

FIRST+PLUS COMPLETE

SUMMARY OF BENEFITS

**January 1, 2010 - December 31, 2010
ENTIRE ISLAND OF PUERTO RICO**

**Introduction to the Summary of Benefits for
FIRST+PLUS COMPLETE
January 1, 2010- December 31, 2010
ENTIRE ISLAND OF PUERTO RICO**

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in First+Plus Complete (HMO). Our plan is offered by FIRST MEDICAL HEALTH PLAN, INC., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

If you have been diagnosed with [Diabetes mellitus] you may be eligible to join this plan.

Please call First+Plus Complete (HMO) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call First+Plus Complete (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 First+Plus Complete (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you have one or more of the listed diseases you may enroll in the plan at any time but you may only leave the plan at certain times.

Please call First+Plus Complete (HMO) at the 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 First+Plus Complete (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 FIRST+PLUS COMPLETE (HMO) AVAILABLE?

The service area for this plan includes: Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamon, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guanica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Diaz, Juncos, Lajas, Lares, Las Marias, Las Piedras, Loiza, Luquillo, Manati, Maricao, Maunabo, Mayaguez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Penuelas, Ponce, Quebradillas, Rincon, Rio Grande, Sabana Grande, Salinas, San German, San Juan, San Lorenzo, San Sebastian, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco Counties, PR. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN FIRST+PLUS COMPLETE (HMO)?

You can join First+Plus Complete (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 generally are not eligible to enroll in First+Plus Complete (HMO) unless they are members of our organization and have been since their dialysis began.

You must have been diagnosed by your doctor with Diabetes mellitus to join this plan.

Please call plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

First+Plus Complete (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.firstpluspr.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 First+Plus Complete (HMO) nor the Original Medicare Plan will pay for these services.

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

First+Plus Complete (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?

First+Plus Complete (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 <http://www.firstpluspr.com>. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

First+Plus Complete (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 <http://www.firstpluspr.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 MY PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you 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 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of First+Plus Complete (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. 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. In Puerto Rico QIO is known as QIPRO and the telephone numbers are 1-800-981-5062 or 1-787-641-1240.

As a member of PBP_007_First+Plus Complete (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. In Puerto Rico QIO is known as QIPRO and the telephone numbers are 1-800-981-5062 or 1-787-641-1240.

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 First+Plus Complete (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 First+Plus Complete (HMO) 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 Alfa 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.

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 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 (888) 767-7717 to obtain a copy of the plan ratings for this plan. TTY users call (877) 672-4242.

Please call First Medical Health Plan, Inc. for more information about First+Plus Complete (HMO).

Visit us at www.firstpluspr.com or, call us:

Customer Service Hours:

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CMS APPROVED 11/23/2009

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)-767-7717 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug Program. (TTY/TDD (877)-672-4242)

Prospective members should call toll-free (877)-662-4242 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug Program. (TTY/TDD (877)-672-4242)

Current members should call locally (888)-767-7717 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug Program. (TTY/TDD (877)-672-4242)

Prospective members should call locally (877)-662-4242 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug Program. (TTY/TDD (877)-672-4242)

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 on the web.

SECTION II - SUMMARY OF BENEFITS

If you have any questions about this plan's benefits or costs, please contact First Medical Health Plan, Inc. at (888)767-7717 (for members) or at (877)662-4242 (for prospects). TTY users should call (877)672-4242. Our office hours are Monday through Friday from 8:00 a.m. to 8:00 p.m.

Benefit	Original Medicare	First+Plus Complete (HMO)
IMPORTANT INFORMATION		
1 - Premium and Other Important Information	<p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</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>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>First Medical Health Plan, Inc. will reduce your monthly Medicare Part B premium by up to \$ 20.00.</p>
2 - Doctor and Hospital Choice	<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> <p>No referral required for network doctors, specialists,</p>

(For more information,

see Emergency - #15 and Urgently Needed Care - #16.)

and hospitals.

SUMMARY OF BENEFITS

INPATIENT CARE

<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period were: 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.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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</p>	<p>In-Network \$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period¹.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
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¹ 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 ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

	period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
4 - Inpatient Mental Health Care	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. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (SNF) (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: \$133.50 per day. These amounts will change for 2010. 100 days for each benefit period. A "benefit period" starts the day you go	General Authorization rules may apply. In-Network \$0 copay for SNF services Plan covers up to 100 days each benefit period ² No prior hospital stay is required.

