

**FIRST+PLUS ADVANTAGE (PPO), FIRST+PLUS ADVANTAGE PLUS (PPO)  
AND FIRST+PLUS ADVANTAGE PREMIUM (PPO)**

**SUMMARY OF BENEFITS**

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

**Introduction to the Summary of Benefits for  
FIRST+PLUS ADVANTAGE (PPO), FIRST+PLUS ADVANTAGE PLUS (PPO)  
AND FIRST+PLUS ADVANTAGE PREMIUM (PPO)**

**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 Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium(PPO). Our plan is offered by FIRST MEDICAL HEALTH PLAN, INC., a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call First+Plus Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium(PPO)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 Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call First+Plus Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium(PPO)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 Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium(PPO)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 ADVANTAGE (PPO), FIRST+PLUS ADVANTAGE PLUS (PPO)  
AND FIRST+PLUS ADVANTAGE PREMIUM (PPO)  
AVAILABLE?**

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

**WHO IS ELIGIBLE TO JOIN FIRST+PLUS ADVANTAGE (PPO),  
FIRST+PLUS ADVANTAGE PLUS (PPO)  
AND FIRST+PLUS ADVANTAGE PREMIUM (PPO)?**

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

**CAN I CHOOSE MY DOCTORS?**

First+Plus Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside 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](http://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?**

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

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

First+Plus Advantage (PPO), do cover Medicare Part B prescription drugs. First+Plus Advantage (PPO) does NOT cover Medicare Part D prescription drugs. First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO) do cover both Medicare Part B and Part D prescription drugs.

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

First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO) 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 Advantage Plus (PPO) and First+Plus Advantage Premium (PPO) 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 Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO), 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\_003\_First+Plus Advantage Plus (PPO) and PBP\_004\_First+Plus Advantage Premium (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Quality Improvement Professional Research Organization (QIPRO), 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 Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO) 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 Advantage (PPO), First+Plus Advantage Plus (PPO) and First+Plus Advantage Premium (PPO) 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](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 First+Plus Advantage (PPO), First+Plus Advantage Plus (PPO)

and First+Plus Advantage Premium (PPO).

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 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](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>First+Plus Advantage (PPO)</b>	<b>First+Plus Advantage Plus (PPO)</b>	<b>First+Plus Advantage Premium (PPO)</b>
<b>IMPORTANT INFORMATION</b>				
<p>1 - Premium and Other Important Information</p>	<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</p>	<p><b>General</b></p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>The plan will reduce \$60.00 monthly of your Medicare Part B Premium.</p>	<p><b>General</b></p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p>	<p><b>General</b></p> <p>\$20 monthly plan premium in addition to your monthly Medicare Part B premium.</p>

	<p>2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.)</p> <p>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>2 - Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.</p> <p><b>Out-of-Network</b> Plan covers you when you travel in the U.S.</p>
<b>SUMMARY OF BENEFITS</b>				
<b>INPATIENT CARE</b>				
<p>3 - Inpatient Hospital Care</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</p>	<p><b>In-Network</b> \$0 copay</p>	<p><b>In-Network</b> \$0 copay</p>	<p><b>In-Network</b> \$0 copay</p>

<p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>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 period has ended, a new benefit period begins. You must</p>	<p>No limit to the number of days covered by the plan each benefit period<sup>1</sup>.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>No limit to the number of days covered by the plan each benefit period<sup>1</sup>.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>No limit to the number of days covered by the plan each benefit period<sup>1</sup>.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
---	---	---	---	---

<sup>1</sup> 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.

