Bone Mass Measurement. Authorization rules may apply for services. Contact plan for details.
Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered Colorectal Screening Exams. See page 24 for additional information about Colorectal Screening Exams.	There is no copayment for Medicare-covered Colorectal Screening Exams. See page 24 for additional information about Colorectal Screening Exams.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<p>Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p>You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.</p>	<p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p>No referral necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>There is no copayment for the Hepatitis B vaccine.</p> <p>See page 24 for additional information about Immunizations.</p>	<p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p>No referral necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>There is no copayment for the Hepatitis B vaccine.</p> <p>See page 24 for additional information about Immunizations.</p>
<p>Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>You pay 20% of Medicare-approved amounts. (2)</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>There is no copayment for Medicare-covered Screening Mammograms.</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>There is no copayment for Medicare-covered Screening Mammograms.</p> <p>No referral necessary for Medicare-covered screenings.</p>
<p>Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2)</p> <p>You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)</p>	<p>You pay:</p> <ul style="list-style-type: none"> • \$0 for each Medicare-covered Pap Smear. • \$0 for each additional Pap Smear up to 1 Pap Smear(s) every year. • \$25 for each Medicare-covered Pelvic Exam. • \$25 for each additional Pelvic Exam up to 1 Pelvic Exam(s) every year. 	<p>You pay:</p> <ul style="list-style-type: none"> • \$0 for each Medicare-covered Pap Smear. • \$0 for each additional Pap Smear up to 1 Pap Smear(s) every year. • \$25 for each Medicare-covered Pelvic Exam. • \$25 for each additional Pelvic Exam up to 1 Pelvic Exam(s) every year.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)	There is no copayment for Medicare-covered Prostate Cancer Screening Exams.	There is no copayment for Medicare-covered Prostate Cancer Screening Exams.
Prescription Drugs	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program		
<i>Drugs covered under Medicare Part B (Original Medicare)</i>		You pay 100% for most prescription drugs. You pay \$0 to \$25 for Part B-covered drugs.	You pay \$0 to \$25 for Part B-covered drugs.
<i>Drugs covered under Medicare Part D (Prescription Drug Benefit)</i>		This plan does not cover Medicare Part D prescription drugs.	This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.amerihealth65.com . <i>(continued on next page)</i>

