INDIVIDUAL MEDICARE SUPPLEMENT HEALTH CARE BENEFITS
AMERIHEALTH MEDIGAP - PLAN F

This Policy is a medically underwritten policy and provides a benefit that supplements your Medicare coverage. Benefits underwritten or administered by AmeriHealth Insurance Company of New Jersey.

NOTICE OF COVERED PERSON’S RIGHT TO EXAMINE THE POLICY: The Applicant has a right to return this Policy within (30) days of delivery for refund of the full premium paid if, after examination of this Policy, the Applicant is not satisfied for any reason. This Policy may be returned to AmeriHealth Medigap Plans, [1901 Market Street, Philadelphia, Pa. 19103-1480.] If the Policy is returned, it will be null and void from the beginning and no benefits will be payable under its terms.

NOTICE TO BUYER
This Policy may not cover all of your medical expenses.

The purchase of multiple polices in addition to Medicare Coverage is often unnecessary. Review your current health insurance coverage and determine your needs before you purchase this Policy.

GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE
Subject to the right of the AmeriHealth of New Jersey to terminate coverage because of the Covered Person’s material misrepresentation or non-payment of premium, this Policy is Guaranteed Renewable and the Policy may be renewed by payment of premiums. AmeriHealth of New Jersey also has the right to change premiums. There are two rating occurrences that might affect your premium rates (attained age and table of rate changes). For the attained rate change, your premiums will change as you enter a new attained age bracket. Additionally, we reserve the right to revise the table of premium rates and we can only raise the premiums for this table of premium rate change, if we raise the premiums for all policies like yours in New Jersey. We will give a 30 day notice of a premium change. For additional information see Section 1. GUARANTEED RENEWABLE and Section 3 POLICY PROVISIONS (Policy Premium Rate) within this Policy.

This Policy is non-participating in any divisible surplus of premium.
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Supplement to Medicare Insurance (Part A and Part B)
(See Limitations in SECTION 4 – Benefits)

This is to certify that, in consideration for and upon the payment of the appropriate premium rate, the Covered Person defined herein is entitled to the benefits set forth in accordance with the terms and conditions specified. SUBJECT TO THE RIGHT OF THE AMERIHEALTH TO TERMINATE COVERAGE BECAUSE OF THE COVERED PERSON’S MATERIAL MISREPRESENTATION, THIS POLICY IS GUARANTEED RENEWABLE AND THE POLICY MAY BE RENEWED BY PAYMENT OF RENEWAL PREMIUMS. FOR ADDITIONAL INFORMATION, REFER TO SECTION 1.

2[Robert J. Smith
Vice-President Sales and Marketing - Medicare]
PLEASE READ YOUR POLICY CAREFULLY

Return of Contract by the Applicant

The Applicant has a right to return this Policy within thirty (30) days of delivery for a refund of the full premium amount paid if, after examination of this Policy, the Applicant is not satisfied for any reason. If benefits are paid for claims incurred by the Applicant during this period, there shall be no right to a full refund of the premium that was paid by the Applicant. The Policy will be null and void if false information is submitted by the Applicant.

A Brief Outline of Coverage Benefits in this Policy

This Policy will describe a program of health care benefits provided by AmeriHealth. These benefits will supplement Medicare coverage, in part, by providing payment for the following:

- The Medicare Part A Deductible
- The Medicare Coinsurance amount of Part A Medicare Eligible Expenses for hospitalization from the 61st through the 90th day in a Benefit Period.
- The Medicare Coinsurance amount of Part A Medicare Eligible Expenses for hospitalization for each Medicare lifetime inpatient reserve day.
- An additional 365 inpatient days of care in a Hospital after the Covered Person has used all of the allowed Medicare days.
- Coverage under Medicare Parts A and B for the first three (3) pints of whole blood during a calendar year.
- The Medicare Part B Deductible.
- Medicare Part B Excess Charges.
- The Medicare Coinsurance or Medicare Copayment amount of Part B Medicare Eligible Expenses, subject to the Medicare Part B Deductible.
- The cost sharing amount of Part A Medicare Eligible Expenses for Hospice and Respite care.
- The Coinsurance for Skilled Nursing Facility Care.
- Medically Necessary Emergency Care in a Foreign Country.
These benefits will be provided to the Covered Person in accordance with the terms and conditions of this Policy when necessary for the treatment of a condition of illness or bodily injury.