² 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 ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

	<p>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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>
7 - Hospice	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>
OUTPATIENT CARE		
8 - Doctor Office Visits	20% coinsurance	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p>

9 - Chiropractic Services	Routine care not covered	<p>In-Network \$0 copay for: Medicare-covered chiropractic visits</p> <p>20% coinsurance 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.</p> <p>up to 1 routine visit(s) every year</p> <p>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.</p>
10 - Podiatry Services	Routine care not covered.	<p>In-Network \$0 copay for Medicare-covered podiatry visits</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>up to 12 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	<p>In-Network \$0 copay for Medicare-covered Mental Health visits.</p>
12 - Outpatient Substance Abuse Care	20% coinsurance	<p>In-Network \$0 copay for Medicare-covered visits.</p>
13 - Outpatient Services/Surgery	<p>20% coinsurance for the doctor</p> <p>20% of outpatient facility charges</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory</p>

		surgical center visit. \$0 copay for each Medicare-covered outpatient hospital facility visit.
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit	General \$25 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General \$0 copay for Medicare-covered urgent-care visits.
17 - Outpatient Rehabilitation Services (Occupational Therapy,	20% coinsurance	General Authorization rules may apply. In-Network

Physical Therapy, Speech and Language Therapy)		\$0 copay for Medicare-covered Occupational Therapy visits. \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance 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 to help you manage your diabetes or kidney disease.	General Authorization rules may apply. In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.
21 - Diagnostic Tests, X-	20% coinsurance for diagnostic tests and	In-Network

<p>Rays, Lab Services, and x-rays Radiology Services</p> <p>\$0 copay for Medicare-covered lab - lab services services</p> <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>	<p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays) - therapeutic radiology services
PREVENTIVE SERVICES	
<p>22 - Bone Mass Measurement</p> <p>20% coinsurance</p> <p>(for people with Medicare who are at risk)</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>
<p>23 - Colorectal Screening Exams</p> <p>20% coinsurance</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>

(for people with Medicare age 50 and older)	Covered when you are high risk or when you are age 50 and older.	
24 - Immunizations	\$0 copay for Flu and Pneumonia vaccines	In-Network \$0 copay for Flu and Pneumonia vaccines.
(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	\$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.
25 - Mammograms (Annual Screening)	20% coinsurance No referral needed.	In-Network \$0 copay for Medicare-covered screening mammograms.
(for women with Medicare age 40 and older)	Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	
26 - Pap Smears and Pelvic Exams	\$0 copay for Pap smears	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.
(for women with Medicare)	Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	

27 - Prostate Cancer Screening Exams	<p>20% coinsurance for the digital rectal exam.</p> <p>(for men with Medicare age 50 and older)</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network</p> <p>\$0 copay for - Medicare-covered prostate cancer screening</p>
28 - End-Stage Renal Disease	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>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 to help you manage your diabetes or kidney disease.</p>	<p>In-Network</p> <p>\$0 copay for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p>
29 - Prescription Drugs	<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>Drugs covered under Medicare Part B General</p> <p>\$0 copay for Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D</p>

General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <http://www.firstpluspr.com> on the web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

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 at 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.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from First+Plus Complete (HMO) for certain drugs.

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.

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.

If you request a formulary exception for a drug and First+Plus Complete (HMO) approves the exception, you will pay Tier 3 cost-sharing for that drug.

In-Network

\$0 deductible.

Initial Coverage

You pay the following until total yearly drug costs reach \$2,830:

Retail Pharmacy

Generics

- \$5 copay for a one-month (30-day) supply of drugs in this tier

- \$15 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Preferred Brand

- \$20 copay for a one-month (30-day) supply of drugs in this tier

- \$60 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this

extended day supply. Please contact the plan for more information.

Non-Preferred Brand

- \$30 copay for a one-month (30-day) supply of drugs in this tier

- \$90 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Specialty Drug

- 25% coinsurance for a one-month (30-day) supply of drugs in this tier

- 25% coinsurance for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Long Term Care Pharmacy

Generics

- \$5 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$20 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$30 copay for a one-month (31-day) supply of

drugs in this tier

Specialty Drugs

- 25% coinsurance for a one-month (31-day) supply of drugs in this tier

Coverage Gap

The plan covers

all generics (100% of formulary generic drugs) through the coverage gap.

