

2013

SUMMARY OF BENEFITS

**First Health Part D Premier (PDP)
First Health Part D Premier Plus (PDP)
First Health Part D Value Plus (PDP)
Prescription Drug Plans**

S5670

S5768



SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), and First Health Part D Premier Plus (PDP). Our plans are offered by Coventry Health and Life Insurance Company and First Health Life & Health Insurance Company /First Health Part D, a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plans. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), or First Health Part D Premier Plus (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 First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), and First Health Part D Premier Plus (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 First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), and First Health Part D Premier Plus (PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

WHERE IS FIRST HEALTH PART D VALUE PLUS (PDP), FIRST HEALTH PART D PREMIER (PDP), AND FIRST HEALTH PART D PREMIER PLUS (PDP) AVAILABLE?

There is more than one plan listed in this Summary of Benefits.

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.

WHERE CAN I GET MY PRESCRIPTIONS?

First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), and First Health Part D Premier Plus (PDP) have 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 www.PharmacyLocator.coventry-medicare.com. Our customer service number is listed at the end of this introduction.

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

First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), and First Health Part D Premier Plus (PDP) do 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.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), and First Health Part D Premier Plus (PDP) use 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 members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.FHDFormulary.coventry-medicare.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. 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 First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), or First Health Part D Premier Plus (PDP). Get this information before you decide to enroll in this plan.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare 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 and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- 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 Prescription Drug Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Prescription Plan leaves the program, you will not lose Medicare coverage. If a plan decides

not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), or First Health Part D Premier Plus (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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we 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 Health Part D Value Plus (PDP), First Health Part D Premier (PDP), or First Health Part D Premier Plus (PDP) for more details.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call First Health Part D for more information about First Health Part D Value Plus (PDP), First Health Part D Premier (PDP), or First Health Part D Premier Plus (PDP).

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

Customer Service Hours for October 1 – February 14:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Local

Customer Service Hours for February 15 – September 30:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Local

Current members should call toll-free (866)-823-5177. (TTY/TDD 711)

Prospective members should call toll-free (877)-815-8163. (TTY/TDD 711)

Current members should call locally (866)-823-5177. (TTY/TDD 711)

Prospective members should call locally (877)-815-8163. (TTY/TDD 711)

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.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en otros idiomas. Para más información llame al número de teléfono de Servicio al cliente que se indicó anteriormente.

If you have any questions about this plan's benefits or costs, please contact First Health Part D for details.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
PRESCRIPTION DRUG BENEFITS				
<p>Outpatient Prescription Drugs</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>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.FHDFormulary.coventry-medicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>\$34.70 monthly premium</p> <p>Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also</p>	<p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.FHDFormulary.coventry-medicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>\$28.10 monthly premium</p> <p>Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call</p>	<p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.FHDFormulary.coventry-medicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>\$98.70 monthly premium</p> <p>Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also</p>

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		<p>call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network-pharmacy although you may have to pay additional charges. Contact the plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from First Health Part D Premier (PDP) for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just</p>	<p>1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network-pharmacy although you may have to pay additional charges. Contact the plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from First Health Part D Value Plus (PDP) for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-</p>	<p>call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from First Health Part D Premier Plus (PDP) for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p>

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		<p>as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and First Health Part D Premier (PDP) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug.</p>	<p>counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and First Health Part D Value Plus (PDP) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug.</p>	<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and First Health Part D Premier Plus (PDP) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug.</p>
		<p>IN-NETWORK \$325 annual deductible.</p>	<p>IN-NETWORK \$0 deductible.</p>	<p>IN-NETWORK \$0 deductible.</p> <p>Supplemental drugs don't count toward your out-of-pocket drug costs.</p>

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		<p>INITIAL COVERAGE After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,970:</p> <p><u>RETAIL PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$1.00 copay for a one-month (30-day) supply of drugs in this tier. • \$3.00 copay for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • 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. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 46% coinsurance for a one-month (30-day) supply of drugs in this tier. • 46% coinsurance for a three- 	<p>INITIAL COVERAGE You pay the following until total yearly drug costs reach \$2,970:</p> <p><u>RETAIL PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy. • \$0 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy. • \$7.00 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy. • \$21.00 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • \$35.00 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy. • \$105.00 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy. • \$45.00 copay for a one-month (30-day) supply of drugs 	<p>INITIAL COVERAGE You pay the following until total yearly drug costs reach \$2,970:</p> <p><u>RETAIL PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier. • \$0 copay for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> • \$20.00 copay for a one-month (30-day) supply of drugs in this tier. • \$60.00 copay for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 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. <p>Not all drugs on this tier are</p>