	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	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b> \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>In-Network</b> \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>In-Network</b> \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
5 - Skilled Nursing Facility (SNF)  (in a Medicare-certified skilled nursing facility)	<p>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.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for SNF services</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for SNF services</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for SNF services</p>

	<p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. 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>	<p>Plan covers up to 100 days each benefit period<sup>2</sup>.</p> <p>No prior hospital stay is required.</p>	<p>Plan covers up to 100 days each benefit period<sup>2</sup>.</p> <p>No prior hospital stay is required.</p>	<p>Plan covers up to 100 days each benefit period<sup>2</sup>.</p> <p>No prior hospital stay is required.</p>
<p>6 - Home Health Care</p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, and</p>	<p>\$0 copay.</p> <p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p>

<sup>2</sup> 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.

rehabilitation services, etc.)		<b>Out-of-Network</b> 20% for home health visits.	<b>Out-of-Network</b> 20% for home health visits.	<b>Out-of-Network</b> 20% for home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care.  You must get care from a Medicare-certified hospice.	<b>General</b> You must get care from a Medicare-certified hospice.	<b>General</b> You must get care from a Medicare- certified hospice.	<b>General</b> You must get care from a Medicare-certified hospice.
<b>OUTPATIENT CARE</b>				
8 - Doctor Office Visits	20% coinsurance	<b>General</b> See "Physical Exams," for more information.  <b>In-Network</b> \$0 copay for each primary care doctor visit for Medicare-covered benefits.  \$0 copay for each specialist doctor visit for Medicare- covered benefits.  <b>Out-of-Network</b> 20% for each primary care doctor visit.  20% for each specialist visit.	<b>General</b> See "Physical Exams," for more information.  <b>In-Network</b> \$0 copay for each primary care doctor visit for Medicare- covered benefits.  \$0 copay for each specialist doctor visit for Medicare-covered benefits.  <b>Out-of-Network</b> 20% for each primary care doctor visit.  20% for each specialist visit.	<b>General</b> See "Physical Exams," for more information.  <b>In-Network</b> \$0 copay for each primary care doctor visit for Medicare-covered benefits.  \$0 copay for each specialist doctor visit for Medicare-covered benefits.  <b>Out-of-Network</b> 20% for each primary care doctor visit.  20% for each specialist visit.

<p>9 - Chiropractic Services</p>	<p>Routine care not covered</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><b>In-Network</b> \$0 copay for: Medicare-covered chiropractic visits</p> <p>up to 3 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> <p><b>Out-of-Network</b> 20% of the cost for chiropractic benefits.</p>	<p><b>In-Network</b> \$0 copay for: Medicare-covered chiropractic visits</p> <p>routine visits</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> <p><b>Out-of-Network</b> 20% of the cost for chiropractic benefits.</p>	<p><b>In-Network</b> \$0 copay for: Medicare-covered chiropractic visits</p> <p>routine visits</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> <p><b>Out-of-Network</b> 20% of the cost for chiropractic benefits.</p>
<p>10 - Podiatry Services</p>	<p>Routine care not covered.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered podiatry</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered podiatry</p>

	<p>visits</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>up to 3 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> 20% of the cost for podiatry benefits.</p>	<p>podiatry visits</p> <p>up to 4 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> 20% of the cost for podiatry benefits.</p>	<p>visits</p> <p>up to 4 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> 20% of the cost for podiatry benefits.</p>
11 - Outpatient Mental Health Care	<p>45% coinsurance for most outpatient mental health services.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered Mental Health visits.</p> <p><b>Out-of-Network</b> 50% of the cost for Mental Health benefits. 50% of the cost for Mental Health benefits with a psychiatrist.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered Mental Health visits.</p> <p><b>Out-of-Network</b> 50% of the cost for Mental Health benefits. 50% of the cost for Mental Health benefits with a psychiatrist.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered Mental Health visits.</p> <p><b>Out-of-Network</b> 50% of the cost for Mental Health benefits. 50% of the cost for Mental Health benefits with a psychiatrist.</p>
12 - Outpatient Substance Abuse Care	<p>20% coinsurance</p> <p><b>In-Network</b> \$0 copay for Medicare-covered visits.</p> <p><b>Out-of-Network</b> 50% of the cost for outpatient substance abuse benefits.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered visits.</p> <p><b>Out-of-Network</b> 50% of the cost for outpatient substance</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered visits.</p> <p><b>Out-of-Network</b> 50% of the cost for outpatient substance abuse</p>

