



AMERICAN  
HEALTH  
MEDICARE

**2010 Summary of Benefits**  
**AHM\_Opal (HMO)**  
January 1, 2010 to December 31, 2010

H5774\_1001\_10\_05\_E  
CMS Approval Date: 10/29/2009

## **SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS**

Thank you for your interest in AHM\_Opal (HMO). Our plan is offered by AMERICAN HEALTH, INC./American Health Medicare, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call AHM\_Opal (HMO) and ask for the "Evidence of Coverage".

### **YOU HAVE CHOICES IN YOUR HEALTH CARE**

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

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

### **HOW CAN I COMPARE MY OPTIONS?**

You can compare AHM\_Opal (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

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

### **WHERE IS AHM\_Opal (HMO) AVAILABLE?**

The service area for this plan includes: Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Añasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamón, Cabo Rojo, Caguas, Camuy, Canóvanas, Carolina, Cataño, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guánica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Díaz, Juncos, Lajas, Lares, Las Marías, Las Piedras, Loíza, Luquillo, Manatí, Maricao, Maunabo, Mayagüez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Peñuelas, Ponce, Quebradillas, Rincón, Río Grande, Sabana Grande, Salinas, San Germán, San Juan, San Lorenzo, San Sebastián, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco Counties in PR. You must live in one of these areas to join the plan.

## **WHO IS ELIGIBLE TO JOIN AHM Opal (HMO)?**

You can join AHM\_Opal (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in AHM\_Opal (HMO) unless they are members of our organization and have been since their dialysis began.

## **CAN I CHOOSE MY DOCTORS?**

AHM\_Opal (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at [www.ahmpr.com](http://www.ahmpr.com). Our customer service number is listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither AHM\_Opal (HMO) nor the Original Medicare Plan will pay for these services.

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

AHM\_Opal (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

AHM\_Opal (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.caremark.com](http://www.caremark.com). Our customer service number is listed at the end of this introduction.

## **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

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

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

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

You may be able to get extra help to pay for your prescription drug premiums and costs. To see qualify for getting extra help, call:

\* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week.

\*The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or

\*Your State Medicaid Office.

### **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

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

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

Quality Improvement Professional Research Organization (QIPRO)

787-641-1240 ext.6221 or 6222 during normal business hours

787-340-2660 on weekends

## **WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

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

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact American Health Medicare for more details.

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

## **PLAN RATINGS**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-888-620-1919 to obtain a copy of the plan ratings for this plan. TTY users call 1-866-620-2520.

Please call **American Health Medicare** for more information about AHM\_Opal (HMO)

Visit us at [www.ahmpr.com](http://www.ahmpr.com) or call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m.  
Atlantic (PR, VI)

Current members should call toll free (888)-620-1919 for questions related to the Medicare Advantage program and/or Medicare Part D Prescription Drug Program.  
TTY/TDD (866)-620-2520

Prospective members should call toll free (866)-620-2420 for questions related to the Medicare Advantage program and/or Medicare Part D Prescription Drug Program.  
TTY/TDD (866)-620-2520

Current members should call locally 787-620-1919 for questions related to the Medicare Advantage program and/or Medicare Part D Prescription Drug Program.  
TTY/TDD (866)-620-2520

Prospective members should call locally (866)-620-2420 for questions related to the Medicare Advantage program and/or Medicare Part D Prescription Drug Program.  
TTY/TDD (866)-620-2520

For more information about Medicare, please call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

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

## AHM\_Opal (HMO)

If you have any questions about this plan's benefits or costs, please contact  
American Health Medicare Toll Free at 1-888-620-1919, hearing impaired users (TTY) call 1-866-620-2420.

SECTION II- SUMMARY OF BENEFITS		
Benefit Category	Original Medicare	AHM_Opal (HMO)
<b>IMPORTANT INFORMATION</b>		
<b>1 - Premium and Other Important Information</b>	<p>In 2009 the monthly Part B Premium was \$0 or \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$0 or \$135 and will change for 2010.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p>
	<p>If a doctor or supplier does not accept assignment, their costs are often <u>higher, which means you pay more.</u></p>	
	<p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	
<b>2 - Doctor and Hospital Choice</b> (For more information, see Emergency - #15 and Urgently Needed Care - #16)	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AHM_Opal (HMO)</b>
		No referral required for network doctors, specialists, and hospitals.
<b>INPATIENT CARE</b>		
<b>3 - Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit period were \$0 or: Days 1 - 60: \$1068 deductible* Days 61 - 90: \$267 per day* Days 91 - 150: \$534 per lifetime reserve day* These amounts will change for 2010.	In-Network \$0 copay
	In 2010 the amounts for each benefit period are: Days 1 - 60: \$____ deductible Days 61 - 90: \$____ per day Days 91 - 150: \$____ per lifetime reserve day	
	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	No limit to the number of days covered by the plan each benefit period.
	Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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SECTION II- SUMMARY OF BENEFITS		
Benefit Category	Original Medicare	AHM_Opal (HMO)
<b>4 - Inpatient Mental Health Care</b> (includes Substance Abuse and Rehabilitation Services)	ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	
	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	In-Network \$0 copay  You get up to 190 days in a Psychiatric Hospital in a Lifetime.
<b>5 – Skilled Nursing Facility</b> (in a Medicare-certified skilled nursing facility)	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day* Days 21 - 100: \$0 or \$133.50 per day* These amounts will change for 2010.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
		General Authorization rules may apply
		In-Network \$0 copay for SNF services
		Plan covers up to 100 days each benefit period.