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<p><i>Drugs covered under Medicare Part D (Prescription Drug Benefit)</i> (continued)</p>			<p>People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs.</p> <p>Contact plan for details.</p> <p>See page 24 for additional information about Outpatient Prescription drugs.</p>
<p><i>Deductible</i></p>			<p>There is no deductible.</p>
<p><i>Initial Coverage</i></p>			<p>Before the total yearly drug costs (paid by both you and your plan) reach \$2,200, you pay the following for prescription drugs:</p>
<p><i>In-Network Retail Pharmacy</i></p>			<ul style="list-style-type: none"> • \$5 for a one month (30 day) supply of Tier 1 - Generic drugs. • \$30 for a one month (30 day) supply of Tier 2 - Preferred Brand drugs. • \$50 for a one month (30 day) supply of Tier 3 - Non-Preferred Brand drugs. • \$15 for a three month (90 day) supply of Tier 1 - Generic drugs. • \$90 for a three month (90 day) supply of Tier 2 - Preferred Brand drugs.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<i>In-Network Retail Pharmacy</i> (continued)			<ul style="list-style-type: none"> • \$150 for a three month (90 day) supply of Tier 3 - Non-Preferred Brand drugs.
<i>Mail Order</i>			<ul style="list-style-type: none"> • \$10 for a three month (90 day) supply of Tier 1 - Generic drugs. • \$60 for a three month (90 day) supply of Tier 2 - Preferred Brand drugs. • \$100 for a three month (90 day) supply of Tier 3 - Non-Preferred Brand drugs.
<i>Coverage After You Reach Your Initial Coverage Limit</i>			<p>After the total yearly drug costs (paid by both you and your plan) reach \$2,200, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach \$3,850.</p>
<i>Catastrophic Coverage</i>			<p>After your yearly out-of-pocket drug costs reach \$3,850, you pay:</p> <ul style="list-style-type: none"> • greater of \$2.15 or 5% coinsurance for Tier 1 - Generic drugs. • greater of \$5.35 or 5% coinsurance for Tier 2 - Preferred Brand drugs. • greater of \$5.35 or 5% coinsurance for Tier 3 - Non-Preferred Brand drugs.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<i>General Information</i>		Please contact the plan for details.	Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from AmeriHealth 65 Plus for certain prescription drugs. 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. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact the plan for details.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
General Information			
Dental Services	In general, you pay 100% for preventive dental services.	<p>You pay:</p> <ul style="list-style-type: none"> • \$10 for an Office Visit that includes the following services: • oral exams up to 1 visit(s) every six months. • cleanings up to 1 visit(s) every six months. 	<p>You pay:</p> <ul style="list-style-type: none"> • \$10 for an Office Visit that includes the following services: • oral exams up to 1 visit(s) every six months. • cleanings up to 1 visit(s) every six months.
Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)</p>	<p>There is no copayment for hearing aids up to 1 aid(s) every three years.</p> <p>You pay:</p> <ul style="list-style-type: none"> • \$25 for each Medicare-covered hearing exam (diagnostic hearing exams). • \$25 for each routine hearing test up to 1 test(s) every three years. • \$25 for each fitting-evaluation for a hearing aid up to 1 fitting(s)-evaluation(s) every three years. <p>You are covered up to \$500 for hearing aids every three years.</p>	<p>There is no copayment for hearing aids up to 1 aid(s) every three years.</p> <p>You pay:</p> <ul style="list-style-type: none"> • \$25 for each Medicare-covered hearing exam (diagnostic hearing exams). • \$25 for each routine hearing test up to 1 test(s) every three years. • \$25 for each fitting-evaluation for a hearing aid up to 1 fitting(s)-evaluation(s) every three years. <p>You are covered up to \$500 for hearing aids every three years.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no copayment for the following items:</p> <ul style="list-style-type: none"> • Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). • Glasses, limited to 1 pair(s) of glasses every two years. • Contacts, limited to 1 pair(s) of contacts every two years. • Lenses, limited to 1 pair(s) of lenses every two years. • Frames, limited to 1 frame(s) every two years. <p>You pay:</p> <ul style="list-style-type: none"> • \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). • \$25 for each Routine eye exam, limited to 1 exam(s) every two years. <p>You are covered up to \$100 for eye wear every two years.</p>	<p>There is no copayment for the following items:</p> <ul style="list-style-type: none"> • Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). • Glasses, limited to 1 pair(s) of glasses every two years. • Contacts, limited to 1 pair(s) of contacts every two years. • Lenses, limited to 1 pair(s) of lenses every two years. • Frames, limited to 1 frame(s) every two years. <p>You pay:</p> <ul style="list-style-type: none"> • \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). • \$25 for each Routine eye exam, limited to 1 exam(s) every two years. <p>You are covered up to \$100 for eye wear every two years.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Physical Exams	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests.</p> <p>Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount.(1)(2)</p>	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests.</p> <p>Please contact your plan for further details.</p> <p>There is no copayment for routine physical exams.</p> <p>You are covered up to 1 exam(s) every year.</p>	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests.</p> <p>Please contact your plan for further details.</p> <p>There is no copayment for routine physical exams.</p> <p>You are covered up to 1 exam(s) every year.</p>
Health/Wellness Education	<p>You pay 100%.</p>	<p>You are covered for the following:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletter • Nutritional Training • Smoking Cessation • Health Club Membership/ Fitness Classes • Other Wellness Services <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p> <p>See page 27 for additional information about Health/Wellness Education.</p>	<p>You are covered for the following:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletter • Nutritional Training • Smoking Cessation • Health Club Membership/ Fitness Classes • Other Wellness Services <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p> <p>See page 27 for additional information about Health/Wellness Education.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Summary of Benefits

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
Point of Service		<p>Point of Service is available for the following benefits:</p> <ul style="list-style-type: none"> • Inpatient Hospital Care • Inpatient Mental Health Care • Skilled Nursing Facility • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Mental Health Care • Outpatient Substance Abuse Care • Outpatient Services/ Surgery • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays, and Lab Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) 	<p>Point of Service is available for the following benefits:</p> <ul style="list-style-type: none"> • Inpatient Hospital Care • Inpatient Mental Health Care • Skilled Nursing Facility • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Mental Health Care • Outpatient Substance Abuse Care • Outpatient Services/ Surgery • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays, and Lab Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) <p style="text-align: right;"><i>(continued on next page)</i></p>

If you have any questions about these plans' benefits or costs, please contact AmeriHealth 65 Plus.