			abuse benefits.	benefits.
13 - Outpatient Services/Surgery	20% coinsurance for the doctor  20% of outpatient facility charges	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for each Medicare-covered ambulatory surgical center visit.  \$0 copay for each Medicare-covered outpatient hospital facility visit.  <b>Out-of-Network</b> 20% of the cost for ambulatory surgical center benefits.  20% of the cost for outpatient hospital facility benefits.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for each Medicare-covered ambulatory surgical center visit.  \$0 copay for each Medicare-covered outpatient hospital facility visit.  <b>Out-of-Network</b> 20% of the cost for ambulatory surgical center benefits.  20% of the cost for outpatient hospital facility benefits.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for each Medicare-covered ambulatory surgical center visit.  \$0 copay for each Medicare-covered outpatient hospital facility visit.  <b>Out-of-Network</b> 20% of the cost for ambulatory surgical center benefits.  20% of the cost for outpatient hospital facility benefits.
14 - Ambulance Services  (medically necessary ambulance services)	20% coinsurance	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered ambulance benefits.  <b>Out-of-Network</b> 20% of the cost for ambulance benefits.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered ambulance benefits.  <b>Out-of-Network</b> 20% of the cost for ambulance benefits.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered ambulance benefits.  <b>Out-of-Network</b> 20% of the cost for ambulance benefits.

<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b></p> <p>\$25 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit</p>	<p><b>General</b></p> <p>\$25 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit</p>	<p><b>General</b></p> <p>\$25 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit</p>
<p>16 - Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b></p> <p>\$0 copay for Medicare-covered urgent-care visits.</p>	<p><b>General</b></p> <p>\$0 copay for Medicare-covered urgent-care visits.</p>	<p><b>General</b></p> <p>\$0 copay for Medicare-covered urgent-care visits.</p>
<p>17 - Outpatient Rehabilitation Services</p>	<p>20% coinsurance</p>	<p><b>General</b></p> <p>Authorization rules may</p>	<p><b>General</b></p> <p>Authorization rules may</p>	<p><b>General</b></p> <p>Authorization rules may</p>

<p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p><b>Out-of-Network</b> 20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for Physical and/or Speech/Language Therapy visits.</p>	<p>apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p><b>Out-of-Network</b> 20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for Physical and/or Speech/Language Therapy visits.</p>	<p>apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p><b>Out-of-Network</b> 20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for Physical and/or Speech/Language Therapy visits.</p>
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>			
<p>18 - Durable Medical Equipment  (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p> <p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered items.</p> <p><b>Out-of-Network</b> 20% of the cost for durable medical equipment.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered items.</p> <p><b>Out-of-Network</b> 20% of the cost for durable medical equipment.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered items.</p> <p><b>Out-of-Network</b> 20% of the cost for durable medical equipment.</p>
<p>19 - Prosthetic Devices</p>	<p>20% coinsurance</p> <p><b>General</b> Authorization rules may</p>	<p><b>General</b> Authorization rules may</p>	<p><b>General</b> Authorization rules may apply.</p>

		apply. <b>In-Network</b> \$0 copay for Medicare-covered items. <b>Out-of-Network</b> 20% of the cost for prosthetic devices.	apply. <b>In-Network</b> \$0 copay for Medicare-covered items. <b>Out-of-Network</b> 20% of the cost for prosthetic devices.	<b>In-Network</b> \$0 copay for Medicare-covered items. <b>Out-of-Network</b> 20% of the cost for prosthetic devices.
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.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Diabetes self-monitoring training.  \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Diabetes self-monitoring training.  \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Diabetes self-monitoring training.  \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes

		<p>supplies.</p> <p><b>Out-of-Network</b> 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p>	<p>supplies.</p> <p><b>Out-of-Network</b> 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p>	<p>supplies.</p> <p><b>Out-of-Network</b> 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p>
<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab 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</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered:</p> <p>- lab services</p> <p>- diagnostic procedures and tests</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered:</p> <p>- lab services</p> <p>- diagnostic procedures and tests</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered:</p> <p>- lab services</p> <p>- diagnostic procedures and tests</p>

