2025
Summary of Benefits

Effective January 1, 2025 through December 31, 2025

- AmeriHealth Medicare Core PPO
- AmeriHealth Medicare Enhanced PPO
- AmeriHealth Medicare Secure PPO
- AmeriHealth Medicare Ultimate PPO

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This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage* or go online at amerihealthmedicare.com.

This *Summary of Benefits* booklet gives you a summary of what AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO cover and what you pay.

AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO are Medicare Advantage PPO (Preferred Provider Organization) plans. With a PPO plan, members don't have to choose a primary care physician (PCP) and can go to doctors in or out of the plan's network. If members use out-of-network doctors, hospitals, or other health care providers, they will pay more for their services.

If you want to compare our plans with other available Medicare health plans, ask the other plan(s) for their *Summary of Benefits* booklet. Or, use the Medicare Plan Finder at **medicare.gov**.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare and You" handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Sections of this booklet

- Monthly Premium and Plan Costs
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Other Medical Benefits

Who can join?

To join an AmeriHealth Medicare PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

The service area for AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO is Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, and Ocean counties in New Jersey.

Which doctors, hospitals, and pharmacies can I use?

The AmeriHealth Medicare PPO plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, a higher cost-sharing may apply. AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and

AmeriHealth Medicare Ultimate PPO have a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy you use. To view our list of network providers and pharmacies *(Provider/Pharmacy Directory)*, please visit **amerihealthmedicare.com.**
AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO cover Part D drugs.

In addition, the plans cover Part B drugs, such as chemotherapy and some other drugs administered by your provider. You can see our complete plan *Formulary (List of Covered Drugs*) and any restrictions on our website: **amerihealthmedicare.com**.

Monthly Plan Premium

AmeriHealth Medicare Core PPO	
If you live in...	And you have...
	AmeriHealth Medicare Core PPO
	You pay...
Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, or Ocean counties	$0

AmeriHealth Medicare Enhanced PPO	
If you live in...	And you have...
	AmeriHealth Medicare Enhanced PPO
	You pay...
Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, or Ocean counties	$30.40

AmeriHealth Medicare Secure PPO	
If you live in...	And you have...
	AmeriHealth Medicare Secure PPO
	You pay...
Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, or Ocean counties	$0

AmeriHealth Medicare Ultimate PPO	
If you live in...	And you have...
	AmeriHealth Medicare Ultimate PPO
	You pay...
Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, or Ocean counties	$0

Plan Costs

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Deductible	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	This plan does not have a deductible for covered medical services. A $200 deductible applies to Part D prescription drugs in tiers 3, 4, and 5.	This plan does not have a deductible for covered medical services. A $150 deductible applies to Part D prescription drugs in tiers 3, 4, and 5.
Part B Premium Giveback*	This plan does not include a Part B Premium Giveback.	This plan does not include a Part B Premium Giveback.	This plan will reduce your monthly Part B premium by $74.	This plan will reduce your monthly Part B premium by $124.
Maximum Out-of-Pocket (MOOP) Amount (the amounts you pay for your premium, Part D prescription drugs, and some medical services do not count toward the annual MOOP amount)	In Network: $9,350 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In Network and Out of Network: $14,000 each year.	In Network: $6,750 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In Network and Out of Network: $10,100 each year.	In Network: $9,350 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In Network and Out of Network: $14,000 each year.	In Network: $9,350 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In Network and Out of Network: $14,000 each year.

*The Part B Premium Giveback is set up by Medicare and administered through the Social Security Administration (SSA). Members who pay their own Part B premium are eligible for the Giveback. The monthly credit is applied on either the member's Social Security check or Medicare Part B statement, depending on how they pay their Part B premium. It can take a few months for this Giveback to be processed, so the member may receive it as a lump sum.