Please review Section 4 for further details concerning the benefits shown above.
SECTION 1.

GUARANTEED RENEWABLE

A. Continuation of this Policy

1. This Policy is guaranteed renewable and may be renewed by payment of the appropriate renewal premium within the grace period.

2. Coverage continues for one month from the Effective Date of the Policy and from month to month thereafter until discontinued, terminated or voided as provided in this Policy.

3. AmeriHealth subject to the approval of the New Jersey Department of Banking and Insurance may alter or revise the premium rates.

B. Termination of this Policy

1. AmeriHealth will not cancel or nonrenew this Policy solely on the grounds of age or deterioration of health or loss experience of the Covered Person.

2. AmeriHealth will not cancel or nonrenew an eligible spouse because of termination of coverage of the Covered Person other than for nonpayment of premium.

3. AmeriHealth shall terminate this Policy if the premium is not received within the grace period. The effective date of the termination shall be the last day of the period for which payment of the Policy premium has been received.

4. AmeriHealth shall terminate this Policy if the Covered Person obtained or attempted to obtain benefits or payment for benefits through deliberate or willful material misrepresentation. If benefits were provided through deliberate or willful material misrepresentation, the Covered Person agrees to reimburse AmeriHealth for such benefits.

C. Grace Period

This Coverage has a grace period of 31 days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period, the Coverage will stay in force, but no benefits will be paid for services incurred subsequent to the Coverage’s then current paid date. If the appropriate payment is not received at the end of the thirty-one (31) days, the Policy will be cancelled and AmeriHealth will have no liability for services that are incurred after the Coverage’s then current paid date.
D. **Reinstatement**

If this Policy is terminated due to solely to nonpayment of premium coverage will be reinstated if the Covered Person, within sixty (60) days from the date of termination, tenders and AmeriHealth receives payment of the premium required for reinstatement. The Covered Person and AmeriHealth have the same rights under the reinstated Plan F as they had under the Policy immediately before the due date of the defaulted premium. The right of the Covered Person to have this Policy reinstated is limited to one (1) reinstatement during any twelve (12) month period and to two (2) reinstatements during the Covered Person’s lifetime.
SECTION 2.
DEFINITIONS

For the purpose of this Policy, the terms below have the following meaning:

**AMERIHEALTH** means AmeriHealth Insurance Company of New Jersey

**APPLICANT** the person who seeks to contract for coverage.

**APPLICATION** means the written request for coverage under this Policy on a form furnished by AmeriHealth, together with any amendments or modifications thereto.

**ASSIGNMENT** means an agreement between the Provider and the Medicare beneficiary. When the Provider accepts Assignment, such Provider agrees to accept the reasonable charge set by Medicare as payment in full.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which the Covered Person was covered by Creditable Coverage, if, during the period of the coverage, the Covered Person had no breaks in coverage greater than 63 days.

**COVERED PERSON** means a Medicare beneficiary who is enrolled in Medicare Part A and Part B, made the appropriate payment in consideration for this Policy, and is eligible for benefits under this Policy.

**COVERED SERVICE** means a service or supply specified in this Policy for which benefits will be provided when rendered by a Provider.

**CREDITABLE COVERAGE** means coverage of the Covered Person under any of the following: (A) A group health plan, (B) Health insurance coverage, (C) Part A or Part B of title XVIII of the Social Security Act, (D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928, (E) Chapter 55 of title 10, United States, (F) A medical care program of the Indian Health Service or of a tribal organization, (G) A state health benefits risk plan, (H) A health plan offered under chapter 89 of title 5, United States code, (I) A public health plan (as defined in federal regulations), or (J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). The term Creditable Coverage does not include coverage consisting solely of excepted benefits as defined in the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 139).