	<p>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> <ul style="list-style-type: none"> <li>- X-rays.</li> <li>- diagnostic radiology services (not including X-rays)</li> <li>- therapeutic radiology services</li> </ul> <p><b>Out-of-Network</b> 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient x-rays.</p> <p>20% of the cost for diagnostic radiology services</p>	<ul style="list-style-type: none"> <li>- X-rays.</li> <li>- diagnostic radiology services (not including X-rays)</li> <li>- therapeutic radiology services</li> </ul> <p><b>Out-of-Network</b> 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient x-rays.</p> <p>20% of the cost for diagnostic radiology services</p>	<ul style="list-style-type: none"> <li>- X-rays.</li> <li>- diagnostic radiology services (not including X-rays)</li> <li>- therapeutic radiology services</li> </ul> <p><b>Out-of-Network</b> 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient x-rays.</p> <p>20% of the cost for diagnostic radiology services</p>	
<b>PREVENTIVE SERVICES</b>				
22 - Bone Mass Measurement	20% coinsurance	<b>In-Network</b> \$0 copay for Medicare-	<b>In-Network</b> \$0 copay for Medicare-	<b>In-Network</b> \$0 copay for Medicare-

(for people with Medicare who are at risk)	Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	covered bone mass measurement <b>Out-of-Network</b> 20% of the cost for Medicare-covered bone mass measurement.	covered bone mass measurement <b>Out-of-Network</b> 20% of the cost for Medicare-covered bone mass measurement.	covered bone mass measurement <b>Out-of-Network</b> 20% of the cost for Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams  (for people with Medicare age 50 and older)	20% coinsurance  Covered when you are high risk or when you are age 50 and older.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.  <b>Out-of-Network</b> 20% of the cost for colorectal screenings.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.  <b>Out-of-Network</b> 20% of the cost for colorectal screenings.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.  <b>Out-of-Network</b> 20% of the cost for colorectal screenings.
24 - Immunizations  (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines  20% coinsurance for Hepatitis B vaccine  You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines.  \$0 copay for Hepatitis B vaccine.  No referral needed for Flu and pneumonia vaccines.	<b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines.  \$0 copay for Hepatitis B vaccine.  No referral needed for Flu and pneumonia vaccines.	<b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines.  \$0 copay for Hepatitis B vaccine.  No referral needed for Flu and pneumonia vaccines.

		<b>Out-of-Network</b> 20% of the cost for immunizations.	<b>Out-of-Network</b> 20% of the cost for immunizations.	<b>Out-of-Network</b> 20% of the cost for immunizations.
25 - Mammograms (Annual Screening)  (for women with Medicare age 40 and older)	20% coinsurance  No referral needed.  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.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.  <b>Out-of-Network</b> 20% of the cost for screening mammograms.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.  <b>Out-of-Network</b> 20% of the cost for screening mammograms.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.  <b>Out-of-Network</b> 20% of the cost for screening mammograms.
26 - Pap Smears and Pelvic Exams  (for women with Medicare)	\$0 copay for Pap smears  Covered once every 2 years. Covered once a year for women with Medicare at high risk.  20% coinsurance for	<b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.  <b>Out-of-Network</b> 20% of the cost for pap smears and pelvic exams.	<b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.  <b>Out-of-Network</b> 20% of the cost for pap smears and pelvic exams.	<b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.  <b>Out-of-Network</b> 20% of the cost for pap smears and pelvic exams.

