

2008


AmeriHealth 65 Basic
A Medicare Advantage Special Needs Plan from AmeriHealth HMO, Inc.



Effective
January 1, 2008
through
December 31, 2008

Summary of Benefits

AmeriHealth 65 Basic

Berks, Lancaster, Lehigh,
Northampton, and York Counties

H3112


AmeriHealth 65

Introduction to the Summary of Benefits for AmeriHealth 65 Basic

January 1, 2008 - December 31, 2008

Berks, Lancaster, Lehigh, Northampton, and York Counties

Thank you for your interest in AmeriHealth 65 Basic. Our plan is offered by AmeriHealth HMO, Inc., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

This includes anyone who receives medical assistance from the state and Medicare.

All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility.

Please call AmeriHealth 65 Basic to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call AmeriHealth 65 Basic 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 Basic. 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 Basic at the telephone 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 Basic 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 BASIC AVAILABLE?

The service area for this plan includes: Berks, Lancaster, Lehigh, Northampton, and York Counties, PA. You must live in one of these places to join the plan.

WHO IS ELIGIBLE TO JOIN AMERIHEALTH 65 BASIC?

You can join AmeriHealth 65 Basic if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

You must also receive medical assistance from the state to join this plan.

Please call plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

AmeriHealth 65 Basic has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part 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?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither AmeriHealth 65 nor the Original Medicare Plan will pay for these services.

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

AmeriHealth 65 Basic does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

AmeriHealth 65 Basic 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 Basic uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or 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 requirements 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 Basic, 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 Basic, 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 Basic for more details.

Please call AmeriHealth 65 for more information about this plan.

Visit us at www.amerihealth65.com or, call us:

Member Services Hours:

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

Current members should call **1-888-457-3018** 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 **1-888-457-3018** 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 this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
------------------	-------------------	----------------------

Important Information

Premium and Other Important Information

\$96.40 monthly Medicare Part B Premium.
 \$135.00 yearly Medicare Part B deductible.
 If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.

General

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

\$0 monthly plan premium in addition to your \$96.40 monthly Medicare Part B premium.

In-Network

\$0 yearly deductible.

Out-of-Network

Unless otherwise noted, out-of-network services not covered.

In- and Out-of-Network

\$0 yearly deductible.

See page 16 for more information.

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.

In-Network

You must go to network doctors, specialists, and hospitals.

Referral required for network specialists (for certain benefits).

You may have to pay a separate copay for certain doctor office visits.

Inpatient Care

Inpatient Hospital Care

(includes Substance Abuse and Rehabilitation Services)

For each benefit period:

Days 1 - 60: \$1,024 deductible

Days 61 - 90: \$256 per day

Days 91 - 150: \$512 per lifetime reserve day

Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.

Lifetime reserve days can only be used once.

In-Network

\$0 yearly deductible.*

\$0 copay*

Plan covers 90 days each benefit period.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
<p>Inpatient Hospital Care <i>(continued)</i></p>	<p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. 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.</p>	<p>See page 17 for more information.</p>
<p>Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above). 190 day limit in a Psychiatric Hospital.</p>	<p><i>In-Network</i> Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care”). \$0 yearly deductible.* \$0 copay* You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. See page 17 for more information.</p>
<p>Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>For each benefit period after at least 3-day covered hospital stay: Days 1 - 20: \$0 per day Days 21 - 100: \$128 per day 100 days for each benefit period. A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.</p>	<p><i>General</i> Prior authorization is required. <i>In-Network</i> \$0 yearly deductible.* \$0 copay for SNF services.* 100 days covered for each benefit period. No prior hospital stay is required.</p>