For the purposes of this Policy, the term Creditable Coverage does not mean creditable prescription drug coverage, as that term is defined under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Title XVIII, Section 1860D-13(b)(4) of the Social Security Act (Medicare).
**DURABLE MEDICAL EQUIPMENT** means Medically Necessary non-disposable equipment, prosthetic devices (artificial devices replacing body parts) and orthopedic braces necessary as a result of an illness or injury.

**EFFECTIVE DATE** according to the Section of Policy Provisions, the date on which coverage for a Covered Person begins under this Policy as shown on the records of AmeriHealth.

**EMERGENCY CARE** means Hospital, physician, and medical care needed immediately because of an emergency or an illness of sudden and unexpected onset.

**HOSPITAL** means an institution which meets the Medicare requirements for a Hospital and participates in the Medicare program.

**IDENTIFICATION CARD** the current effective date issued to the Covered Person by AmeriHealth.

**INPATIENT** means a person admitted to a Hospital or Skilled Nursing Facility for an overnight stay.

**MEDICALLY NECESSARY (or MEDICAL NECESSITY)** health care Services or Supplies that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating and illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations an the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

A. “Medicare Part A” means the Hospital Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.

B. “Medicare Part B” means the Supplementary Medical Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.
C. “Medicare Part D” means the Voluntary Prescription Drug Benefit Program provided by the United States Government under Public Law 108-173, Title XVIII of the Social Security Act as amended from time to time.

**MEDICARE BENEFIT PERIOD** for the purposes of Medicare Part A expenses, the period that begins on the first day (which is not part of a prior Benefit Period) of confinement in a Hospital or Skilled Nursing Facility. The Benefit Period ends when the Covered Person has not been an inpatient of a Hospital or Skilled Nursing Facility for 60 consecutive days.

For the purposes of Medicare Part B expenses, the calendar year beginning January 1\(^{st}\) and ending December 31\(^{st}\).

**MEDICARE COINSURANCE OR COPAYMENT** means that portion of Medicare Eligible Expenses, or Medicare Reasonable Charges over and above the Medicare Deductible, which the Covered Person has the responsibility to pay under Medicare.

**MEDICARE DEDUCTIBLE** means the amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or other insurance begins to pay. For example, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**MEDICARE NON-PARTICIPATING PROVIDER** means a Provider eligible to provide services or supplies under Medicare Part B but who does not sign a participation agreement with Medicare, and may or may not elect to accept Assignment on each Medicare claim that is filed. A Medicare Non-Participating Provider who does not accept Assignment will not accept the Medicare Reasonable Charge for a certain service or supply as payment in full, and may charge his/her patient more than the Medicare Reasonable Charge, unless otherwise prohibited by law.

**MEDICARE REASONABLE CHARGE** means the approved amount for services and supplies, as determined by Medicare.

**OUTPATIENT** means a person who is receiving services or supplies while not an Inpatient in a Hospital or Skilled Nursing Facility.

**PACE** means the program of All-Inclusive Care for the Elderly, the federal Medicare program permanently established by the United States Government under the Balanced Budget Act of 997, Public Law 101-33 intended to provide comprehensive, community-based care and services to individuals otherwise in need of nursing home level of care. The term PACE does not include income-based prescription drug assistance programs offered and administered by states for the benefit of their qualified residents, age 65 or older, which are intended to provide individuals with greater access to prescription drug medications. ..

**POLICY** shall mean any policy, contract, certificate or other document which sets forth or summaries the essential features of the coverage issued to an individual or group by a carrier,
for the purpose of providing Medicare supplement coverage, including any such policy issued pursuant to a conversion privilege to an individual 65 years of age or older, except as otherwise provided in this subchapter or Federal law.

**PRIVATE CONTRACT**: is a written agreement between the Covered Person and a physician or other health care provider who has decided not to provide services to anyone through Medicare. The Private Contract only applies to the services provided by the physician or other provider who asked you to sign it.