Pelvic Exams				
27 - Prostate Cancer Screening Exams  (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam.  \$0 for the PSA test; 20% coinsurance for other related services.  Covered once a year for all men with Medicare over age 50.	<b>In-Network</b> \$0 copay for - Medicare-covered prostate cancer screening  <b>Out-of-Network</b> 20% of the cost for prostate cancer screening.	<b>In-Network</b> \$0 copay for - Medicare-covered prostate cancer screening  <b>Out-of-Network</b> 20% of the cost for prostate cancer screening.	<b>In-Network</b> \$0 copay for - Medicare-covered prostate cancer screening  <b>Out-of-Network</b> 20% of the cost for prostate cancer screening.
28 - End-Stage Renal Disease	20% coinsurance for renal dialysis  20% coinsurance for Nutrition Therapy for End-Stage Renal Disease  Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a	<b>In-Network</b> \$0 copay for renal dialysis  \$0 copay for Nutrition Therapy for End-Stage Renal Disease  <b>Out-of-Network</b> 20% of the cost for renal dialysis.	<b>In-Network</b> \$0 copay for renal dialysis  \$0 copay for Nutrition Therapy for End-Stage Renal Disease  <b>Out-of-Network</b> 20% of the cost for renal dialysis.	<b>In-Network</b> \$0 copay for renal dialysis  \$0 copay for Nutrition Therapy for End-Stage Renal Disease  <b>Out-of-Network</b> 20% of the cost for renal dialysis.

<p>29 - Prescription Drugs</p>	<p>registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p> <p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>20% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Drugs covered under Medicare Part B General</b>  <b>Most drugs not covered</b>          \$0 copay for Part B-covered drugs.</p> <p>20% of the cost for Part</p>	<p>20% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Drugs covered under Medicare Part B General</b>          \$0 copay for Part B-covered drugs.</p> <p>20% of the cost for Part B</p>	<p>20% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Drugs covered under Medicare Part B General</b>          \$0 copay for Part B-covered drugs.</p> <p>20% of the cost for Part B</p>
--------------------------------	---	---	--	--

<p>B drugs out-of-network.</p> <p><b>Drugs covered under Medicare Part D</b></p> <p>This plan does not offer prescription drug coverage.</p>	<p>drugs out-of-network.</p> <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>	<p>drugs out-of-network.</p> <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>
	<p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's</p>	<p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p>

	service area (for instance when you travel).	
	Total yearly drug costs are the total drug costs paid by both you and the plan.	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.	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.	Some drugs have quantity limits.
	Your provider must get prior authorization from First+Plus Advantage Plus (PPO) for certain drugs.	Your provider must get prior authorization from First+Plus Advantage Premium (PPO) 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,	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

	formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.	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 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 Advantage Plus (PPO) approves the exception, you will pay Tier (3) Non Preferred Brand cost-sharing for that drug.	If you request a formulary exception for a drug and First+Plus Advantage Premium (PPO) approves the exception, you will pay Tier (3) Non Preferred Brand cost-sharing for that drug.
	<b>In-Network</b> \$0 deductible.	<b>In-Network</b> \$0 deductible.
	<b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$2,830:	<b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$2,830:
	<b>Retail Pharmacy</b> Generics	<b>Retail Pharmacy</b> Generics
	- \$0 copay for a one-month (30-day) supply	- \$0 copay for a one-month (30-day) supply of drugs in

	of drugs in this tier	this tier
	- \$0 copay for a three-month (90-day) supply of drugs in this tier	- \$0 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.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
	Preferred Brand	Preferred Brand
	- \$20 copay for a one-month (30-day) supply of drugs in this tier	- \$15 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	- \$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.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
	Non-Preferred Brand	Non-Preferred Brand
	- \$30 copay for a one-month (30-day) supply of drugs in this tier	- \$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	- \$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.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
	Specialty Drugs	Specialized Drugs
	- 25% coinsurance for a one-month (30-day) supply of drugs in this tier	- 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	- 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.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
	<b>Long Term Care Pharmacy</b> Generics	<b>Long Term Care Pharmacy</b> Generics
	- \$0 copay for a one-month (31-day) supply of drugs in this tier	- \$0 copay for a one-month (31-day) supply of drugs in this tier
	Preferred Brand	Preferred Brand
	- \$20 copay for a one-month (31-day) supply	- \$15 copay for a one-month (31-day) supply of drugs in