Covered Medical and Hospital Benefits

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Inpatient Hospital Coverage (1)	In-Network: $300 copayment per day for days 1 through 5 per admission; $0 copayment per day for days 6 and beyond per admission; $1,500 maximum copayment per admission; $0 copayment on day of discharge; unlimited days per benefit period Out of Network: 20% coinsurance	In-Network: $300 copayment per day for days 1 through 4 per admission; $0 copayment per day for days 5 and beyond per admission; $1,200 maximum copayment per admission; $0 copayment on day of discharge; unlimited days per benefit period Out-of-Network: 50% coinsurance	In-Network: $370 copayment per day for days 1 through 6 per admission; $0 copayment per day for days 7 and beyond per admission; $2,220 maximum copayment per admission; $0 copayment on day of discharge; unlimited days per benefit period Out-of-Network: 50% coinsurance	In-Network: $370 copayment per day for days 1 through 6 per admission; $0 copayment per day for days 7 and beyond per admission; $2,220 maximum copayment per admission; $0 copayment on day of discharge; unlimited days per benefit period Out-of-Network: 50% coinsurance
Outpatient Hospital Services (1)	In-Network: $235 copayment Out-of-Network: 20% coinsurance	In-Network: $325 copayment Out-of-Network: 50% coinsurance	In-Network: $400 copayment Out-of-Network: 50% coinsurance	In-Network: $425 copayment Out-of-Network: 50% coinsurance
Outpatient Observation Services	In Network: $235 copayment per visit Out-of-Network: 20% coinsurance	In-Network: $325 copayment per visit Out-of-Network: 50% coinsurance	In-Network: $400 copayment per visit Out-of-Network: 50% coinsurance	In-Network: $425 copayment per visit Out-of-Network: 50% coinsurance
Ambulatory Surgical Services (1)	In-Network: $225 copayment Out-of-Network: 20% coinsurance	In-Network: $300 copayment Out-of-Network: 50% coinsurance	In-Network: $375 copayment Out-of-Network: 50% coinsurance	In-Network: $400 copayment Out-of-Network: 50% coinsurance
Doctor's Office Visits				
• Primary Care Physician	In-Network: $0 copayment Out-of-Network:20% coinsurance	In-Network: $0 copayment Out-of-Network: 50% coinsurance	In-Network: $0 copayment Out-of-Network: 50% coinsurance	In-Network: $0 copayment Out-of-Network: 50% coinsurance
• Specialist	In-Network: $20 copayment Out-of-Network: 20% coinsurance	In-Network: $5 copayment Out-of-Network: 50% coinsurance	In-Network: $30 copayment Out-of-Network: 50% coinsurance	In-Network: $50 copayment Out-of-Network: 50% coinsurance

Services with a (1) may require prior authorization (in-network only).

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Preventive Care (1) (e.g., flu vaccine, diabetic screenings)	In-Network: $0 copayment Out-of-Network: 20% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.	In-Network: $0 copayment Out-of-Network: 50% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.	In-Network: $0 copayment Out-of-Network: 50% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.	In-Network: $0 copayment Out-of-Network: 50% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Emergency Care — Covered Worldwide Worldwide copayment outside the U.S. does not count toward the annual MOOP amount	In-Network and Out-of-Network: $110 copayment Not waived if admitted	In-Network and Out-of-Network: $125 copayment Not waived if admitted	In-Network and Out-of-Network: $110 copayment Not waived if admitted	In-Network and Out-of-Network: $110 copayment Not waived if admitted
Urgently Needed Services — Covered Worldwide Worldwide copayment outside the U.S. does not count toward the annual MOOP amount	In-Network and Out-of-Network: $10 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $110 copayment per visit outside of U.S. Not waived if admitted	In-Network and Out-of-Network: $5 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $125 copayment per visit outside of U.S. Not waived if admitted	In-Network and Out-of-Network: $15 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $110 copayment per visit outside of U.S. Not waived if admitted	In-Network and Out-of-Network: $15 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $110 copayment per visit outside of U.S. Not waived if admitted

Services with a (1) may require prior authorization (in-network only).

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Diagnostic Services, Lab and Radiology Services, and X-rays				
• Diagnostic Radiology Services (1)	In-Network: $0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) In-Network: $20 or $200 copayment depending on service Out-of-Network: 20% coinsurance	In-Network: $0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) In-Network: $20 or $275 copayment depending on service Out-of-Network: 50% coinsurance	In-Network: $0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) In-Network: $40 or $350 copayment depending on service Out-of-Network: 50% coinsurance	In-Network: $0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) In-Network: $40 or $400 copayment depending on service Out-of-Network: 50% coinsurance
• Diagnostic Procedures, Tests, and Lab Services (1)	In-Network: $0 copayment Out-of-Network: 20% coinsurance	In-Network: $0 copayment Out-of-Network: 50% coinsurance	In-Network: $0 copayment Out-of-Network: 50% coinsurance	In-Network: $0 copayment Out-of-Network: 50% coinsurance
• Outpatient X-rays	In-Network: $20 copayment for routine radiology services Out-of-Network: 20% coinsurance	In-Network: $20 copayment for routine radiology services Out-of-Network: 50% coinsurance for routine radiology services	In-Network: $40 copayment for routine radiology services Out-of-Network: 50% coinsurance for routine radiology services	In-Network: $40 copayment for routine radiology services Out-of-Network: 50% coinsurance for routine radiology services
• Therapeutic Radiology (1) (Radiation Therapy)	In-Network: $60 copayment Out-of-Network: 20% coinsurance	In-Network: $60 copayment Out-of-Network: 50% coinsurance	In-Network: $60 copayment Out-of-Network: 50% coinsurance	In-Network: $60 copayment Out-of-Network: 50% coinsurance
• Therapeutic Radiology for Breast Cancer (Uniform Flexibility)	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 20% coinsurance	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 50% coinsurance	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network:50% coinsurance	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 50% coinsurance