**PROVIDER** means any health care provider eligible to provide services or supplies under Medicare Part B such as licensed doctor of medicine, doctor of osteopathy, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic, psychologist, nurse midwife or Certified Registered Nurse (RN) acting within the authority of his/her license.

**SICKNESS** means a sickness or disease which causes loss commencing while the insurance or coverage is in force and which is not excluded under a preexisting condition limitation. It does not include sickness or diseases for which benefits are provided under any worker’s compensation, occupational disease, employer’s liability or similar law.

**SKILLED NURSING FACILITY** means an institution that meets the Medicare requirements for a Skilled Nursing Facility and participates in the Medicare program.

**TOTALLY DISABLED** means:

A. an injury or Sickness that continuously confines an individual in a Hospital or Skilled Nursing Facility; or

B. a continuous disability resulting from an injury or Sickness not requiring confinement of an individual in a Hospital or Skilled Nursing Facility, but which a Physician certifies as preventing that individual from engaging in the normal activities of a person of like age and sex in good health.

**UNITED STATES** means all of the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, Northern Mariana Islands and for purposes of Covered Services rendered on board ship, the territorial waters adjoining the land areas of the United States, subject to those limitations imposed by Medicare.
SECTION 3.

POLICY PROVISIONS

ENTIRE CONTRACT

The entire contract between and the Covered Person consists of the Application, this Policy, including any amendments, riders or endorsements or required notice of change issued by AmeriHealth, the Covered Person’s Identification Card and the applicable Covered Person rate. No change in this Policy will be effective until approved by an authorized officer of AmeriHealth, along with an approval by the New Jersey Department of Banking and Insurance. This approval must be noted on, or attached to this Policy. No agent or representative of AmeriHealth, other than an officer of AmeriHealth may otherwise change this Policy or waive any of its provisions.

RIDER OR ENDORSEMENT CHANGES

All riders or endorsements added after the date of issue or at reinstatement or renewal which would reduce or eliminate benefits of coverage will require a signed acceptance by the Covered Person. After the date of the Policy issuance, any rider or endorsement which increases benefits or coverage with an increase in premium charges during the policy term shall be agreed to in writing signed by the Covered Person, except if the increased benefits or coverage are required by the minimum standards of this State for Medicare supplement coverage, or if required by other law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth clearly.

POLICY PREMIUM RATE

The Policy premium rate that applies to this Policy at any given time are those on file with and approved by the New Jersey Department of Banking and Insurance. There are two distinct rates that will affect your premium:

1. Attained Age Rating are those premium rates that are set based upon your age. These premium rates will change as you enter a new attained age bracket.

2. Table of Rate changes are those rates which AmeriHealth has the right to revise, but can only change these premium rates if we raise the premium rates for all policies like yours in our service area.

Coverage will renew every month thereafter but only at the premium rate for the age which the Covered Person has then attained.

POLICY REVISION OF RATES

AmeriHealth, subject to the approval of the New Jersey Department of Banking and Insurance may:
1. alter or revise the terms of this Policy by endorsement or required notice of change issued by AmeriHealth; and/or

2. modify the applicable Policy premium rates.

Any such alteration or revision of the terms of the Policy shall become applicable for all Covered Persons on the effective date of the alteration or revision, whether or not the Covered Persons have paid the Policy premium rates in advance. In the event of a modification of the Policy premium rates, the Covered Person shall be notified 30 days in advance of the new Policy premium rate and the effective date. Any notice shall be considered to have been given when mailed to the Covered Person at the address on the records of AmeriHealth.

EFFECTIVE DATE

The date on which your benefits begin under this Policy as shown on Policy records of AmeriHealth. The Identification Card identifies you as the Covered Person on this Policy.

CHANGE OF RESIDENCE

If the Covered Person establishes a residence outside of the United States, benefits provided outside the United States as defined in this Policy shall not be available.