	of drugs in this tier	this tier
	Non Preferred Brand	Non-Preferred Brand
	- \$30 copay for a one-month (31-day) supply of drugs in this tier	- \$30 copay for a one-month (31-day) supply of drugs in this tier
	Specialty Drugs	Specialized Brand
	- 25% coinsurance for a one-month (31-day) supply of drugs in this tier	- 25% coinsurance for a one-month (31-day) supply of drugs in this tier
	<b>Coverage Gap</b> The plan covers	<b>Coverage Gap</b> The plan covers
	all generics (100% of formulary generic drugs)	all generics (100% of formulary generic drugs)
	through the coverage gap.	through the coverage gap.
	You pay the following:	You pay the following:
	<b>Retail Pharmacy</b> Generics	<b>Retail Pharmacy</b> Generics
	- \$0 copay for a one-month (30-day) supply of all drugs covered in this tier	- \$0 copay for a one-month (30-day) supply of all drugs covered in this tier
	- \$0 copay for a three-month (90-day) supply of all drugs covered in	- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier

	this tier	
	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
	Specialty Drugs	Specialty Drugs
	- 25% coinsurance for a one-month (30-day) supply of All Formulary Generics drugs covered in this tier	- 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	- 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.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
	<b>Long Term Care Pharmacy</b> Generics	<b>Long Term Care Pharmacy</b> Generics
	- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier	- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier

	Specialty Drugs	Specialized Drugs
	- 25% coinsurance for a one-month (31-day) supply of All Formulary Generics drugs covered in this tier	- 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.	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.	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.
	<p><b>Catastrophic Coverage</b>  After your yearly out-of-pocket drug costs reach \$ 4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>	<p><b>Catastrophic Coverage</b>  After your yearly out-of-pocket drug costs reach \$ 4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>
	<b>Out-of-Network</b> Plan drugs may be	<b>Out-of-Network</b> Plan drugs may be covered in

	<p>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 Advantage Plus (PPO).</p>	<p>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 Advantage Premium (PPO).</p>
	<p><b>Out-of-Network Initial Coverage</b>  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:</p>	<p><b>Out-of-Network Initial Coverage</b>  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:</p>
	<p>Generics</p>	<p>Generics</p>

	- \$0 copay for a one-month (30-day) supply of drugs in this tier	- \$0 copay for a one-month (30-day) supply of drugs in this tier
	Preferred Brand	Preferred Brand
	- \$20 copay for a one-month (30-day) supply of drugs in this tier	- \$15 copay for a one-month (30-day) supply of drugs in this tier
	Non-Preferred Brand	Non-Preferred Brand
	- \$30 copay for a one-month (30-day) supply of drugs in this tier	- \$30 copay for a one-month (30-day) supply of drugs in this tier
	Specialty Drugs	Specialized Brand
	- 25% coinsurance for a one-month (30-day) supply of drugs in this tier	- 25% coinsurance for a one-month (30-day) supply of drugs in this tier
	<b>Out-of-Network Coverage Gap</b> You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:	<b>Out-of-Network Coverage Gap</b> You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:
	Generics	Generics

	- \$0 copay for a one-month (30-day) supply of all drugs covered in this tier	- \$0 copay for a one-month (30-day) supply of all drugs covered in this tier
	Preferred Brand	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 Advantage Plus (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to First+Plus Advantage Plus (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	-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 Advantage Premium (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to First+Plus Advantage Premium (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

	Non-Preferred Brand	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 Advantage Plus (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to First+Plus Advantage Plus (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	-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 Advantage Premium (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to First+Plus Advantage Premium (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.
	Specialty Drugs	Specialized Brand
	- 25% coinsurance for a one-month (30-day) supply of All	- 25% coinsurance for a one-month (30-day) supply of All Formulary Generics drugs

