

**PHARMA PREMIUM (PDP)**

**Summary of Benefits**

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

**Introduction to the Summary of Benefits for  
PHARMA PREMIUM (PDP)  
January 1, 2010 - December 31, 2010  
ENTIRE ISLAND OF PUERTO RICO**

**SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS**

Thank you for your interest in Pharma Premium (PDP). Our plan is offered by FIRST MEDICAL HEALTH PLAN, INC/First Medical Health Plan, Inc., a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call Pharma Premium (PDP) and ask for the "Evidence of Coverage".

**YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE**

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like Pharma Premium (PDP). Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

**HOW CAN I COMPARE MY OPTIONS?**

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by Pharma Premium (PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

**WHERE IS PHARMA PREMIUM (PDP) AVAILABLE?**

The service area for this plan includes: Puerto Rico. You must live in one of these areas to join this plan.

**WHO IS ELIGIBLE TO JOIN?**

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area.

If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

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

Pharma Premium (PDP) does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

### **WHERE CAN I GET MY PRESCRIPTIONS?**

Pharma Premium (PDP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will 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?**

Pharma Premium (PDP) 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.

### **WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?**

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. This will occur as of the effective date of your coverage in the Medicare Prescription Drug Plan. Your Issuer will adjust your premium. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join Pharma Premium (PDP). Get this information before you decide to enroll in this plan.

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

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Pharma Premium (PDP), Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227). TTY/TTD users should call 1-877-486-2048.

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

All Medicare Prescription Drug 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 Prescription Drug Plan leaves the program, you will not lose Medicare prescription drug 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 PBP\_002\_Pharma Premium (PDP), 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 Pharma Premium (PDP) for more details.

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 (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 Pharma Premium (PDP).

Visit us at [www.firstpluspr.com](http://www.firstpluspr.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)-767-7717 . (TTY/TDD (877)-672-4242 )

Prospective members should call toll-free (877)-662-4242 . (TTY/TDD (877)-672-4242 )

Current members should call locally (888)-767-7717 . (TTY/TDD (877)-672-4242 )

Prospective members should call locally (877)-662-4242 . (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](http://www.medicare.gov) on the web.

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

**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.

<b>Benefit</b>	<b>Original Medicare</b>	<b>Pharma Premium (PDP)</b>
Prescription Drugs	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><b>Drugs covered under Medicare Part D General</b></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.firstpluspr.com">http://www.firstpluspr.com</a> on the web.</p> <p>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>

\$50.60 monthly premium

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 Pharma Premium (PDP) 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 Pharma Premium (PDP) approves the exception, you will pay 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

- \$15 copay for a one-month (30-day) supply of drugs in this tier

- \$45 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

Specialty Drugs

- 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

- \$15 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 Pharma Premium (PDP).

**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

- \$15 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 Pharma Premium (PDP) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Pharma Premium (PDP) 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 Pharma Premium (PDP) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Pharma Premium (PDP) 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.