Services with a (1) may require prior authorization (in-network only).

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Hearing Services				
• Hearing Exam	In-Network: $20 copayment for Medicare-covered hearing exams Out-of-Network: 20% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In-Network: $5 copayment for Medicare-covered hearing exams Out-of-Network: 50% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In-Network: $30 copayment for Medicare-covered hearing exams Out-of-Network: 50% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In-Network: $50 copayment for Medicare-covered hearing exams Out-of-Network: 50% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year
• Hearing Aid	In-Network and Out-of-Network: $699 copayment for an advanced digital hearing aid, per aid; or $999 copayment for a premium digital hearing aid, per aid. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $499 copayment for an advanced digital hearing aid, per aid; or $799 copayment for a premium digital hearing aid, per aid. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $699 copayment for an advanced digital hearing aid, per aid; or $999 copayment for a premium digital hearing aid, per aid. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $699 copayment for an advanced digital hearing aid, per aid; or $999 copayment for a premium digital hearing aid, per aid. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Dental Services • Medicare-covered Dental Services	In-Network: $20 copayment for Medicare-covered dental services Out-of-Network: 20% coinsurance	In-Network: $5 copayment for Medicare-covered dental services Out-of-Network: 50% coinsurance for Medicare-covered dental services	In-Network: $30 copayment for Medicare-covered dental services Out-of-Network: 50% coinsurance for Medicare-covered dental services	In-Network: $50 copayment for Medicare-covered dental services Out-of-Network: 50% coinsurance for Medicare-covered dental services
• Routine Dental Care (includes preventive and comprehensive dental)	In-Network: $0 copayment for routine non-Medicare-covered exam/cleaning/fluoride services $0 copayment for 1 set of dental bitewing X-rays every year 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 20% coinsurance for restorative services, endodontics, periodontics, and extractions 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery Out-of-Network: 80% coinsurance for exam/cleaning/fluoride services 80% coinsurance for dental X-ray 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery In-Network and Out-of-Network: Combined $1,500 plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Member must use in-network Dominion Dental providers. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	In-Network: $0 copayment for routine non-Medicare-covered exam/cleaning/fluoride services $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 20% coinsurance for restorative services, endodontics, periodontics, and extractions 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery Out-of-Network: 80% coinsurance for exam/cleaning/fluoride services 80% coinsurance for dental X-ray 80% coinsurance for restorative services,endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery In-Network and Out-of-Network: $2,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Member must use in-network Dominion Dental providers. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	In-Network: $0 copayment for routine non-Medicare-covered exam/cleaning/fluoride services $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 20% coinsurance for restorative services, endodontics, periodontics, and extractions 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery Out-of-Network: 80% coinsurance for exam/cleaning/fluoride services 80% coinsurance for dental X-ray 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery In-Network and Out-of-Network: $1,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Member must use in-network Dominion Dental providers. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	In-Network: $0 copayment for routine non-Medicare-covered exam/cleaning/fluoride services $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 20% coinsurance for restorative services, endodontics, periodontics, and extractions 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery Out-of-Network: 80% coinsurance for exam/cleaning/fluoride services 80% coinsurance for dental X-ray 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery In-Network and Out-of-Network: $1,000 combined plan allowance every year for restorative dental services,endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Member must use in-network Dominion Dental providers. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Vision Services • Medicare-covered Vision Services	In-Network: $20 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 20% coinsurance for Medicare-covered eye exams, Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery	In-Network: $0–$5 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 50% coinsurance for Medicare-covered eye exams, Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery	In-Network: $0–$30 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 50% coinsurance for Medicare-covered eye exams, Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery	In-Network: $0–$50 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 50% coinsurance for Medicare-covered eye exams, Medicare-covered diabetic or dilated retinal eye exam, Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery
• Routine Vision Care (includes routine exam and eyewear)	In-Network: $0 copayment for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection; $200 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $100 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider; $100 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses) Eyewear coverage does not include lens options such as tints, progressives, Transitions® lenses, polish, and insurance. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $100 combined in- and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $200 combined maximum applies when in or out of the service area.	In-Network: $0 copayment for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection; $200 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $100 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider; $100 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses) Eyewear coverage does not include lens options such as tints, progressives, Transitions® lenses, polish, and insurance. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $100 combined in- and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $200 combined maximum applies when in or out of the service area.	In-Network: $0 copayment for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection; $200 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $100 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider; $100 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses) Eyewear coverage does not include lens options such as tints, progressives, Transitions® lenses, polish, and insurance. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $100 combined in- and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $200 combined maximum applies when in or out of the service area.	In-Network: $0 copayment for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection; $200 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $100 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider; $100 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses) Eyewear coverage does not include lens options such as tints, progressives, Transitions® lenses, polish, and insurance. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $100 combined in- and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $200 combined maximum applies when in or out of the service area.