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Skilled Nursing Facility <i>(continued)</i>	You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.
Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	In-Network You must get care from a Medicare-certified hospice.
Outpatient Care		
Doctor Office Visits	20% coinsurance	General See "Routine Physical Exams" for more information. In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.* \$0 copay for each specialist/doctor visit for Medicare-covered benefits.*
Chiropractic Services	20% coinsurance Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider.	In-Network \$0 copay for Medicare-covered visits.* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Podiatry Services	20% coinsurance Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<i>In-Network</i> \$0 copay for Medicare-covered podiatry visit.* \$0 copay for up to 4 routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care.
Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.	<i>General</i> Authorization rules may apply. <i>In-Network</i> \$0 copay for Medicare-covered Mental Health visit.* \$0 copay for each Medicare-covered visit with a psychiatrist.*
Outpatient Substance Abuse Care	20% coinsurance	<i>General</i> Authorization rules may apply. <i>In-Network</i> \$0 copay for Medicare-covered visits.*
Outpatient Services/Surgery	20% coinsurance for the doctor. 20% of outpatient facility.	<i>General</i> Authorization rules may apply. <i>In-Network</i> \$0 copay for each Medicare-covered ambulatory surgical center visit.* \$0 copay for each Medicare-covered outpatient hospital facility visit.*
Ambulance Services (medically necessary ambulance services)	20% coinsurance	<i>General</i> Authorization rules may apply. <i>In-Network</i> \$0 copay for Medicare-covered ambulance benefits.*

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
<p>Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered emergency room visits.*</p> <p><i>Out-of-Network</i> Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p>
<p>Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.</p>	<p><i>General</i> \$0 copay for Medicare-covered Urgently Needed Care visits.*</p>
<p>Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered Occupational Therapy visits.* \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.* See page 17 for more information.</p>
<p><i>Outpatient Medical Services and Supplies</i></p>		
<p>Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> \$0 copay for Medicare-covered items.*</p>

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
<p>Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered items.*</p>
<p>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance</p>	<p>In-Network \$0 copay for Diabetes Self-Monitoring Training.* \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.*</p>
<p>Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for Diagnostic Tests and X-rays. \$0 copay for Medicare-covered Lab Services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests - X-rays* - diagnostic radiology services (not including X-rays)* - therapeutic radiology services*

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Preventive Services		
Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<i>In-Network</i> \$0 copay for Medicare-covered Bone Mass Measurement.
Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	<i>In-Network</i> \$0 copay for Medicare-covered colorectal screenings.
Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<i>In-Network</i> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. See page 17 for more information.
Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	<i>In-Network</i> \$0 copay for Medicare-covered screening mammograms.
Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap Smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams.	<i>In-Network</i> \$0 copay for Medicare-covered Pap Smears and Pelvic Exams and - up to 1 additional Pap Smear(s) and Pelvic Exam(s) every year

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
<p>Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered prostate cancer screening.</p>
<p>ESRD</p>	<p>20% coinsurance for dialysis.</p>	<p><i>General</i> Authorization rules may apply. Out-of-area Renal Dialysis services do not require Authorization. <i>In-Network</i> \$0 copay for in and out-of-area dialysis. \$0 copay for nutrition therapy for renal disease.*</p>
<p>Prescription Drugs</p>	<p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p>	<p><i>Drugs covered under Medicare Part B</i> <i>General</i> 0% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).* 0% of the cost for Part B-covered chemotherapy drugs.*</p>
		<p><i>Drugs Covered under Medicare Part D</i> <i>General</i> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.amerihealth65.com on the web. The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p>

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Prescription Drugs <i>(continued)</i>		<p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from AmeriHealth 65 for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p>
		<p><i>In-Network</i></p> <p>\$0 yearly deductible.</p>
		<p><i>Initial Coverage</i></p> <p>Depending on your income and institutional status, you pay the following for generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> - A \$1.05 copay; or - A \$2.25 copay for generic drugs <p>Depending on your income and institutional status, you pay the following for all other drugs:</p> <ul style="list-style-type: none"> - A \$3.10 copay; or - A \$5.60 copay
		<p><i>Catastrophic Coverage</i></p> <p>After your yearly out-of-pocket drug costs reach \$4,050 you pay a \$0 copay.</p>