			Formulary Generics drugs covered in this tier	covered in this tier
			<p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> <li>- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>	<p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> <li>- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 2 oral exam(s) every year</li> <li>- up to 2 cleaning(s)</li> </ul>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 2 oral exam(s) every year</li> <li>- up to 2 cleaning(s)</li> </ul>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 2 oral exam(s) every year</li> <li>- up to 2 cleaning(s) every year</li> </ul>

	every year - up to 2 dental x-ray(s) every year <b>Out-of-Network</b> 20% of the cost for preventive dental benefits.	every year - up to 2 dental x-ray(s) every year <b>Out-of-Network</b> 20% of the cost for preventive dental benefits.	- up to 2 dental x-ray(s) every year <b>Out-of-Network</b> 20% of the cost for preventive dental benefits.
		20% of the cost for comprehensive dental benefits.	20% of the cost for comprehensive dental benefits.
		<b>In and Out-of-Network</b> \$600 limit for comprehensive dental benefits every year. This limit applies to both in-network and out-of-network benefits.	<b>In and Out-of-Network</b> \$800 limit for comprehensive dental benefits every year. This limit applies to both in-network and out-of-network benefits.
		Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.	Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
31 - Hearing Services	Routine hearing exams and hearing aids not covered.  20% coinsurance for	<b>In-Network</b> \$0 copay for Medicare-covered diagnostic hearing exams  \$0 copay for	<b>In-Network</b> \$0 copay for Medicare-covered diagnostic hearing exams  \$0 copay for

	<p>diagnostic hearing exams.</p> <ul style="list-style-type: none"> <li>- up to 1 routine hearing test(s) every year</li> <li>- fitting-evaluations for a hearing aid</li> <li>\$0 copay for hearing aids.</li> <li>\$300 limit for hearing aids every three years.</li> <li><b>Out-of-Network</b> 20% of the cost for hearing exams.</li> <li>\$0 copay for hearing aids.</li> </ul>	<ul style="list-style-type: none"> <li>- up to 1 routine hearing test(s) every year</li> <li>- fitting-evaluations for a hearing aid</li> <li>\$0 copay for hearing aids.</li> <li>\$400 limit for hearing aids every three years.</li> <li><b>Out-of-Network</b> 20% of the cost for hearing exams.</li> <li>\$0 copay for hearing aids.</li> </ul>	<ul style="list-style-type: none"> <li>- up to 1 routine hearing test(s) every year</li> <li>- fitting-evaluations for a hearing aid</li> <li>\$0 copay for hearing aids.</li> <li>\$500 limit for hearing aids every three years.</li> <li><b>Out-of-Network</b> 20% of the cost for hearing exams.</li> <li>\$0 copay for hearing aids.</li> </ul>	
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</p>	<p><b>In-Network</b> \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <ul style="list-style-type: none"> <li>- and up to 1 routine eye exam(s) every year</li> <li>\$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery</li> <li>- up to 1 pair(s) of</li> </ul>	<p><b>In-Network</b> \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <ul style="list-style-type: none"> <li>- and up to 1 routine eye exam(s) every year</li> <li>\$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery</li> <li>- up to 1 pair(s) of</li> </ul>	<p><b>In-Network</b> \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <ul style="list-style-type: none"> <li>- and up to 1 routine eye exam(s) every year</li> <li>\$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery</li> <li>- up to 1 pair(s) of glasses</li> </ul>

	<p>screenings covered for people at risk.</p> <p>glasses every year</p> <p>- up to 1 pair(s) of contacts every year</p> <p>\$100 limit for eye wear every year.</p> <p><b>Out-of-Network</b> 20% of the cost for eye exams.</p> <p>\$0 copay for eye wear.</p>	<p>glasses every year</p> <p>- up to 1 pair(s) of contacts every year</p> <p>\$100 limit for eye wear every year.</p> <p><b>Out-of-Network</b> 20% of the cost for eye exams.</p> <p>\$0 copay for eye wear.</p>	<p>every year</p> <p>- up to 1 pair(s) of contacts every year</p> <p>\$100 limit for eye wear every year.</p> <p><b>Out-of-Network</b> 20% of the cost for eye exams.</p> <p>\$0 copay for eye wear.</p>
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><b>In-Network</b> \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p><b>Out-of-Network</b> 20% of the cost for routine exams.</p>	<p><b>In-Network</b> \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p><b>Out-of-Network</b> 20% of the cost for routine exams.</p>	<p><b>In-Network</b> \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p><b>Out-of-Network</b> 20% of the cost for routine exams.</p>
Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor.</p> <p><b>In-Network</b> The plan covers the following</p>	<p><b>General</b> Please visit our plan website to see our list</p>	<p><b>General</b> Please visit our plan website to see our list of covered Over-</p>