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		<p>month (90-day) supply of drugs in this tier.</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p>in this tier from a non-preferred pharmacy.</p> <ul style="list-style-type: none"> • \$135.00 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$70.00 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy. • \$210.00 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy. • \$95.00 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy. • \$285.00 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred 	<p>available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 44% coinsurance for a one-month (30-day) supply of drugs in this tier. • 44% coinsurance for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
			pharmacy. <ul style="list-style-type: none"> 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy. 	
		<p><u>LONG TERM CARE PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> \$1.00 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> 25% coinsurance for a one-month (31-day) supply of drugs in this tier. <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> 46% coinsurance for a one-month (31-day) supply of drugs in this tier. <p>Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.</p>	<p><u>LONG TERM CARE PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> \$7.00 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> \$45.00 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> \$95.00 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier 4: Specialty Tier</p> <ul style="list-style-type: none"> 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <p>Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.</p>	<p><u>LONG TERM CARE PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> \$20.00 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> 25% coinsurance for a one-month (31-day) supply of drugs in this tier. <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> 44% coinsurance for a one-month (31-day) supply of drugs in this tier. <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <p>Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.</p>

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		<p><u>MAIL ORDER</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$1.00 copay for a one-month (30-day) supply of drugs in this tier. • \$3.00 copay for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • 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. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 46% coinsurance for a one-month (30-day) supply of drugs in this tier. • 46% coinsurance for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan</p>		<p><u>MAIL ORDER</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier. • \$0 copay for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> • \$20.00 copay for a one-month (30-day) supply of drugs in this tier. • \$50.00 copay for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 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. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		for more information.		<p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 44% coinsurance for a one-month (30-day) supply of drugs in this tier. • 44% coinsurance for a three-month (90-day) supply of drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>
		<p>COVERAGE GAP</p> <p>After your total yearly drug costs reach \$2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,750.</p>	<p>COVERAGE GAP</p> <p>After your total yearly drug costs reach \$2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,750.</p>	<p>COVERAGE GAP</p> <p>After your total yearly drug costs reach \$2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,750.</p>
				<p>ADDITIONAL COVERAGE GAP</p> <p>The plan covers some formulary generics (10%-64% of formulary generic drugs), some formulary brands (10%-64% of formulary brand drugs) through the coverage gap.</p> <p>The plan offers additional</p>

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
				<p>coverage in the gap for the following tiers. You pay the following:</p> <p><u>RETAIL PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$3.00 copay for a one-month (30-day) supply of all drugs in this tier. • \$9.00 copay for a three-month (90-day) supply of all drugs in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 25% coinsurance for a one-month (30-day) supply of select drugs covered in this tier. • 25% coinsurance for a three-month (90-day) supply of select drugs covered in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 44% coinsurance for a one-month (30-day) supply of select drugs covered in this tier. • 44% coinsurance for a three-month (90-day) supply of select drugs covered in this tier.

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
				<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><u>LONG TERM CARE PHARMACY</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$3.00 copay for a one-month (31-day) supply of all drugs in this tier. <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 25% coinsurance for a one-month (31-day) supply of select drugs covered in this tier. <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 44% coinsurance for a one-month (31-day) supply of select drugs covered in this tier. <p>Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.</p> <p><u>MAIL ORDER</u></p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$3.00 copay for a one-month (30-day) supply of all drugs in covered this tier. • \$7.50 copay for a three-month

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
				<p>(90-day) supply of all drugs covered in this tier.</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 25% coinsurance for a one-month (30-day) supply of select drugs covered in this tier. • 25% coinsurance for a three-month (90-day) supply of select drugs covered in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 44% coinsurance for a one-month (30-day) supply of select drugs covered in this tier. • 44% coinsurance for a three-month (90-day) supply of select drugs covered in this tier. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Please contact the plan for a complete list of drugs covered through the gap.</p>
		CATASTROPHIC COVERAGE	CATASTROPHIC COVERAGE	CATASTROPHIC COVERAGE