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Prescription Drugs <i>(continued)</i>		<p><i>Out-of-Network</i></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy.</p>
		<p><i>Out-of-Network Initial Coverage</i></p> <p>Depending on your income and institutional status, you pay the following for generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> - A \$1.05 copay; or - A \$2.25 copay for generic drugs <p>Depending on your income and institutional status, you pay the following for all other drugs:</p> <ul style="list-style-type: none"> - A \$3.10 copay; or - A \$5.60 copay
		<p><i>Out-of-Network Catastrophic Coverage</i></p> <p>After your yearly out-of-pocket drug costs reach \$4,050 you pay a \$0 copay.</p> <p>See page 17 for more information.</p>
Dental Services	Preventive dental services (such as cleaning) not covered.	<p><i>In-Network</i></p> <p>\$0 copay for Medicare-covered dental benefits.*</p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p>
Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	<p><i>In-Network</i></p> <p>\$0 copay for diagnostic hearing exams.*</p> <p>\$0 copay for up to 2 hearing aid(s) every three years.</p>

(continued on next page)

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Hearing Services <i>(continued)</i>		<ul style="list-style-type: none"> - 0% of the cost for up to 1 routine hearing test(s) every three years - 0% of the cost for up to 1 hearing aid fitting evaluation(s) every three years \$2,000 limit for routine hearing aids every three years. See page 18 for more information.
Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><i>In-Network</i></p> <p>\$0 copay for diagnosis and treatment for diseases and conditions of the eye.*</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.*</p> <ul style="list-style-type: none"> - up to 1 pair(s) of contacts every year - up to 1 pair(s) of lenses every year - up to 1 frame(s) every year - 0% of the cost for up to 1 routine eye exam(s) every year <p>\$35 limit for eye wear every year.</p> <p>See page 18 for more information.</p>
Physical Exams	<p>20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><i>In-Network</i></p> <p>\$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$0 copay for Medicare-covered benefits.</p>

If you have any questions about this plan's benefits or costs, please contact AmeriHealth 65 Basic.

Benefit Category	Original Medicare	AmeriHealth 65 Basic
Health/Wellness Education	Not covered.	<p>General Authorization rules may apply.</p> <p>In-Network This plan covers Health/Wellness Education benefits.</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Smoking Cessation - Health Club Membership/Fitness Classes - Other Wellness Benefits <p>See page 18 for more information.</p>
Transportation (Routine)	Not covered.	<p>In-Network \$0 copay for each round trip to plan-approved location.</p>
Optional Benefits		

I. WHAT IS AMERIHEALTH 65 BASIC?

AmeriHealth 65 Basic is a Medicare Advantage HMO Special Needs Plan with a federal contract. You get extra benefits from this plan that you may not get from Medicare, Medicaid, or a Medicare Savings Program (MSP) alone.

II. HOW CAN I JOIN?

You can join AmeriHealth 65 Basic as long as you're:

- enrolled with the state and federally funded Medical Assistance program (including Healthy Horizons). This plan is for people who are full dual eligibles (Medicare and Medicaid); Categorically Needy Qualified Medicare Beneficiaries (Healthy Horizons); and Qualified Medicare Beneficiaries;
- the owner of a Medicaid ACCESS card (please see page 20 of this book for a picture of the card);
- living in Berks, Lancaster, Lehigh, Northampton, or York counties;
- able to get Medicare Part A (hospital insurance) and enrolled in Medicare Part B (doctors' services and outpatient care); and
- paying your Medicare Part A (if applicable) and Part B premiums (If you get Medicaid, you don't have to pay Part B.)

III. HOW MUCH IS IT?

Qualified individuals who are eligible for full Medicare and Medicaid are not responsible for cost sharing. Medicaid will also pay for the Medicare Part B premium. To have these costs paid for, the member should always show **both** ID cards when seeing doctors or going to the hospital. The two cards are: AmeriHealth 65 Basic and Medicaid ACCESS. Please see page 20 of this book for pictures of these two cards.

Please note: Doctors and other people who give you health care can't balance bill (they can't get more money from you after Medicaid pays them for your costs).