You pay the following:

Retail Pharmacy

Generics

- \$5 copay for a one-month (30-day) supply of all drugs covered in this tier

- \$15 copay for a three-month (90-day) supply of all drugs covered in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Specialty Drugs

- 25% coinsurance for a one-month (30-day) supply of All Formulary Generics drugs covered in this tier

- 25% coinsurance for a three-month (90-day) supply of All Formulary Generics drugs covered in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Long Term Care Pharmacy

Generics

- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier

Specialty Drugs

- 25% coinsurance for a one-month (31-day) supply of All Formulary Generics drugs covered in this tier

Please contact the plan for a complete list of drugs covered through the gap.

For all other covered drugs, after your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or
- 5% coinsurance.

Out-of-Network

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 First+Plus Complete (HMO).

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:

Generics

- \$5 copay for a one-month (30-day) supply of drugs in this tier

Preferred Brand

- \$20 copay for a one-month (30-day) supply of drugs in this tier

Non Preferred Brand

- \$30 copay for a one-month (30-day) supply of drugs in this tier

Specialty Drugs

- 25% coinsurance for a one-month (30-day) supply of drugs in this tier

Out-of-Network Coverage Gap

You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:

Generics

- \$5 copay for a one-month (30-day) supply of all drugs covered in this tier

Preferred Brand

-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 First+Plus Complete (HMO) for out-

of-network purchases when you are in the coverage gap. However, you should still submit documentation to First+Plus Complete (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Non-Preferred Brand

-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 First+Plus Complete (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to First+Plus Complete (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Specialty Drugs

- 25% coinsurance for a one-month (30-day) supply of All Formulary Generics drugs covered in this tier

Out-of-Network Catastrophic Coverage

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:

- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or
- 5% coinsurance.

30 - Dental Services

Preventive dental services (such as cleaning) not covered.

In-Network

\$0 copay for Medicare-covered dental benefits

		<p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 2 dental x-ray(s) every year <p>Plan offers additional comprehensive dental benefits. \$500 limit for comprehensive dental benefits every year</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> - up to 1 routine hearing test(s) every year - fitting-evaluations for a hearing aid <p>\$0 copay for hearing aids. \$300 limit for hearing aids every three years.</p>
32 - Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</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>In-Network</p> <p>\$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <ul style="list-style-type: none"> - and up to 1 routine eye exam(s) every year <p>\$0 copay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair(s) of glasses every year - up to 1 pair(s) of contacts every year

		\$100 limit for eye wear every year.
33 - Physical Exams	<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 \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p>
Health/Wellness Education	<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 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>	<p>General Please visit our plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.</p> <p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> -Nutritional benefit - Nursing Hotline <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p>
Transportation	Not covered.	<p>In-Network \$0 copay for up to 6 round trip(s) to plan-approved location every year.</p>
(Routine)		

Acupuncture	Not covered.	<p>In-Network This plan does not cover Acupuncture.</p>
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- (1) If a doctor or provider chooses not to accept the assignment, the costs are frequently high, which means that you pay more
- (2) 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 ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
- (3) Lifetime reserve days can only be used once.

**SECTION III.
SUMMARY OF BENEFITS
FIRST+PLUS COMPLETE**

If you have any questions about this plan's benefits or costs, please contact First Medical Health Plan, Inc. at (888)767-7717 (for members) or at (877)662-4242 (for prospects). TTY users should call (877)672-4242.

Our office hours are Monday through Friday from 8:00 a.m. to 8:00 p.m.

- (1) VIP service will be available in selected network hospitals. VIP areas and private room upgrades will be granted subject to availability. Contact the Plan for more information.
- (2) Transportation benefit is limited to \$6 each way. Service must be provided by a licensed commercial carrier (taxi, bus, etc.) and must be for the purpose of obtaining medical services or prescriptions.
- (3) Over the counter benefit is available through home delivery service with a specific plan supplier. Contact the plan for more information.
- (4) Basket Benefit includes Gym, Acupuncture and Nutritionist. The \$200.00 maximum is combined for this benefit. Contact the plan for more information.
- (5) Nutritionist visits are limited to 3 visits annually. Additional visits may be available through you Basket Benefit. Please contact plan for more information.