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<b>SECTION II- SUMMARY OF BENEFITS</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AHM_Opal (HMO)</b>
	A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	3-day prior hospital stay is required.
<b>6 - Home Health Care</b> (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	General Authorization rules may apply.
		In-Network \$0 copay for each Medicare-covered home health visits.
<b>7- Hospice</b>	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care.	General You must get care from a Medicare-certified hospice.
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<b>SECTION II- SUMMARY OF BENEFITS</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AHM_Opal (HMO)</b>
<b>OUTPATIENT CARE</b>		
<b>8 - Doctor Office Visits</b>	20% coinsurance	In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.
		\$5 copay for the cost of each in-area, network urgent care Medicare-covered visit.
		\$0 copay for each specialist doctor visit for Medicare-covered benefits.
<b>9 - Chiropractic Services</b>	Routine care not covered	General Authorization rules may apply.
		In-Network \$0 copay for Medicare-covered visit.
		Up to 5 routine visit(s) every year
<b>10 - Podiatry Services</b>	Routine care not covered	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
		General Authorization rules may apply.

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
	<p style="text-align: center;"><b>Original Medicare</b></p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>
	<p>In-Network \$0 copay for each Medicare-covered podiatry benefits.</p> <p>up to 4 routine visit(s) every year.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<b>11 - Outpatient Mental Health Care</b>	<p>In-Network \$10 copay for Medicare-covered individual or group therapy visit.</p>
<b>12 - Outpatient Substance Abuse Care</b>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered individual or group therapy visits.</p>
<b>13 - Outpatient Services/Surgery</b>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p>

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SECTION II- SUMMARY OF BENEFITS	
Benefit Category	AHM_Opal (HMO)
	<b>Original Medicare</b>
	\$0 copay for each Medicare-covered outpatient hospital facility visit.
<b>14- Ambulance Services</b> (medically necessary ambulance services)	General Authorization rules may apply.
	In-Network \$0 copay for Medicare-covered ambulance benefits.
<b>15 - Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	General \$25 copay for Medicare-covered emergency room visits.
	Worldwide coverage
<b>16 - Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)	If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit.
	General \$25 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit.

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<b>SECTION II- SUMMARY OF BENEFITS</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AHM_Opal (HMO)</b>
<b>17 - Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance.	General Authorization rules may apply.
		In-Network \$0 copay for Medicare-covered Occupational Therapy visits.
		\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>		
<b>18 - Durable Medical Equipment</b> (Includes wheelchairs, oxygen, etc.)	20% coinsurance.	General Authorization rules may apply.
		In-Network \$0 copay for Medicare-covered items.
<b>19 - Prosthetic Devices</b> (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance.	General Authorization rules may apply.
		In-Network \$0 copay for Medicare-covered items.
<b>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance.	General Authorization rules may apply.
		In-Network \$0 copay for Diabetes self-monitoring training.
		\$0 copay for Nutrition Therapy for Diabetes.

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
	<p><b>Original Medicare</b></p> <p>have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>
<p><b>21 - Diagnostic Tests, X-Rays, and Lab Services and Radiology Services</b></p>	<p>\$0 copay for Diabetes supplies.</p>
	<p>20% coinsurance for diagnostic tests and x-rays.</p>
	<p>\$0 copay for Medicare-covered lab services.</p>
	<p>General Authorization rules may apply.</p>
	<p>In-Network \$0 copay for Medicare-covered:</p>
	<ul style="list-style-type: none"> <li>- lab services</li> <li>- diagnostic procedures and tests</li> <li>- X-rays</li> <li>- diagnostic radiology services(not including X-rays)</li> <li>- Therapeutic radiology services</li> </ul>
	<p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>