Benefit Category	Original Medicare	AmeriHealth 65 Plus Medical Only	AmeriHealth 65 Plus Rx Option II
<p>Point of Service (continued)</p>		<ul style="list-style-type: none"> • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Dental Services • Hearing Services • Vision Services • Physical Exams • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Other Health Care Professional Services • Cardiac Rehabilitation Services • Outpatient Blood <p>Authorization rules may apply for services. Contact plan for details. You pay 30% of the cost for each stay at a non-network hospital. You pay 30% of the cost for each stay at a non-network Inpatient Psychiatric Hospital.</p>	<ul style="list-style-type: none"> • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Dental Services • Hearing Services • Vision Services • Physical Exams • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Other Health Care Professional Services • Cardiac Rehabilitation Services • Outpatient Blood <p>Authorization rules may apply for services. Contact plan for details. You pay 30% of the cost for each stay at a non-network hospital. You pay 30% of the cost for each stay at a non-network Inpatient Psychiatric Hospital.</p>

Here's what you'll find in the following section:

- *Expanded information about benefits*
- *Easy-to-understand details about Part D, Medicare's prescription drug benefit*
- *Health and Wellness Education information*
- *... and more!*

I. BENEFITS INFORMATION

Additional Information on Inpatient Hospital Care and Inpatient Mental Health Care (...from pages 5-6)

Treatment in a Substance Abuse Treatment Facility: A 90-day lifetime maximum applies to inpatient substance abuse treatment received in a substance abuse treatment facility. This benefit is separate from any substance abuse services received in an inpatient hospital.

Treatment in a Psychiatric Hospital: Substance abuse treatment received in a psychiatric hospital will count toward the 190-day lifetime maximum for inpatient mental health.

Additional Information on Emergency Care and Urgently Needed Care (...from pages 10-11)

Urgent and emergency services received outside the United States (except under limited circumstances) are subject to out-of-network coinsurance.

Additional Information on Outpatient Rehabilitation Services (...from page 11)

Physical therapy and occupational therapy require a referral and prior authorization (approval in advance) if not performed at a capitated site*.

Cardiac rehabilitation therapy is 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.

Speech therapy and cardiac rehabilitation require prior authorization (approval in advance) to be covered.

*Please refer to page 29 for a definition of capitated site.

Additional Information on Colorectal Screening Exams (...from page 13)

If a colonoscopy is performed in an outpatient hospital setting, the outpatient hospital facility cost-sharing applies.

Additional Information on Immunizations (...from page 14)

Immunizations are not covered for the purpose of travel.

Additional Information on Outpatient Prescription Drugs (...from pages 15-18)

MEDICARE PART D

Medicare Part D officially began on January 1, 2006. Part D is Medicare's way of guaranteeing that every beneficiary has access to prescription drug coverage. AmeriHealth 65 Plus Rx Option II includes prescription drug coverage, while AmeriHealth 65 Plus Medical Only does not.

Part D also gives low-income beneficiaries access to comprehensive coverage with low cost sharing. See the next section for more information about this extra help, which is called the low-income subsidy.

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

If you are a member and have questions, please call Member Services at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** Monday–Sunday from 8 a.m. to 8 p.m.

If you are not yet a member and would like to enroll and/or have additional questions, please call **1-800-898-3492 (TTY/TDD: 1-877-219-5457)** Monday–Sunday from 8 a.m. to 8 p.m.

WHAT IS A FORMULARY?

A formulary is a list of U.S. Food and Drug Administration (FDA)-approved prescription medications selected by AmeriHealth 65 Plus in consultation with a team of health care providers (the Pharmacy and Therapeutics Committee), which represents the prescription therapies believed to be a necessary part of a quality treatment program. AmeriHealth 65 Plus will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an AmeriHealth 65 Plus network pharmacy, and other plan rules are followed.

HOW CAN I SAVE MONEY ON PRESCRIPTION DRUG COSTS?

Ask your doctor to prescribe a generic drug in place of a brand-name drug. Generic drugs are sold under generic, often unfamiliar, names, but by law, they must have the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. More generic drugs are approved each year and become available for those who need them.