SUSPENSION AND REINSTITUTION OF COVERAGE

1. Suspension of Coverage – A Covered Person may request that benefits and premiums under this Policy be suspended under the following conditions:

   a. Covered Person entitled to medical assistance

      1) The Covered Person has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid) and;

      2) The Covered Person must notify AmeriHealth within ninety (90) days after the Covered Person becomes entitled to Medicaid.

      The Policy will be suspended for up to a total of 24 months.

   b. Disabled Covered Persons

      A Covered Person who is entitled to Medicare by reason of disability becomes covered under an employer group health plan.

2. Reinstitution of Coverage – A Covered Person whose Policy is suspended and who loses entitlement to Medicaid coverage or coverage under an employer group health plan may have their Policy reinstated under the following conditions:
a. Coverage will be automatically reinstated effective as of the date of termination of either Medicaid coverage or coverage under an employer group health plan, provided the Covered Person notified AmeriHealth of the Covered Person’s loss of entitlement to Medicaid or group coverage within ninety (90) days after the date of such loss and pays the premium attributable to the period effective as of the date of termination of the Covered Person’s entitlement to Medicaid coverage or coverage under an employer group health plan.

b. Upon reinstatement of Coverage the Covered Person will not impose any waiting period with respect to treatment of preexisting conditions.

c. Coverage provided will be substantially equivalent to Coverage in effect before the date of suspension.

d. Classification of premiums upon reinstatement shall be on terms as least as favorable as the premium classification terms that would have applied to the Covered Person had the Coverage not been suspended.

VOIDANCE OF COVERAGE DUE TO MATERIAL MISREPRESENTATIONS

In the event a Covered Person makes a material misrepresentation or a false statement in obtaining Coverage under this Policy, this Policy is void. If benefits were provided under a Policy issued under such circumstances, the Covered Person agrees to reimburse AmeriHealth for benefits which were provided.
SECTION 4

AMERIHEALTH MEDIGAP – PLAN F
MEDICARE SUPPLEMENTAL BENEFITS

Benefits under this Policy are available for Medicare Eligible Expenses to the extent not covered by Medicare as set forth in the Schedule of Benefits, except as otherwise excluded or limited in this Policy. In addition, certain benefits that are not covered by Medicare are available under this Policy only when and so long as they are determined by the AmeriHealth to be Medically Necessary for the treatment of the Covered Person's condition of illness or bodily injury. This Policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts, if any, in response to which premiums may be modified subject to restrictions in the regulation.

PRE-EXISTING CONDITION LIMITATIONS

The benefits stated in this Section will not be provided with respect to any pre-existing condition until after the expiration of at least six (6) consecutive months (one hundred eighty (180) days) from the Effective Date of this Policy. “Pre-existing Condition” means a disease or physical condition for which the Covered Person has received medical advice or treatment within one hundred eighty (180) days immediately prior to the Covered Person’s initial Effective Date under this Policy.

Unless otherwise required or permitted by state or federal law, this Pre-existing Condition Limitation may be reduced or waived in its entirety in the following instances:

A. Waiver or Reduction Based on Creditable Coverage:

1. If the Covered Person submitted his/her application for benefits under this Policy prior to or during the six (6) month period beginning with the first month in which the Covered Person was enrolled for benefits under Medicare Part B (regardless of age), or prior to or during the six (6) month period beginning with the first day of the first month in which the Covered Person was enrolled for benefits under Medicare Part B after turning sixty-five (65) years of age, and

2. As of the date of the application, the Covered Person had a Continuous Period of Creditable Coverage of less than six (6) months, or

3. If the Covered Person has replaced a prior Medicare Supplement Program with coverage under this Policy, the six (6) month pre-existing condition limitation will be reduced by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the date of enrollment. If, however, as of the date of application the Covered Person had a continuous Period of Creditable Coverage of at least six (6) months, the pre-existing condition limitation will be waived in its entirety.