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		<p>After your yearly out-of-pocket drug costs reach \$4,750, you pay the greater of:</p> <ul style="list-style-type: none"> -5% coinsurance or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. 	<p>After your yearly out-of-pocket drug costs reach \$4,750, you pay the greater of:</p> <ul style="list-style-type: none"> -5% coinsurance or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. 	<p>After your yearly out-of-pocket drug costs reach \$4,750, you pay the greater of:</p> <ul style="list-style-type: none"> -5% coinsurance or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs.
		<p>OUT-OF-NETWORK</p> <p>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 Health Part D Premier (PDP).</p>	<p>OUT-OF-NETWORK</p> <p>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 Health Part D Value Plus (PDP).</p>	<p>OUT-OF-NETWORK</p> <p>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 Health Part D Premier Plus (PDP).</p>
		<p>OUT-OF-NETWORK INITIAL COVERAGE</p> <p>After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,970:</p>	<p>OUT-OF-NETWORK INITIAL COVERAGE</p> <p>You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,970:</p> <p>Tier 1: Preferred Generic</p>	<p>OUT-OF-NETWORK INITIAL COVERAGE</p> <p>You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,970:</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		<p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$1.00 copay for a one-month (30-day) supply of drugs in this tier. <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • 25% coinsurance for a one-month (30-day) supply of drugs in this tier. <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 46% coinsurance for a one-month (30-day) supply of drugs in this tier. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<ul style="list-style-type: none"> • \$7.00 copay for a one-month (30-day) supply of drugs in this tier. <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • \$45.00 copay for a one-month (30-day) supply of drugs in this tier. <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$95.00 copay for a one-month (30-day) supply of drugs in this tier. <p>Tier 4: Specialty Tier</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>day) supply of drugs in this tier.</p> <p>Tier 2: Non-Preferred Generic</p> <ul style="list-style-type: none"> • \$20.00 copay for a one-month (30-day) supply of drugs in this tier. <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 25% coinsurance for a one-month (30-day) supply of drugs in this tier. <p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> • 44% coinsurance for a one-month (30-day) supply of drugs in this tier. <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
		<p>OUT-OF-NETWORK COVERAGE GAP</p> <p>You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,750. Please note that the plan allowable cost may be less</p>	<p>OUT-OF-NETWORK COVERAGE GAP</p> <p>You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,750. Please note that the plan allowable cost may be</p>	<p>OUT-OF-NETWORK COVERAGE GAP</p> <p>You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,750. Please note that the plan allowable cost may be less than</p>

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
		<p>than the out-of-network pharmacy price paid for your drug(s).</p> <p>You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p>	<p>less than the out-of-network pharmacy price paid for your drug(s).</p> <p>You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p>	<p>the out-of-network pharmacy price paid for your drug(s).</p> <p>You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,750. Please note that the plan allowable cost may be less than the out-of network pharmacy price paid for your drug(s).</p>
		<p>ADDITIONAL OUT-OF-NETWORK COVERAGE GAP</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>ADDITIONAL OUT-OF-NETWORK COVERAGE GAP</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>ADDITIONAL OUT-OF-NETWORK COVERAGE GAP</p> <p>The plan covers some formulary generics (10%-64% of formulary generic drugs), some formulary brands (10%-64% of formulary brand drugs) through the coverage gap.</p> <p>You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> • \$3.00 copay for a one-month (30-day) supply of all drugs covered in this tier. <p>Tier 3: Preferred Brand</p> <ul style="list-style-type: none"> • 25% coinsurance for a one-month (30-day) supply of select drugs covered in this tier.

Benefit	Original Medicare	First Health Part D Premier (PDP)	First Health Part D Value Plus (PDP)	First Health Part D Premier Plus (PDP)
				<p>Tier 4: Non-Preferred Brand</p> <ul style="list-style-type: none"> 44% coinsurance for a one-month (30-day) supply of select drugs covered in this tier. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
		<p>OUT-OF-NETWORK CATASTROPHIC COVERAGE</p> <p>After your yearly out-of-pocket drug costs reach \$4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>OUT-OF-NETWORK CATASTROPHIC COVERAGE</p> <p>After your yearly out-of-pocket drug costs reach \$4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>OUT-OF-NETWORK CATASTROPHIC COVERAGE</p> <p>After your yearly out-of-pocket drug costs reach \$4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

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