Additional Information on Premium and Other Important Information (... from page 4)

As we said in the first section of this booklet, if you qualify for this plan, you don't pay for your premium, copayments, or coinsurance. In fact, your doctors can't bill you for any of these costs. These costs get passed on to your Medical Assistance program for possible payment. If your doctors ask you for payment, you should call your plan right away. You can reach our Member Services Department at 1-888-457-3018 (TTY/TDD: 1-888-857-4816), seven days a week, from 8 a.m. to 8 p.m.

Please know that, to get all of your benefits, you must follow the rules of your plan. These rules include:

- Choosing one primary care physician (PCP), who is a plan (in-network) doctor;
- Getting referrals from your PCP for any specialist care;
- Always using plan (in-network) providers, except for emergencies;
- Making sure you have prior authorization (approval in advance) for certain services.

Here is an example of when you need prior authorization (approval in advance): If you get inpatient hospital care (if you have surgery scheduled, for instance), your doctor should contact your plan for prior authorization. If he or she does not, you may not be able to get all your benefits.

Keep in mind that your PCP is the key to your care. He or she should manage your referrals and help you with all of your medical care.

PAYING FOR MEDICARE PART D

Medicare Part D is prescription drug coverage. **As a member of AmeriHealth 65 Basic, you get this prescription drug coverage already. Part D is included in your plan, and you don't have to join another prescription drug plan. You're covered!**

If you need help paying for Part D, the government provides assistance. In order to be eligible for this plan you must meet certain requirements. Find out more by calling the Social Security Administration, at 1-800-772-1213 (TTY/TDD: 1-800-325-0778) Monday–Friday, from 7 a.m. to 7 p.m. You can also visit www.socialsecurity.gov on the Web. Or you can apply for this extra help through your State Medical Assistance Office.

IV. BENEFITS INFORMATION

Additional Information on Inpatient Hospital Care and Inpatient Mental Health Care (...from pages 4-5)

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 inpatient substance abuse hospital care.

Treatment in a Psychiatric Hospital: A 190-day lifetime maximum for substance abuse treatment received in a psychiatric hospital is combined with inpatient mental health in a psychiatric hospital.

Additional Information on Outpatient Rehabilitation Services (...from page 8)

Physical and occupational therapy only require prior authorization (approval in advance) if not performed at a designated site. See page 19 for a definition of a designated 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.

Additional Information on Immunizations (...from page 10)

Immunizations are not covered for the purpose of travel.

Additional Information on Outpatient Prescription Drugs (...from pages 11-13)

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 Basic includes prescription drug coverage.

Part D also gives low-income beneficiaries access to comprehensive coverage with low cost sharing. See the top of this page 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 you get your covered prescriptions, you'll need to pay the cost of the drug and then AmeriHealth 65 Basic will reimburse you the full amount minus any applicable copayments.

For more information please call the numbers on page 3 of this booklet.

INFORMATION ABOUT THE MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM

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 MTM 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.

Additional Information on Hearing Services (...from pages 13-14)

Members will be reimbursed up to \$1,000 per hearing aid. Members can receive two (2) hearing aids every three years.

Additional Information on Vision Services (...from page 14)

Davis Vision, our contracted eyewear provider, offers our members two ways to utilize this Vision benefit. As a member you can choose eyewear from the Davis Collection and have your glasses covered in full. If you choose eyewear that is not in the collection you will receive \$35 towards frames and lenses.

Current multi year benefits such as vision and hearing are not guaranteed in future contract years.

V. MEMBER ADVANTAGE

Additional Information on Health and Wellness Education (...from page 15)

HEALTHY LIFESTYLESSM

Live Healthy!

As a member of AmeriHealth 65 Basic, you can use the following programs to keep you and your family healthy.

Healthy Lifestyles can help you make smart changes to your life and your health! We'll even give you some of your money back when you finish any or all of the following Healthy Lifestyles programs:

Fitness Program*: get up to \$150 of your fitness center fees when you complete 120 workouts within a year.