B. Waiver Based on “Eligible Person” Status:
This pre-existing condition limitation does not apply to certain “eligible persons” as defined in the Balanced Budget Act of 1997, the Balance Budget Refinement act of 1999, the Ticket to Work and Work Incentive Improvement Act, and your State Laws and regulations. For purposes of this provision, a general summary of an “eligible person” is and individual:

1. Who was covered under an employer group health benefit plan, and that Plan was (a) supplemental to Medicare and the benefits under AmeriHealth were terminated, or (b) primary to Medicare and the benefits under AmeriHealth were terminated; or

2. Who was covered under a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan, or who is sixty-five (65) years of age or older and was enrolled in a Program of All-Inclusive Care for the Elderly (PACE), which plan or program was terminated or otherwise discontinued by the organization that offered AmeriHealth or program, or the organization has notified the individual of an impending termination; or

3. Who was covered under a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan, or who is sixty-five (65) years of age or older and was enrolled in a PACE program, and moved out of the organizations service area; or

4. Who was covered under a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan, or Medicare Supplement coverage, or who is sixty-five (65) years of age or older and was enrolled in a PACE program, and left AmeriHealth or program because the insurer or organization offering AmeriHealth or program was bankrupt the insurer or organization breached the Policy or terms of the program, or the Policy or program was misrepresented upon purchase or enrollment; or

5. Who was first covered under this AmeriHealth Medicare Supplement coverage, cancelled that coverage to join, for the first time, a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan, or a PACE program, and within 12 months of the date the original AmeriHealth Medicare Supplement coverage was terminated, elects to terminate the Medicare Advantage/Medicare SELECT/Medicare Demonstration/Medicare Cost or Risk plan or PACE program and return to the original available Medicare Supplemental plan; or

6. Who was covered under a Medicare Supplement coverage, cancelled that coverage to join a Medicare Advantage or Medicare SELECT plan or a PACE program, and, within twelve (12) months of joining such plan, elects to terminate the Medicare Advantage, Medicare SELECT, or PACE coverage and enroll in this AmeriHealth Medicare Supplement coverage because the initial Medicare supplemental plan is not longer available from the insurer; or

7. Who was covered under a Medicare Advantage or Medicare SELECT plan or
PACE program when first eligible for Medicare, and, within twelve (12) months of joining such plan, elects to terminate that coverage; or

8. Who enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the Covered Person terminates enrollment in that Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with an Application for coverage under a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible, K or L.

This Plan provides payment for the following:

**Basic Core Benefits**

A. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from day 61 through day 90 in any Medicare benefit period.

B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

D. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under Federal regulations, unless replaced in accordance with Federal regulations.

E. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

F. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

**Additional Benefits:**

A. 100% of the Medicare Part A deductible: Coverage for 100% of the Medicare Part A inpatient Hospital deductible amount per Medicare Benefit Period.

B. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Medicare Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Care eligible under Medicare Part A.
C 100% of the Medicare Part B deductible: Coverage for all of the Medicare Part B Deductible amount per calendar year regardless of hospital confinement.

D 100% of the Medicare Part B excess charges: Coverage for 100% of the difference between the Medicare Part B charges billed, not to exceed a charge limitation established by the Medicare program or state law including the Health Care Practitioner Medicare Fee Control Act, and the Medicare-approved Part B charge.

E. Medically necessary emergency care in a foreign country.

Coverage to the extent not covered by Medicare for 80% of the billed charges, for Medicare-eligible expenses for Medically Necessary emergency hospital, physician and medical care received in a foreign country which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days for each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For the purposes of this benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset.
SECTION 5

EXCLUSIONS

Benefits will not be paid for services, supplies or changes under this Plan F as follows:

- Benefits which are not specifically provided in Section 4 of this Policy.

- Services, supplies or charges which are not covered by Medicare or for which benefits provided under Medicare have been exhausted, except as otherwise provided for in Section 4 of this Policy.

- Services, supplies or charges, covered under this Policy, which are not covered by Medicare.

- Services, supplies or charges, not covered by Medicare, which are incurred due to confinement in a free-standing psychiatric facility unless payment of charges is required by law.