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Mental Health Services • Inpatient Mental Health Care (1)	In-Network: $335 copayment per day for days 1–6 per admission $0 copayment per day for days 7 and beyond $0 copayment on day of discharge $2,010 maximum copayment per admission 190-day lifetime maximum Out-of-Network: 20% coinsurance	In-Network: $300 copayment per day for days 1–4 per admission $0 copayment per day for days 5 and beyond $0 copayment on day of discharge $1,200 maximum copayment per admission 190-day lifetime maximum Out-of-Network: 50% coinsurance	In-Network: $335 copayment per day for days 1–6 per admission $0 copayment per day for days 7 and beyond $0 copayment on day of discharge $2,010 maximum copayment per admission 190-day lifetime maximum Out-of-Network: 50% coinsurance	In-Network: $335 copayment per day for days 1–6 per admission $0 copayment per day for days 7 and beyond $0 copayment on day of discharge $2,010 maximum copayment per admission 190-day lifetime maximum Out-of-Network: 50% coinsurance
• Outpatient Mental Health Care (1) (Group, Individual, and Psychiatric)	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 20% coinsurance	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 50% coinsurance	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 50% coinsurance	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 50% coinsurance
• Outpatient Substance Abuse Services (Group and Individual)	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 20% coinsurance	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 50% coinsurance	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 50% coinsurance	In-Network: $30 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 50% coinsurance
• Partial Hospitalization and Intensive Outpatient Services (1)	In-Network: $40 copayment per day Out-of-Network: 20% coinsurance	In-Network: $40 copayment per day Out-of-Network: 50% coinsurance	In-Network: $40 copayment per day Out-of-Network: 50% coinsurance	In-Network: $40 copayment per day Out-of-Network: 50% coinsurance
Skilled Nursing Facility (1)	In-Network: $0 copayment per day for days 1–20 $214 copayment per day for days 21–100 Out-of-Network: 20% coinsurance per day for days 1–100 100 days per benefit period	In-Network: $0 copayment per day for days 1–20 $214 copayment per day for days 21–100 Out-of-Network: 50% coinsurance per day for days 1–100 100 days per benefit period	In-Network: $0 copayment per day for days 1–20 $214 copayment per day for days 21–100 Out-of-Network: 50% coinsurance per day for days 1–100 100 days per benefit period	In-Network: $0 copayment per day for days 1–20 $214 copayment per day for days 21–100 Out-of-Network: 50% coinsurance per day for days 1–100 100 days per benefit period
Outpatient Rehabilitation Services (includes Physical Therapy, Occupational Therapy, and Speech Therapy)	In-Network: $30 copayment per visit Out-of-Network: 20% coinsurance per visit	In-Network: $25 copayment per visit Out-of-Network: 50% coinsurance per visit	In-Network: $35 copayment per visit Out-of-Network: 50% coinsurance per visit	In-Network: $35 copayment per visit Out-of-Network: 50% coinsurance per visit

Services with a (1) may require prior authorization (in-network only).

