AmeriHealth 65 HMO

www.amerihealthmedicare.com

AmeriHealth 65® NJ HMO
2013 community-rated plans for new groups

	HMO T129, Y, JN	HMO T132, Y, JN	HMO T119, Y, JN	HMO T120, Y, JN	PLUS (HMO POS) T133[6], Y, JN	
Premium	☐ $339.90	☐ $312.10	☐ $257.40	☐ $228.00	☐ $314.90	
					In-network	Out-of-network
Annual maximum out-of-pocket	$6,700	$6,700	$6,700	$6,700	$6,700	
In-network out-of-pocket maximum (DME & Prosthetic devices only)	N/A	N/A	N/A	N/A	$3,000	
Annual deductible	N/A	N/A	N/A	N/A	N/A	$500
Annual out-of-network coinsurance maximum	N/A	N/A	N/A	N/A	N/A	$5,000
Primary care physician	$10	$15	$15	$15	$15	30%
Specialist	$15	$20	$30	$40	$25	30%
Emergency room	$40[1]	$40[1]	$50[2]	$50[1]	$50[3]	In-network level in U.S.
Inpatient hospital services	$0	$100/admission	$150/day, days 1-10; $1,500 annual maximum	$175/day, days 1-10; $1,750 annual maximum	Tier 1: $100/day, days 1-5; $0/day, days 6-90; $500 out-of-pocket maximum per stay Tier 2: $175/day, days 1-5; $0/day, days 6-90; $1,750 out-of-pocket maximum per stay	30%
Outpatient surgery	$0	$100	$150	$300 outpatient hospital facility; $150 ambulatory surgical center	Tier 1: $75 Tier 2: $150	30%
Urgent care	$10-$40[1]	$15-$40[1]	$15-$30[2]	$15-$40[1]	$15-$25[3]	In-network level in U.S.
Ambulance	$0	$0	$50	$125	$50	30%
Durable medical equipment	$0	$0	20%	25%	20%	30%
Skilled nursing facility	$0/day, days 1-100	$0/day, days 1-100	$25/day, days 1-100	$0/day, days 1-10; $100/day, days 11-100	$25/day, days 1-100	30%
Dialysis	$0	$0	$0	$0	$0	$0
Radiation therapy	$0	$0	$0	$0	$0	30%
Part B Rx	$0	$0	$0	$0	$25	30%
Hearing / Vision	$15[4] / $15[5]	$20[4] / $20[5]	$30[4] / $30[5]	$40[4] / $40[5]	$25[4] / $25[5]	30% / 30%
Preventive dental	$10	$10	$10	$10	$10	100%

[1] Emergency and urgent care copayment is waived if the member is admitted as an inpatient immediately following the ER visit. Worldwide coverage.
[2] Copay will not be waived if the member is admitted to the hospital. Emergency care is not covered outside the U.S. except under limited circumstances and as defined by Medicare.
[3] Copay will not be waived if the member is admitted to the hospital. Urgent and emergency care received outside the U.S. (except under limited circumstances) are subject to out-of-network deductible and coinsurance.
[4] Up to $500 reimbursement for hearing aids every three years.
[5] Up to $100 reimbursement for eyewear every two years.
[6] NOTE: Internal Use Only – Use #B4V when selected Benefit Pkg is T133.

Preventive services are covered at $0 copay.
This summary is a partial listing of benefits. Refer to the Evidence of Coverage (EOC) for more details.
Refer to separate Part D prescription plan rates on reverse side for options available with AmeriHealth 65 New Jersey HMO.

OVER, PLEASE

Medicare Part D

AmeriHealth 65 New Jersey HMO & HMO POS - Part D community-rated plans

	Unlimited plans (EGWP with Wrap)		Limited plans	
Part D drug coverage	**#B4V**	**#B4W[3]**	**#496**	**#B1C**
Premium[1]	☐ $297.90	☐ $297.90	☐ $212.40	☐ $152.40
Deductible	$0	$0	$0	$50
Cost sharing	$10/$25/$50	$10/$25/$50	$5/$20/$40	$5/$35/$75
Initial coverage limit (ICL)	N/A	N/A	$2,970	$2,970
Gap coverage	Unlimited	Unlimited	$5 generic; 47.5% brand	$5 generic; 47.5% brand
TrOOP[2]	$4,750	$4,750	$4,750	$4,750
Mail order (90 days)	1 copay	1 copay	1 copay	2 copays

[1]These rates do not reflect a late enrollment penalty that some members may incur if they are transferring from non-creditable prescription coverage, or "extra help" subsidy for which some members qualify.
[2]At true out-of-pocket (TrOOP) catastrophic trigger of $4,750, member pays catastrophic copays at greater of $2.65/$6.60 or 5%.
You must be enrolled in Part D through AmeriHealth 65 to take advantage of these rates.
This summary is a partial listing of benefits. Refer to the Evidence of Coverage (EOC) for more details.
[3] NOTE: Internal Use Only – Use #B4V when selected Benefit Pkg is T133.

Medical Rate* _____ + Part D drug rate _____ = Total Monthly Premium _____
(from reverse side) (from this side)

*Discount drug #L61 is included when "medical only" is selected and a Part D drug option is not selected.

Customer name (please print) _____ CID# (if applicable) _____ Desired effective date _____

Group leader signature _____ Today's date _____

Customer phone # _____ Customer email _____

Customer Employer Identification Number _____

Medicare Certified Agent Name: _____ Agent NPN: _____

Medicare Certified Agent Signature: _____ Signature Date: _____