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SECTION II- SUMMARY OF BENEFITS		AHM_Opal (HMO)
Benefit Category	Original Medicare	
PREVENTIVE SERVICES		
<b>22 - Bone Mass Measurement</b> (for people with Medicare who are at risk)	20% coinsurance.	General Authorization rules may apply.
	Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network \$0 copay for Medicare-covered bone mass measurement
<b>23 - Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	20% coinsurance.	General Authorization rules may apply.
	Covered when you are high risk or when you are age 50 and older.	In-Network \$0 copay for Medicare-covered colorectal screenings.
<b>24 - Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines	General Authorization rules may apply.
	20% coinsurance for Hepatitis B vaccine.	In-Network \$0 copay for Flu and Pneumonia vaccines
	You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	\$0 copay for Hepatitis B vaccine
<b>25 - Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)	20% coinsurance	No referral needed for Flu and Pneumonia vaccines.
	No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for	In-Network \$0 copay for Medicare-covered screening mammograms.

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Benefit Category	AHM_Opal (HMO)
	<b>Original Medicare</b> women with Medicare between age 35 and 39.
<b>26 - Pap Smears and Pelvic Exams</b> (for women with Medicare)	\$0 copay for Pap smears
	Covered once every 2 years. Covered once a year for women with Medicare at high risk.
	20% coinsurance for Pelvic Exams
<b>27 - Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam.
	\$0 for the PSA test; 0% or 20% coinsurance for other related services.
	Covered once a year for all men with Medicare over age 50.
<b>28 - End-Stage Renal Disease</b>	20% coinsurance for renal dialysis
	20% coinsurance for Nutrition Therapy for End-Stage Renal Disease
	Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling
	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

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Benefit Category	AHM_Opal (HMO)
<p><b>29 - Prescription Drugs</b></p>	<p><b>Original Medicare</b> to help you manage your diabetes or kidney disease.</p> <p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p> <p><b>Drugs covered under Medicare Part B</b> General \$0 copay for Part B-covered drugs.</p> <p><b>Drugs covered under Medicare Part D</b> General This plan uses a formulary. Then plan will send you the formulary. You can also see the formulary at <a href="http://www.caremark.com">www.caremark.com</a> on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>- have limited incomes,</li> <li>- live in long term care facilities, or</li> <li>- have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage. (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan.</p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from AHM_Opal (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and AHM_Opal (HMO) approves the exception, you will pay Specialty cost-sharing for that drug.</p> <p>In-Network \$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p><b>Initial Coverage</b></p>