Stop Smoking*: If you smoke, quitting is great for your health. And, when you kick the habit, we'll help pay the bill! You can get up to \$200 back when you finish a smoking cessation program. If you choose one that costs less than \$200, you can use that money toward a nicotine replacement product or other prescription smoking cessation aids.

Weight Management*: You will get back 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.

Current multi year benefits such as the fitness program are not guaranteed in future contract years.

STAY HEALTHY!

Care Management and Coordination

It's hard to find your way around the health care system. If you're having surgery, or are trying to get home health care, our nurses will work with your doctors to help with your care.

Support from the ConnectionsSM Health Management Program

If you have diabetes, lung or breathing problems, heart conditions, or other health concerns, Connections can help you lead a healthier life. It can also help if you're deciding on treatment for back pain, breast or prostate cancer, or surgery.

Connections gives you:

- A Health Coach to talk to anytime, day or night, 24 hours a day, 7 days a week.
- Check-in calls from your Health Coach about your health.
- Educational materials mailed to your home.
- Reminders about important tests.
- Access to health information—our Healthwise[®] Knowledgebase gives you information on the Web, on audiotape, or by mail.

Connections is free. The program helps you work with your health care provider for the support you need. Call a Connections Health Coach at **1-800-275-2583** to see how we can help you.

VI. HELPFUL DEFINITIONS

Coinsurance – A type of cost-share in which the member pays a percentage of the covered expense for covered services.

Designated 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.

HMO – a type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to people with Medicare. In return, they get a set amount of money from Medicare every month. When you have an HMO, you usually have to get your care from the providers in the plan.

Medicaid – a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare – a health insurance program for people 65 years and older, people under age 65 with certain disabilities, or people of all ages with end-stage renal disease (ESRD).

Medicare Part A – health insurance that helps to cover inpatient care in hospitals and skilled nursing care. It also helps to cover some home health care.

Medicare Part B – health insurance that helps to cover doctors' services and outpatient care.

Medicare Part D – drug coverage under Medicare that is available to people who have either Medicare Part A or Medicare Part B.


Special Needs Plan (SNP) – An HMO that only enrolls people who get both Medicare and Medicaid.

CALL US!

Thanks for reading this booklet. It's a lot of information, so please feel free to call our Member Services Department if you have questions. You can reach us seven days a week, from 8 a.m. to 8 p.m., at **1-888-457-3018 (TTY/TDD: 1-888-857-4816)**.

Thanks for being a member of AmeriHealth 65 Basic.

SAMPLE AmeriHealth 65 Basic ID Card & Medicaid ACCESS Card



A Medicare Advantage Special Needs Plan from AmeriHealth HMO, Inc.

SAMPLE, JOHN Q
QCM12345678 00
MARCUS WELBY, MD
215-555-1212

RX

ISSUER: 80840
CMS - H3112-XXXX

MedicareRx
Prescription Drug Coverage

PerformRx RXBIN:012353 RXPCN:03670000
The Next Generation PBM
Submit paper prescription claims to PerformRx, P.O. Box 516, Essington, PA 19029.



ACCESS

RECIP # 0123456789
SS # 9876543212
NAME # DOE JOHN
CARD ISSUE # 00

Your ACCESS Card may not look exactly like this picture. It may be green or yellow. Just make sure you show your ACCESS card, along with your AmeriHealth 65 Basic ID Card, every time you see your doctor or any health care provider.



AmeriHealth65[®]

1901 Market Street
Philadelphia, PA 19103

www.amerihealth65.com



If you are a **member** and have questions,
please call toll free, **1-888-457-3018**
(TTY/TDD: **1-888-857-4816**)
Seven days a week 8 a.m. to 8 p.m.

If you are **not yet a member** and have questions,
please call toll free, **1-800-898-3492**
(TTY/TDD: **1-877-219-5457**)
Seven days a week 8 a.m. to 8 p.m.

AmeriHealth HMO, Inc.

M0014_H3112_AP08_02a (11/07)
10848 (2007-0208) 11/07

AH2154 (11/07)

