AmeriHealth Insurance Company of New Jersey
Outline of Medicare Supplement Coverage
Benefit Plans Available: A, C, F and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
Medical expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood: First three pints of blood each year
Hospice: Part A coinsurance

A	B	C	D	F|F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4,940; paid at 100% after limit reached	Out-of-pocket limit $2,470; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

AmeriHealth Insurance Company of New Jersey

Medicare Supplement Premium Information

AmeriHealth Insurance Company of New Jersey can only raise your premium if we raise the premium for all policies like yours in this State. We will not change your premium or cancel your policy because of age or poor health. These monthly rates are subject to change with the approval of the New Jersey Department of Banking and Insurance.

Attained Age Rated	Age 50-64*	Age 65	Age 66	Age 67	Age 68	Age 69	Age 70	Age 71	Age 72	Age 73	Age 74	Age 75-79	Age 80-84	Age 85+
Plan A														
NT	N/A	$98.89	$104.40	$108.71	$113.64	$118.25	$123.21	$128.42	$132.98	$137.05	$140.52	$150.42	$159.77	$159.77
T	N/A	$108.78	$114.84	$119.58	$125.00	$130.07	$135.53	$141.26	$146.28	$150.76	$154.57	$165.46	$175.74	$175.74
Plan C														
NT	$164.65	$164.65	$170.21	$177.08	$184.89	$192.21	$200.80	$209.61	$217.31	$225.57	$232.69	$253.71	$293.13	$336.79
T	$181.11	$181.11	$187.23	$194.78	$203.38	$211.44	$220.88	$230.57	$239.04	$248.13	$255.96	$279.08	$322.44	$370.47
Plan F														
NT	N/A	$156.81	$162.11	$168.64	$176.08	$183.06	$191.23	$199.63	$206.96	$214.83	$221.61	$241.63	$279.17	$320.75
T	N/A	$172.49	$178.32	$185.51	$193.69	$201.37	$210.36	$219.59	$227.66	$236.32	$243.77	$265.79	$307.09	$352.83
Plan N														
NT	N/A	$108.81	$115.27	$120.28	$126.05	$131.47	$137.91	$144.52	$150.31	$156.68	$162.16	$178.63	$210.44	$247.98
T	N/A	$119.69	$126.79	$132.31	$138.65	$144.61	$151.71	$158.97	$165.34	$172.35	$178.38	$196.49	$231.48	$272.78

*This includes people 50 and older and under 65 on Medicare due to Disability.

NT – Non-Tobacco T – Tobacco Non-Tobacco rates apply to applications submitted during the 6-month open enrollment or in a guaranteed issue situation. Applicants NOT enrolling during the 6 month open enrollment period or in a guaranteed issue situation will be evaluated for tobacco usage and charged the corresponding tobacco or non-tobacco rates.

PREMIUM INFORMATION

We, AmeriHealth Insurance Company of New Jersey, can only raise your premium if we raise the premium for all policies like yours in the State of New Jersey. Premiums for attained age plans A, C, F and N will increase beginning with the first full month that the member moved into a new age range in accordance with the premium schedule on the previous page.

Disclosures

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to AmeriHealth Medigap Plans, 1901 Market Street, Philadelphia, PA 19103-1480. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. AmeriHealth is not connected with Medicare. This *Outline of Coverage* does not give all of the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and complete any questions about your medical health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.			
MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,260	$0	$1,260 (Part A deductible)
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
• Once lifetime reserve days are used:			
o Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
o Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $157.50 a day	$0	Up to $157.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these benefits.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(continued)

Plan A *(continued)*

† Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.			
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $147 of Medicare-approved amounts†	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts†	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE — MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $147 of Medicare-approved amounts†	$0	$0	$147 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

Deductible amounts announced annually by CMS.

Plan C

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.			
MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
• Once lifetime reserve days are used:			
o Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
o Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these benefits.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(continued)

Plan C *(continued)*

† Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.			
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $147 of Medicare-approved amounts†	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts†	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE — MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $147 of Medicare-approved amounts†	$0	$147 (Part B deductible)	$0
• Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Deductible amounts announced annually by CMS.

Plan F

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.			
MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
• Once lifetime reserve days are used:			
o Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
o Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these benefits.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(continued)

Plan F *(continued)*

† Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.			
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $147 of Medicare-approved amounts†	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts†	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE — MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $147 of Medicare-approved amounts†	$0	$147 (Part B deductible)	$0
• Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Deductible amounts announced annually by CMS.

Plan N

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.			
MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
• Once lifetime reserve days are used:			
o Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
o Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these benefits.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(continued)

Plan N *(continued)*

† Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.			
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $147 of Medicare-approved amounts†	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts†	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES —TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Plan N *(continued)*

† Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.			
MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE — MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $147 of Medicare-approved amounts†	$0	$0	$147 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Deductible amounts announced annually by CMS.

Questions?
Need more information?

Call one of our Medicare sales representatives at
1-866-365-5345
(TTY/TDD: 711)

Monday - Friday, 8 a.m. to 8 p.m.
www.amerihealthmedicare.com

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