Covered Medical and Hospital Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Ambulance (1) (Ground and air transportation)	In-Network and Out-of-Network: $275 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $250 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $300 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $320 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Transportation Services	In-Network: $0 copayment 12 one-way trips per year (or 6 round trips) to plan-approved medical facilities Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Maximum 80 miles per trip. Out-of-Network: Same benefit offered INN/OON; must coordinate through our designated vendor	In-Network: $0 copayment 12 one-way trips per year (or 6 round trips) to plan-approved medical facilities Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Maximum 80 miles per trip. Out-of-Network: Same benefit offered INN/OON; must coordinate through our designated vendor	Not covered	Not covered
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	In-Network: 0-20% coinsurance for Part B drugs, including chemotherapy drugs Part B insulin: $35 copayment for 1 month supply For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 20% coinsurance	In-Network: 0-20% coinsurance for Part B drugs, including chemotherapy drugs Part B insulin: $35 copayment for 1 month supply For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 50% coinsurance	In-Network: 0-20% coinsurance for Part B drugs, including chemotherapy drugs Part B insulin: $35 copayment for 1 month supply For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 50% coinsurance	In-Network: 0-20% coinsurance for Part B drugs, including chemotherapy drugs Part B insulin: $35 copayment for 1 month supply For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 50% coinsurance

Services with a (1) may require prior authorization (in-network only).

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO.

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Prescription Drug Benefits	You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have $0 copayments when filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the AmeriHealth Rx PPO *Evidence of Coverage*	You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have $0 copayments when filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the AmeriHealth Rx PPO *Evidence of Coverage*	You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have $0 copayments when filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the AmeriHealth Rx PPO *Evidence of Coverage*	You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have $0 copayments when filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the AmeriHealth Rx PPO *Evidence of Coverage*
True Out-of-Pocket Limit	An annual maximum of $2,000 in out-of-pocket costs for covered drugs (Medicare Part B drugs not included)	An annual maximum of $2,000 in out-of-pocket costs for covered drugs (Medicare Part B drugs not included)	An annual maximum of $2,000 in out-of-pocket costs for covered drugs (Medicare Part B drugs not included)	An annual maximum of $2,000 in out-of-pocket costs for covered drugs (Medicare Part B drugs not included)
Catastrophic	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000 you pay: • No cost-share	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000 you pay: • No cost-share	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000 you pay: • No cost-share	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000 you pay: • No cost-share

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO.

	AmeriHealth Medicare Core PPO			AmeriHealth Medicare Enhanced PPO			AmeriHealth Medicare Secure PPO			AmeriHealth Medicare Ultimate PPO		
Retail Cost-sharing (what you pay at a pharmacy location)	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)												
• **Preferred Pharmacy**	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
• **Standard Pharmacy**	$9 copayment	$18 copayment	$27 copayment	$7 copayment	$14 copayment	$21 copayment	$9 copayment	$18 copayment	$27 copayment	$9 copayment	$18 copayment	$27 copayment
Tier 2 (Generic Drugs)												
• **Preferred Pharmacy**	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
• **Standard Pharmacy**	$20 copayment	$40 copayment	$60 copayment	$8 copayment	$16 copayment	$24 copayment	$20 copayment	$40 copayment	$60 copayment	$20 copayment	$40 copayment	$60 copayment
Tier 3 (Preferred Brand Drugs)												
• **Preferred Pharmacy**	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
• **Standard Pharmacy**	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs)												
• **Preferred Pharmacy**	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
• **Standard Pharmacy**	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Drugs)												
• **Preferred Pharmacy**	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	31% coinsurance	31% coinsurance	31% coinsurance
• **Standard Pharmacy**	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	31% coinsurance	31% coinsurance	31% coinsurance
Insulin (Tier 3, Tier 4, and Tier 5)												
• **Preferred Pharmacy**	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment
• **Standard Pharmacy**	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO.

	AmeriHealth Medicare Core PPO			AmeriHealth Medicare Enhanced PPO			AmeriHealth Medicare Secure PPO			AmeriHealth Medicare Ultimate PPO		
Mail-order Cost-sharing (what you pay when you order a prescription by mail)	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic Drugs)	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 3 (Preferred Brand Drugs)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs)	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	31% coinsurance	31% coinsurance	31% coinsurance
Insulin (Tier 3, Tier 4, and Tier 5)	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment

Other Medical Benefits

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Over-the-Counter (OTC) Items	In-Network and Out-of-Network: $50 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the AmeriHealth Medicare PPO Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Must use InComm to purchase OTC items. Each order cannot exceed the $50 quarterly allowance. OTC costs do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $100 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the AmeriHealth Medicare PPO Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Must use InComm to purchase OTC items. Each order cannot exceed the $100 quarterly allowance. OTC costs do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $30 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the AmeriHealth Medicare PPO Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Must use InComm to purchase OTC items. Each order cannot exceed the $30 quarterly allowance. OTC costs do not count toward the annual MOOP amount.	Not covered
Dental, Vision, and Hearing (DVH) Flex Benefit	$300 allowance every calendar year Allowance can be used to cover cost-sharing for covered dental, vision, and hearing benefits. It can also be used for any dental, vision, or hearing services or supplies provided by a licensed in-network or out-of-network provider. The allowance can be used for any combination of dental, vision, and hearing services or supplies. Must use AmeriHealth Care Card.	$300 allowance every calendar year Allowance can be used to cover cost-sharing for covered dental, vision, and hearing benefits. It can also be used for any dental, vision, or hearing services or supplies provided by a licensed in-network or out-of-network provider. The allowance can be used for any combination of dental, vision, and hearing services or supplies. Must use AmeriHealth Care Card.	$300 allowance every calendar year Allowance can be used to cover cost-sharing for covered dental, vision, and hearing benefits. It can also be used for any dental, vision, or hearing services or supplies provided by a licensed in-network or out-of-network provider. The allowance can be used for any combination of dental, vision, and hearing services or supplies. Must use AmeriHealth Care Card.	Not covered

Other Medical Benefits

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Telemedicine • Telemedicine Visits	In-Network and Out-of-Network: $0 copayment for general medical visits focused on urgent-care like visits; $0 copayment to talk to a therapist or psychiatrist by appointment for depression, anxiety, stress and more. $0 copayment for dermatology visits focused to diagnose and treat skin conditions like eczema, psoriasis, acne and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.*	In-Network and Out-of-Network: $0 copayment for medical doctor visits focused on urgent-care like visits; $0 copayment to talk to a therapist or psychiatrist by appointment for depression, anxiety, stress and more. $0 copayment for dermatology visits focused to diagnose and treat skin conditions like eczema, psoriasis, acne and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.*	In-Network and Out-of-Network: $0 copayment for medical doctor visits focused on urgent-care like visits; $0 copayment to talk to a therapist or psychiatrist by appointment for depression, anxiety, stress and more. $0 copayment for dermatology visits focused to diagnose and treat skin conditions like eczema, psoriasis, acne and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.*	In-Network and Out-of-Network: $0 copayment for medical doctor visits focused on urgent-care like visits; $0 copayment to talk to a therapist or psychiatrist by appointment for depression, anxiety, stress and more. $0 copayment for dermatology visits focused to diagnose and treat skin conditions like eczema, psoriasis, acne and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.*
• **Additional Telehealth** (Primary care physician (PCP), specialist, physical therapy, occupational therapy, speech therapy, and other health care professionals)	In-Network: $0 copayment per PCP visit; $20 copayment per specialist visit; $30 copayment per physical therapy, occupational therapy, and speech therapy visit; $20 copayment per other health care professional visit Out-of-Network: Not covered	In-Network: $0 copayment per PCP visit; $5 copayment per specialist visit; $25 copayment per physical therapy, occupational therapy, and speech therapy visit; $5 copayment per other health care professional visit Out-of-Network: Not covered	In-Network: $0 copayment per PCP visit; $30 copayment per specialist visit; $35 copayment per physical therapy, occupational therapy, and speech therapy visit; $30 copayment per other health care professional visit Out-of-Network: Not covered	In-Network: $0 copayment per PCP visit; $50 copayment per specialist visit; $35 copayment per physical therapy, occupational therapy, and speech therapy visit; $50 copayment per other health care professional visit Out-of-Network: Not covered
Chiropractic Services • **Medical** (Medicare-covered) Medicare-covered chiropractic care is ONLY for spinal manipulation to correct subluxation.	In-Network: $15 copayment per visit Out-of-Network: 20% coinsurance	In-Network: $20 copayment per visit for spinal manipulation Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit for spinal manipulation Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit for spinal manipulation Out-of-Network: 50% coinsurance
• **Routine Care** (non-Medicare-covered) Non-Medicare-covered routine visits are in addition to Medicare-covered spinal manipulation visits. Routine visits do NOT count toward the annual MOOP amount.	In-Network: $15 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 20% coinsurance	In-Network: $20 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 50% coinsurance

* Mental/behavioral health visits must be scheduled via the online platform teladochealth.com/signin. Visits cannot be scheduled by phone. Members must complete a mental health assessment via the website platform prior to scheduling a mental health visit.