**AHM\_Opal (HMO)**

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p>You pay the following until total yearly drug costs reach \$2,830:</p> <p><b>Retail Pharmacy</b></p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$30 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>- \$25 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$75 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Brand</b></p> <ul style="list-style-type: none"> <li>- \$40 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$120 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.</li> </ul>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<ul style="list-style-type: none"> <li>- 33% coinsurance for a three-month (90 day) supply of drugs in this tier.</li> </ul>
	<b>Part D Excluded Drugs</b>
	<ul style="list-style-type: none"> <li>- \$0 copay for a one-month (30-day) supply of drugs in this tier.</li> </ul>
	<b>Long Term Care Pharmacy</b>
	<b>Preferred Generic</b>
	<ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul>
	<b>Non Preferred Generic</b>
	<ul style="list-style-type: none"> <li>- \$10 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul>
	<b>Preferred Brand</b>
	<ul style="list-style-type: none"> <li>- \$25 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul>
	<b>Non Preferred Brand</b>
	<ul style="list-style-type: none"> <li>- \$40 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul>
	<b>Specialty</b>
	<ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier.</li> </ul>
	<b>Part D Excluded Drugs</b>
	<ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul>
	<b>Mail Order</b>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$30copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>- \$25 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$75 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Brand</b></p> <ul style="list-style-type: none"> <li>- \$40 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$120 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.</li> <li>- 33% coinsurance for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Part D Excluded Drugs</b></p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<ul style="list-style-type: none"> <li>- \$0 copay for a one-month (30-day) supply of drugs in this tier.</li> </ul> <p><b>Coverage Gap</b> The plan covers many generics (65%-99% of formulary generic drugs)</p> <p><b>AND</b> few brands (less than 10% of formulary brand drugs) through the coverage gap. You pay the following:</p> <p><b>Retail Pharmacy</b></p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$30 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Part D Excluded Drugs</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (30-day) supply of drugs in this tier.</li> </ul> <p><b>Long Term Care Pharmacy</b></p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Part D Excluded Drugs</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (31-day) supply of drugs in this tier.</li> </ul> <p><b>Mail Order</b></p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$30 copay for a three-month (90 day) supply of drugs in this tier.</li> </ul> <p><b>Part D Excluded Drugs</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (30-day) supply of drugs in this tier.</li> </ul> <p>For all other covered drugs, after your total yearly drug costs reach \$2,830, you pay 100% until your</p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p>yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>- 5% coinsurance</li> </ul> <p><b>Out-of-Network</b> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from AHM_Opal (HMO).</p> <p><b>Out-of-Network Initial Coverage</b> You will be reimbursed up to the full cost of the drug minus the following drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p>
	<b>Preferred Generic</b>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>Original Medicare</b>
	<p><b>AHM_Opal (HMO)</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a (10-day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a (10-day) supply of drugs in this tier.</li> </ul> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>- \$25 copay for a (10-day) supply of drugs in this tier.</li> </ul> <p><b>Non Preferred Brand</b></p> <ul style="list-style-type: none"> <li>- \$40 copay for a (10-day) supply of drugs in this tier.</li> </ul> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a (10-day) supply of drugs in this tier.</li> </ul> <p><b>Part D Excluded Drugs</b></p> <ul style="list-style-type: none"> <li>- \$0 copay for a (10-day) supply of drugs in this tier.</li> </ul> <p><b>Out-of-Network Coverage Gap</b> You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a (10-day) supply of all drugs covered in this tier</li> </ul> <p><b>Non Preferred Generic</b></p> <ul style="list-style-type: none"> <li>- \$10 copay for a (10-day) supply of all drugs covered in this tier</li> </ul>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p><b>Preferred Brand</b></p> <p>-After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by AHM_Opal (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AHM_Opal (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Non Preferred Brand</b></p> <p>-After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by AHM_Opal (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AHM_Opal (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Specialty</b></p> <p>-After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by AHM_Opal (HMO) for out-</p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<b>Original Medicare</b>	<p>of-network purchases when you are in the coverage gap. However, you should still submit documentation to AHM_Opal (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Part D Excluded Drugs</b></p> <p>\$0 copay for a (10-day) supply of all drugs covered in this tier</p> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> <li>- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>
<b>30 – Dental Services</b>	<p>General Authorization rules may apply.</p> <p>In- Network \$0 copay for Medicare covered dental benefits.</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- Up to 2 oral exam(s) every year</li> <li>- Up to 2 cleaning(s) every year</li> </ul>

## AHM\_Opal (HMO)

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SECTION II- SUMMARY OF BENEFITS	
Benefit Category	AHM_Opal (HMO)
<b>Original Medicare</b>	<ul style="list-style-type: none"> <li>- Up to 2 fluoride treatment(s) every year</li> <li>- Up to 2 dental x-ray(s) every year.</li> </ul> <p>Plan offers additional comprehensive dental benefits every year</p> <p>\$750 limit for comprehensive dental benefits every two years.</p> <p>General Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> <li>- 1 routine hearing test(s) every year</li> <li>- up to 1 hearing aid fitting evaluation(s) every year.</li> </ul> <p>\$0 copay for up to 1 hearing aid(s) every year.</p> <p>\$300 limit for hearing aids every three years.</p> <p>General Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for diagnosis and treatment for diseases and conditions of the eye</p>
<b>31 - Hearing Services</b>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>
<b>32 - Vision Services</b>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
<p><b>Original Medicare</b></p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>- and up to 1 routine eye exam(s) every year</p> <p>\$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery</p> <p>- up to 1 pair(s) of glasses every year - up to 1 pair(s) of contacts every year - up to 1 pair(s) of lenses every year - up to 1 frame(s) every year \$100 limit for eye wear every year.</p>
<p><b>33 - Physical Exams</b></p> <p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p> <p>Routine exams not covered.</p>
<p><b>Health/Wellness Education</b></p> <p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking- related</p>	<p>General Authorization rules may apply.</p> <p>In-Network The Plan covers the following health/wellness education benefits:</p>

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<b>SECTION II- SUMMARY OF BENEFITS</b>	
<b>Benefit Category</b>	<b>AHM_Opal (HMO)</b>
	<p><b>Original Medicare</b></p> <p>illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p> <ul style="list-style-type: none"> <li>- Additional Smoking Cessation</li> <li>- Health Club Membership/Fitness Classes</li> <li>- Other Wellness Benefits</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p>
<b>Transportation (Routine)</b>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 1 round trip(s) to plan-approved locations every year.</p>
<b>Acupuncture</b>	<p>In-Network \$5 copay per visit up to 6 visits every year.</p>

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<b>SECTION III- ADDITIONAL BENEFITS</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AHM_Opal (HMO)</b>
<b>Erectile Dysfunction Medication</b>	Not Covered	Up to 5 pills per month. As medically necessary.