- Services, supplies or charges based on a Private Contract between you and a doctor or other health care provider who has decided not to provide services through Medicare.
SECTION 6
CLAIMS PROVISIONS

IDENTIFICATION CARD

The Identification Card issued by AmeriHealth must be presented by the Covered Person to anyone furnishing the Covered Person with services or supplies.

NOTICE OF CLAIM

Written notice of claim for treatment of illness or injury must be given to AmeriHealth within 20 days after the date when such treatment occurred. Failure to furnish within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice that is given by the Covered Person shall be sent to AmeriHealth at the address listed in Section 7-General Provisions, “How to Obtain Benefits”, in both paragraphs. It can also be given to any authorized agent of AmeriHealth, with information sufficient to identify the Covered Person. This shall be deemed notice to this company.

PROOF OF LOSS

In the case of a claim for any loss, written proof of such loss must be furnished to AmeriHealth, within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

CLAIM FORMS

AmeriHealth, upon receipt of a notice of claim, will furnish to the Covered Person such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Covered Person shall be deemed to have compiled with the requirements of this Policy as to proof of loss.

TIME OF PAYMENT OF CLAIMS

Benefits for any loss covered by this AmeriHealth Medigap Plan F will be paid as soon as AmeriHealth receives the proper written proof.

PAYMENT OF CLAIM

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall
be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the
Covered Person’s death may, at the option of the Covered Person, be paid either to such
beneficiary or to such estate. All other indemnities will be payable to the Covered Person.
SECTION 7
GENERAL PROVISIONS

HOW TO OBTAIN BENEFITS

1. The AmeriHealth Identification Card must be presented by the Covered Person to anyone furnishing the Covered Person with services and supplies.

2. Medicare Part A portion of AmeriHealth Medigap Plan F covers your hospital bills. The hospital should apply for Medicare and AmeriHealth Medigap Plan F payments. You need to present your Medicare Health Insurance Card and your Identification Card to the admitting clerk. If the hospital will not file a claim for your AmeriHealth Medigap Plan F portion of Covered Services forward a copy of the Medicare Hospital, Extended Care and Home Health Benefits record to:

   AmeriHealth Medigap Plans
   1[1901 Market Street
   Philadelphia, Pa. 19103]

   Be sure to note your AmeriHealth identification number on all correspondence.

3. Medicare Part B portion of AmeriHealth Medigap Plan F covers your doctor’s reasonable charges. A Medicare claim form must be submitted to the Medicare Part B carrier in the state where the services were performed. After Medicare part B makes it payments, the balance that is not covered is processed by AmeriHealth. If the services were performed in New Jersey, the processing is automatic. If the services were performed outside of New Jersey, the Explanation of Medicare Benefits (EOMB), which explains your Medicare medical claim, that you receive must be sent to:

   AmeriHealth Medigap Plans
   1[1901 Market Street
   Philadelphia, Pa. 19103]

   Be sure to note your AmeriHealth identification number on all correspondence.
METHOD OF PAYMENT

1. Supplementing Medicare Part A

Payment for the benefits provided under this Plan will ordinarily be made to the hospital, but AmeriHealth may make a payment directly to you. In no event, however, may such payment be assigned without the consent of AmeriHealth. AmeriHealth reserves the right to make payment directly to you.

2. Supplementing Medicare Part B

a. Providers who Accept Assignment

Under the terms of Assignment, the Covered Person transfers to the Provider the right to both the Medicare Part B and the AmeriHealth payment under this Plan based on Covered Services specified on the claim. The Provider, in turn agrees to accept the Medicare Reasonable Charge set by the Medicare Part B as the total charge for the Covered Service. The sum of the Medicare Reasonable Charge payments, 80 percent by Medicare Part B and 20 percent by this Plan, (or in the case of Hospital outpatient charges under a prospective payment system, the applicable Medicare Copayment), constitute payment in full, except where maximums, deductibles or other Medicare reductions are specified.

AmeriHealth reserves the right to make payment directly to the Provider.

b. Providers Who Do Not Accept Assignment

If the Provider does not accept Assignment, any difference between the Provider’s charge and the combined Medicare Part B/AmeriHealth payment shall be the personal responsibility of the Covered Person, except where prohibited by law.