Other Medical Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Acupuncture				
• **Medical** (Medicare-covered)	In-Network: $15 copayment per visit, up to 12 visits per 90 days; 8 additional if determined that progress is made Out-of-Network: 20% coinsurance	In-Network: $20 copayment per visit, up to 12 visits per 90 days; 8 additional if determined that progress is made Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit, up to 12 visits per 90 days; 8 additional if determined that progress is made Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit, up to 12 visits per 90 days; 8 additional if determined that progress is made Out-of-Network: 50% coinsurance
• **Routine Care** (non-Medicare-covered) (Routine visits do NOT count toward the annual MOOP amount).	$15 copayment per visit (up to 6 visits each year) Out-of-Network: 20% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.	$20 copayment per visit (up to 6 visits each year) Out-of-Network: 50% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.	$15 copayment per visit (up to 6 visits each year) Out-of-Network: 50% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.	$15 copayment per visit (up to 6 visits each year) Out-of-Network: 50% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.
Podiatry Services				
• **Medical Condition** (Medicare-covered)	In-Network: $15 copayment per visit Out-of-Network: 20% coinsurance	In-Network: $20 copayment per visit for condition treatment Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit for condition treatment Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit for condition treatment Out-of-Network: 50% coinsurance
• **Routine Foot Care** (non-Medicare-covered) (Routine visits do NOT count toward the annual MOOP amount).	In-Network: $15 copayment per visit (up to 6 visits each year) Out-of-Network: 20% coinsurance	In-Network: $20 copayment per visit (up to 6 visits each year) Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit (up to 6 visits each year) Out-of-Network: 50% coinsurance	In-Network: $15 copayment per visit (up to 6 visits each year) Out-of-Network: 50% coinsurance

Other Medical Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Fitness Benefit	In Network and Out of Network: No copayment or coinsurance Members receive a physical and mental fitness program through a plan specific vendor with the goal of improving general health and wellbeing. The program includes: Access to a participating gym network, on-demand and livestreamed digital content, home fitness kits include fitness equipment (eg. resistance bands, yoga mats, exercise tubes), vendor curated activities that are exercise driven to promote physical activity, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises Members must use a One Pass network gym/fitness center and enroll in the One Pass program Gym memberships and services received from non-One Pass fitness centers will be denied	In Network and Out of Network: No copayment or coinsurance Members receive a physical and mental fitness program through a plan specific vendor with the goal of improving general health and wellbeing. The program includes: Access to a participating gym network, on-demand and livestreamed digital content, home fitness kits include fitness equipment (eg. resistance bands, yoga mats, exercise tubes), vendor curated activities that are exercise driven to promote physical activity, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises Members must use a One Pass network gym/fitness center and enroll in the One Pass program Gym memberships and services received from non-One Pass fitness centers will be denied	In Network and Out of Network: No copayment or coinsurance Members receive a physical and mental fitness program through a plan specific vendor with the goal of improving general health and wellbeing. The program includes: Access to a participating gym network, on-demand and livestreamed digital content, home fitness kits include fitness equipment (eg. resistance bands, yoga mats, exercise tubes), vendor curated activities that are exercise driven to promote physical activity, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises Members must use a One Pass network gym/fitness center and enroll in the One Pass program Gym memberships and services received from non-One Pass fitness centers will be denied	In Network and Out of Network: No copayment or coinsurance Members receive a physical and mental fitness program through a plan specific vendor with the goal of improving general health and wellbeing. The program includes: Access to a participating gym network, on-demand and livestreamed digital content, home fitness kits include fitness equipment (eg. resistance bands, yoga mats, exercise tubes), vendor curated activities that are exercise driven to promote physical activity, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises Members must use a One Pass network gym/fitness center and enroll in the One Pass program Gym memberships and services received from non-One Pass fitness centers will be denied

Other Medical Benefits (continued)

	AmeriHealth Medicare Core PPO	AmeriHealth Medicare Enhanced PPO	AmeriHealth Medicare Secure PPO	AmeriHealth Medicare Ultimate PPO
Meals Program* †	In-Network: $0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year provided after discharge to home from a qualifying location. To qualify, members must fall into one of two groups: Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer Group 2: Must be diagnosed with both diabetes and congestive heart failure Meals program does not count toward the annual MOOP amount. Out-of-Network: Not Covered	In-Network: $0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year provided after discharge to home from a qualifying location. To qualify, members must fall into one of two groups: Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer Group 2: Must be diagnosed with both diabetes and congestive heart failure Meals program does not count toward the annual MOOP amount. Out-of-Network: Not Covered	Not covered	Not covered

*These benefits are a part of a special supplemental program for the chronically ill. Not all members qualify.
† Meals will be provided after discharge to the home following an inpatient acute hospital, skilled nursing facility, long-term acute care facility, acute rehabilitation facility, or rehabilitation facility stay. Participation in our medical management Transitions of Care Program is required.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Help Team representative at **1-866-569-5190 (TTY/TDD: 711)**.