WHAT TYPES OF DRUGS ARE COVERED UNDER PART D?

Any drug that may have been covered by AmeriHealth 65 Plus in the past under your medical benefit (although not covered by Medicare) is required by Medicare to be covered under your Part D benefit. In addition, injectable drugs that are “usually self-administered” (Intron-A, for instance) are required to be covered under your Part D benefit.

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

COVERED INJECTABLES

The following covered injectables are subject to a copay of \$25: Lupron, Zoladex, and Trelstar.

WHAT IS THE MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

We offer Medication Therapy Management (MTM) 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.

II. LOW-INCOME SUBSIDY: EXTRA HELP IS AVAILABLE FOR THOSE WHO NEED IT MOST

If you need help paying for Part D prescription drug coverage, the federal government offers three separate levels of assistance. Depending on your level of need, your deductibles and premiums may be reduced or even eliminated. In addition, your coinsurance and copayments may also be reduced.

Your level of need is determined by such factors as your annual income (specifically as it relates to the federal poverty level) and your assets. For more detailed information about the low-income subsidy, you should contact **1-800-MEDICARE**, 24 hours a day, 7 days a week (TTY/TDD users should call **1-877-486-2048**). You can also call the Social Security Administration, at 1-800-772-1213 (TTY/TDD: 1-800-325-0778) or visit www.socialsecurity.gov on the Web.

Low-Income Subsidy Groups and Costs

Requirements and Costs	Group 1: Eligible for Medicare and Medicaid		Group 2**: Medicare Savings Programs or Federal Poverty Level Income Requirements	Group 3: Federal Poverty Level Income Requirements
Income (single)	Less than \$9,570A	Greater than \$9,570B	Less than \$12,920C	Less than \$14,355D
Income (married)	Less than \$12,830A	Greater than \$12,830B	Less than \$17,321C	Less than \$19,245D
Resources*** (single)	N/A	N/A	Less than \$6,000	Less than \$10,000
Resources (married)	N/A	N/A	Less than \$9,000	Less than \$20,000
Premium	\$0	\$0	\$0	Sliding scaleE
Deductible	\$0	\$0	\$0	\$53
Cost-sharing – Up to \$3,850 out-of-pocket (no gap in coverage)	\$1.00/\$3.10 (generic/brand name)	\$2.15/\$5.35 (generic/brand name)	\$2.15/\$5.35 (generic/brand name)	15% coinsurance
Cost-sharing – After member spends \$3,850 out-of-pocket (catastrophic coverage)	\$0	\$0	\$0	\$2.15/\$5.35 (generic/brand name)

A Income less than or equal to 100% FPL (Federal Poverty Level. Income limits are subject to change as of April 1 of each year.)

B Income greater than 100% FPL

C Income less than or equal to 135% FPL

D Income less than or equal to 150% FPL

E Members with income 135%–140% FPL pay 25% of premium; members with income 140%–145% FPL pay 50% of premium; members with income 145%–150% pay 75% of premium.

** Medicare Savings Program (QMB=Qualified Medicare Beneficiary; SLMB= Specified Limited Income Beneficiary; Q1-1=Qualifying Individuals)

***Resources include your savings and investments

III. HEALTH AND WELLNESS

Additional Information on Health and Wellness Education (...from page 21)

HEALTHY LIFESTYLESSM

Live Healthy!

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 back up to \$150 of your fitness center fees when you complete 120 workouts within a year.

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! You can get up to \$200 back when you finish a smoking cessation program. If you choose a smoking cessation program that costs less than \$200, you can apply the difference toward the purchase of nicotine replacement products or other prescription smoking cessation aids.

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

*These programs require enrollment.

¹ Weight Watchers[®] 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. Remember: as an AmeriHealth 65 Plus member, you have open access to OB/GYN providers, which means that you do not need a referral to see an OB/GYN provider for preventive care.

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 ConnectionsSM 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.

Connections provides:

- Access to a Health Coach to talk to anytime, day or night, 24 hours a day, 7 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 at **1-800-275-2583 (TTY/TDD: 1-888-857-4816)** 24 hours a day, 7 days a week and see how we can help you.

IV. ADDITIONAL INFORMATION ABOUT AMERIHEALTH 65 PLUS

Open Access Care (Point-of-Service)

AmeriHealth 65 Plus gives members the opportunity to access care without a referral for most covered services.