AmeriHealth reserves the right to make payment directly to the Covered Person.

BENEFITS TO WHICH YOU ARE ENTITLED

1. The liability of AmeriHealth is limited to the benefits specified in this Policy. AmeriHealth determination of the benefit provisions applicable for the services and supplies rendered a Covered Person hereunder will be conclusive.

2. No person other than the Covered Person is entitled to receive benefits under this Policy. Such right to benefits and coverage is not transferable.

3. Benefits for Covered Services specified in this Policy will be provided only for
services and supplies that are rendered by a Provider specified in the Definitions section of this Policy.

**RELEASE OF INFORMATION**

The Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this coverage may furnish to AmeriHealth, upon its request, any information (including copies of records relating to the illness or injury).

In addition, AmeriHealth may furnish similar information to other entities providing similar benefits at their request.

AmeriHealth shall provide to the Covered Person, upon their request, certain information regarding claims and charges submitted to AmeriHealth.

AmeriHealth may also furnish membership and/or coverage information to affiliated plans or other entities for the purpose of claims processing or facilitating patient care.

When AmeriHealth needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, AmeriHealth will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Covered Person.

**DUPLICATE AMERIHEALTH MEDICARE SUPPLEMENT COVERAGE**

If any benefits to which a Covered Person is entitled to under this Plan, are also provided in full or part by another AmeriHealth Medigap Plan, AmeriHealth may treat either one of such Plan void and without effect.

**LEGAL ACTIONS**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**TIME LIMITS ON CERTAIN DEFENSES**

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements made by the Covered Person in the application for such Policy shall be used to void the Policy or deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such three year period. No claim for loss incurred after one hundred-eighty (180) days from the date of issue of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of Coverage of this Policy.
NOTICE TO COVERED PERSON

Any notice mailed by AmeriHealth to the Covered Person at the last address as shown on the records of AmeriHealth will be considered notice to the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP

- The choice of a Provider is solely yours.

AmeriHealth does not furnish Covered Services but only makes payment for Covered Services received by the Covered Person. AmeriHealth is not liable for any act or omission of any Provider. AmeriHealth has no responsibility for a Provider’s failure or refusal to render Covered Services to a Covered Person.

EXTENSION OF BENEFITS AND TERMINATION OF COVERAGE

A Covered Person’s benefit under this AmeriHealth Medigap – Plan F Medicare Supplement Coverage may be extended after the date the person ceases to be a Covered Person under this coverage if the Covered Person’s coverage terminates for any reason other than the request of the Covered Person. Termination of a Medicare supplement policy or certificate shall be without prejudice to a continuous loss which commenced while the policy was in force may be predicated upon the continuous total disability of the Covered Person limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

AmeriHealth will provide benefits under this coverage during the extension of coverage as if the person were still a Covered Person, except the individual must provide documentation, which evidences continuous Total Disability as required by AmeriHealth. In addition, coverage will apply only to the extent that other coverage for the Covered Service is not provided for the Covered Person under another insurance company plan.
PHYSICAL EXAMINATIONS

AmeriHealth at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

MISSTATEMENT OF AGE

If the age of the Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

OTHER INSURANCE IN THIS INSURER

Any excess insurance shall be void and all premiums paid for such excess shall be returned to the Covered Person or to his or her estate or, in lieu thereof, insurance effective at any one time on the Covered Person under a like Policy or policies in this Covered Person is limited to the one such Policy elected by the Covered Person, his or her beneficiary or his or her estate, as the case may be, and the Covered Person will return all premiums paid for all other such policies.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

RELATIONSHIP TO AMERIHEALTH PLANS

The Subscriber is hereby notified:

This Policy is between the Covered Person and AmeriHealth Insurance Company of New Jersey only. Only AmeriHealth Insurance Company of New Jersey shall be liable to the Covered Person for any obligation of AmeriHealth’s obligations under this Policy. This paragraph does not add any obligations to this Policy.