	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.	health/wellness education benefits:	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.	the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.
		- Nursing Hotline \$0 copay for each Medicare-covered smoking cessation counseling session. <b>Out-of-Network</b> 20% of the cost for Health and Wellness services.	<b>In-Network</b> The plan covers the following health/wellness education benefits: - Nursing Hotline \$0 copay for each Medicare-covered smoking cessation counseling session. <b>Out-of-Network</b> 20% of the cost for Health and Wellness services.	<b>In-Network</b> The plan covers the following health/wellness education benefits: - Nursing Hotline \$0 copay for each Medicare-covered smoking cessation counseling session. <b>Out-of-Network</b> 20% of the cost for Health and Wellness services.
Transportation	Not covered.	<b>In-Network</b> \$0 copay for up to 6	<b>In-Network</b> \$0 copay for up to 6	<b>In-Network</b> \$0 copay for up to 6 round

(Routine)		round trip(s) to plan-approved location every year. <b>Out-of-Network</b> \$0 copay for transportation.	round trip(s) to plan-approved location every year. <b>Out-of-Network</b> \$0 copay for transportation.	trip(s) to plan-approved location every year. <b>Out-of-Network</b> \$0 copay for transportation.
Acupuncture	Not covered.	<b>In-Network</b> This plan does not cover Acupuncture.	<b>In-Network</b> This plan does not cover Acupuncture.	<b>In-Network</b> This plan does not cover Acupuncture.

- (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 ADVANTAGE (PPO)**

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) Eye Wear - \$100 maximum benefit coverage every year also applies to out-of-network services.
- (4) Hearing Aids - \$300 maximum benefit coverage every three years also applies to out-of-network services.
- (5) Out-of-network services are subject to the plan maximum indicated in in-network services. Please contact the Plan for additional information.
- (6) Out of network Routine Transportation, eye wear and hearing aids are subject to the same plan maximum as indicated in in-network benefits.
- (7) Out-of-Network- \$300 copay for Inpatient Hospital Care
- (8) Out-of-Network- \$300 copay for Inpatient Mental Health Care
- (9) Out-of Network- \$200 copay for services received in a Skilled Nursing Facility

### **FIRST+PLUS ADVANTAGE PLUS (PPO)**

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) Out-of-network services are subject to the plan maximum indicated in in-network services. Please contact the Plan for additional information.
- (5) Out of network Routine Transportation, eye wear and hearing aids are subject to the same plan maximum as indicated in in-network benefits.
- (6) Over the counter benefit is available through home delivery service with a specific plan supplier. Contact the plan for more information.
- (7) Out-of-Network- \$300 copay for Inpatient Hospital Care
- (8) Out-of-Network- \$300 copay for Inpatient Mental Health Care
- (9) Out-of Network- \$200 copay for services received in a Skilled Nursing Facility

### **FIRST+PLUS ADVANTAGE PREMIUM (PPO)**

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) Out-of-network services are subject to the plan maximum indicated in in-network services. Please contact the Plan for additional information.
- (6) Out of network Routine Transportation, eye wear and hearing aids are subject to the same plan maximum as indicated in in-network benefits.
- (7) Out-of-Network- \$300 copay for Inpatient Hospital Care
- (8) Out-of-Network- \$300 copay for Inpatient Mental Health Care
- (9) Out-of Network- \$200 copay for services received in a Skilled Nursing Facility