As an AmeriHealth 65 Plus member, you must select a primary care physician (PCP) from the AmeriHealth 65 Plus provider directory. However, with AmeriHealth 65 Plus, you also can 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.

In addition, AmeriHealth 65 Plus members can receive most covered services from any out-of-network physician or hospital that accepts Medicare, and AmeriHealth 65 Plus will pay up to 70 percent of the Medicare allowed amount. After that, you will be responsible for paying the remaining balance of 30 percent.

For out-of-network services that require prior authorization, please call **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** Monday–Sunday from 8 a.m. to 8 p.m.

Hospital Tiering

In 2006, AmeriHealth 65 Plus introduced a new way to access care. As an AmeriHealth 65 Plus plan member, you have access to all hospitals in our provider network.

However, by receiving services at a Tier I hospital, you can significantly lower your out-of-pocket costs for inpatient hospital stays and outpatient surgery. Your copay will be \$150 per day, with a \$1,500 out-of-pocket maximum per hospital stay. If you receive services from a Tier II hospital, you will be responsible for a \$200 copay per day with a \$1,000 out-of-pocket maximum per hospital stay.

Check the enclosed insert for a complete list of AmeriHealth 65 Plus Tier 1 hospitals in your area.

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

V. ENROLLMENT DATES

There are limits to when and how often you can change the way you get your Medicare coverage. If you switch from one plan to one of the other plans we offer, or to a plan offered by another organization, that counts toward making a change.

1. **From November 15, 2006 through December 31, 2006**, anyone with Medicare will have an opportunity to switch from one way of getting Medicare to another.
2. **From January 1, 2007 until March 31, 2007**, anyone with Medicare has another chance to make a change in the way you get Medicare. However, during this period, you are limited in the type of plan you can join. You can't add or drop Medicare prescription drug coverage during this time. For example, if you don't have Medicare prescription drug coverage when you make this change, you can only choose to join another plan that doesn't offer Medicare prescription drug coverage, or you can choose to return to the Original Medicare plan without prescription drug coverage. If you have Medicare prescription drug coverage, you can't use this chance to drop it.
3. Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move out of the plan's service area or if you have Medicaid coverage in addition to your Medicare coverage. Later in the year, from November 15, 2007 through December 31, 2007, you will again be able to change your Medicare plan for the following year (2008).

VI. SOME HELPFUL DEFINITIONS

AmeriHealth 65 Plus offers plans with varying premiums and levels of cost share. You should consider cost when you decide which plan best meets your needs. It's important for you to understand the various types of cost share associated with our plans.

Capitated Site—In some cases, PCPs are required to choose one particular provider for specialty services for members in the PCP's practice. These plan specialists may be paid on a capitated basis, which means that the Plan specialist receives a set dollar amount per member, per month for services such as radiology, laboratory, Physical and Occupational Therapy, and podiatry. If you are referred for any of these services (or other services that are capitated), you will be required to use the particular provider (including sites) that your PCP chooses.

Copay—A set dollar amount that a member is responsible for that is applied to a specific covered service. An example of a copay is the \$15 you pay each time you see your primary care physician (PCP).

Deductible—A specific dollar amount the member is responsible for before the plan will assume any responsibility.

Medicare Allowed Amount—The amount Medicare determines to be the maximum amount allowable. Out-of-network providers may not charge more than the Medicare Allowed Amount.

CALL US

Thank you for taking the time to read this Summary of Benefits carefully. We've given you a lot of information at once, so please feel free to call our Member Services Department if you have any questions. You can reach us Monday–Sunday from 8 a.m. to 8 p.m., at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)**.

We are please to provide your health care coverage. We value your membership in AmeriHealth 65 Plus, and look forward to serving you now and in the future!



If you are a **member** and have questions,
please call **Toll Free 1-800-645-3965**
(TTY/TDD: 1-888-857-4816)

Monday—Sunday 8:00am to 8:00pm.

If you are **not yet a member** and have questions,
please call **1-800-898-3492 (TTY/TDD: 1-877-219-5457)**

Monday—Sunday 8:00am to 8:00pm.



AmeriHealth®

1901 Market Street • Philadelphia, PA • 19103-1480

AmeriHealth HMO, Inc.