Understanding the Benefits

- [ ] The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **amerihealthmedicare.com** or call **1-866-569-5190 (TTY/TDD: 711)** to view a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.
- [ ] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- [ ] Effect on Current Coverage. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

For More Information

For updated information regarding plan providers, visit our website at **amerihealthmedicare.com**, or call our Member Help Team at **1-866-569-5190 (TTY/TDD: 711)**, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

If you are not yet a member and have questions, please call **1-800-898-3492 (TTY/TDD: 711)**, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from January 1 through September 30, your call may be sent to voicemail. By calling this number you will be directed to a licensed sales agent.

AmeriHealth Insurance Company of New Jersey offers PPO plans with a Medicare contract. Enrollment in AmeriHealth PPO plans depends on contract renewal.

AmeriHealth Medicare coverage issued by AmeriHealth Insurance Company of New Jersey.

TruHearing® is a registered trademark of TruHearing, Inc.

Vision benefits are underwritten by AmeriHealth Insurance Company of New Jersey and administered by Davis Vision.

An affiliate of AmeriHealth has a financial interest in Visionworks.

Dental benefits are underwritten by AmeriHealth Insurance Company of New Jersey and administered by Dominion Dental Service, Inc.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Telemedicine is provided by Teladoc.

Roundtrip administers our transportation benefit.

To receive this document in an alternate format such as Braille, large print, or audio, please call **1-800-898-3492 (TTY/TDD: 711)** (non-members) (by calling this number you will be directed to a licensed sales agent) or **1-866-569-5190 (TTY/TDD: 711)** (members).

This information is not a complete description of benefits. Contact **1-800-898-3492 (TTY/TDD: 711)** for more information.

Notes

Notes

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-275-2583. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-275-2583. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-275-2583。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-275-2583。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-275-2583. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-275-2583. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-275-2583 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-275-2583. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Form CMS-10802
(Expires 12/31/25)

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-275-2583 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-275-2583. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-275-2583 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-275-2583 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-275-2583. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-275-2583. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-275-2583. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-275-2583. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-275-2583 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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Multi-language Interpreter Services

Gujarati: અમારી આરોગ્ય અથવા દવા યોજના વિશે તમને હોય શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે નિ:શુલ્ક દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, અમને ફક્ત 1-800-275-2583 પર કૉલ કરો. ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. આ એક નિ:શુલ્ક સેવા છે.

Urdu: آپ کی صحت یا دوا کے متعلق کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت ترجمانی کی خدمات دستیاب ہیں۔ مترجم کی سہولت کے لیے، 1-800-275-2583 پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ مفت سروس ہے۔

Khmer: យើងមានផ្តល់សេវាកម្មអ្នកបកប្រែផ្ទាល់មាត់ឥតគិតថ្លៃ ដើម្បីឆ្លើយសំណួរណាមួយដែលអ្នកប្រហែលជាមានអំពីគម្រោងសុខភាព ឬឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ គ្រាន់តែហៅទូរសព្ទមកយើងតាមលេខ 1-800-275-2583 ។ អ្នកណាម្នាក់ដែលនិយាយភាសាខ្មែរអាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មឥតគិតថ្លៃ។

Telugu: మా ఆరోగ్యం లేదా ఔషధ ప్రణాళిక గురించి మీకు ఏవైనా ప్రశ్నలకు సమాధానం ఇవ్వడానికి మాకు ఉచిత ఇంటర్‌ప్రెటర్ సర్వీస్‌లు అందుబాటులో ఉన్నాయి. అనువాదకుడిని పొందడానికి, 1-800-275-2583 ద్వారా మాకు కాల్ చేయండి. తెలుగు మాట్లాడగలిగే ఎవరైనా మీకు సహాయం చేయగలరు. ఇది ఉచిత సర్వీస్.

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

You can file a grievance in the following ways:

- In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103
- By phone: 1-888-377-3933 (TTY: 711)
- By fax: 215-761-0245
- By email: civilrightscoordinator@1901market.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

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