

Table of Contents

Introduction to the Summary of Benefits for The Health Plus Elite Plan	2	Inpatient Hospital Care	6
You have choices in your health care	2	Inpatient Mental Health Care	8
How can I compare my options?	2	Mammograms (Annual Screening)	16
Where is the Health Plus Elite plan available?	2	Outpatient Mental Health Care	10
Who is eligible to join the Health Plus Elite plan	2	Outpatient Rehabilitation Services	12
Can I choose my doctors?	2	Outpatient Services/Surgery	10
What happens if I go to a doctor who's not in your network?	2	Outpatient Substance Abuse Care	10
Does my plan cover Medicare Part B or Part D drugs?	2	Pap Smears and Pelvic Exams	16
Where can I get my prescriptions if I join this plan?	2	Physical Exams	22
What is a prescription drug formulary?	2	Podiatry Services	10
How can I get extra help with Prescription Drug Plan costs?	3	Premium and Other Important Information	6
What are my protections in this plan?	3	Prescription Drugs	18
What is a Medication Therapy Management (MTM) program?	3	Prostate Cancer Screening Exams	16
What types of drugs may be covered under Medicare Part B?	3	Prosthetic Devices	12
		Skilled Nursing Facility	8
		Transportation	22
		Urgently Needed Care	12
		Vision Services	22
Summary of Benefits	6	Good Health is Your Most Important Asset	24
Acupuncture	22	Your Primary Care Physician	24
Ambulance Services	12	Services from a Specialist	24
Bone Mass Measurement	14	Emergency and Urgent Care	24
Chiropractic Services	10	Member Services Department: Dedicated to Health Plus Members	24
Colorectal Screening Exams	14	Healthy Extras	24
Dental Services	22	Smoking Cessation	25
Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies	14	For Your Satisfaction	25
Diagnostic Tests, X-Rays, and Lab Services	14	Privacy Matters	25
Doctor and Hospital Choice	6		
Doctor Office Visits	10		
Durable Medical Equipment	12		
Emergency Care	12		
ESRD	16		
Health/Wellness Education	22		
Hearing Services	22		
Home Health Care	8		
Hospice	8		
Immunizations	14		

Introduction to the Summary of Benefits for The Health Plus Elite Plan.

January 1, 2009 — December 31, 2009

Bronx, Kings, Queens, Richmond, Manhattan and Nassau Counties, NY

Thank you for your interest in Health Plus Elite. Our plan is offered by HEALTH PLUS PHSP, INC./Health Plus Elite, a Medicare Advantage Health Maintenance Organization (HMO). 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 Health Plus Elite 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 Health Plus Elite. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Health Plus Elite at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY 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 Health Plus Elite 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 the Health Plus Elite Plan available?

The service area for this plan includes: Bronx, Kings, Queens, Richmond, Manhattan and Nassau Counties, NY. You must live in one of these areas to join the plan.

Who is eligible to join Health Plus Elite Plan?

You can join Health Plus Elite 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 Health Plus Elite unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?

Health Plus Elite has formed a network of doctors, specialists, and hospitals. You can only use doctors

who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list visit us at www.healthplus-ny.org. Our customer service number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Health Plus Elite nor the Original Medicare Plan will pay for these services.

Does my plan cover Medicare Part B or Part D drugs?

Health Plus Elite does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where can I get my prescriptions if I join this plan?

Health Plus Elite 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 <https://mp.medimpact.com/pharmacyportal/public/Login.jsp?viewtype=mi>. Our customer service number is listed at the end of this introduction.

What is a prescription drug formulary?

Health Plus Elite 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 <https://mp.medimpact.com/pharmacyportal/public/Login.jsp?viewtype=mi>. 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 Prescription Drug Plan costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Health Plus Elite, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

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 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area. As a member of Health Plus Elite, 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.

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 Health Plus Elite 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 Health Plus Elite 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 alpha 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.

Please call Health Plus for more information about this plan.

Visit us at www.healthplus-ny.org or, call us:
Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free (800)-300-8181 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-662-1229)
Prospective members should call toll-free (866)-509-7999 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-662-1229)
Current and Prospective members should call locally (718)-369-5400 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-662-1229).
Current members should call toll-free (800)-300-8181 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-662-1229)

Prospective members should call toll-free
(866)-509-7999 for questions related to the
Medicare Part D Prescription Drug program.
(TTY/TDD (800)-662-1229)

Current and Prospective members should call
locally (718)-369-5400 for questions related to
the Medicare Part D Prescription Drug program.
(TTY/TDD (718)-369-5400)

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. If you have special needs,
this document may be available in other formats.
If you have any questions about this plan's benefits
or costs, please contact Health Plus Elite for details.

Summary of Benefits

	<i>Benefit Category</i>	<i>Original Medicare</i>
IMPORTANT INFORMATION		
1	Premium and Other Important Information	<p>In 2009 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$135.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>
2	Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.
SUMMARY OF BENEFITS INPATIENT CARE		
3	Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>In 2009 the amounts for each benefit period were: Days 1 - 60: \$1068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day</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 pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>

HEALTH PLUS ELITE	
<p>General \$27.00 monthly plan premium in addition to your monthly Medicare Part B premium.</p>	
<p>In-Network In 2009 the yearly Part B deductible amount is \$135. Contact the plan for services that apply.</p>	
<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> <p>You may have to pay a separate copayment for certain doctor office visits.</p>	
<p>In-Network In 2009 the amounts for each benefit period were: Days 1 - 60: \$1,068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day</p> <p>You will not be charged additional cost sharing for professional services. Plan covers 90 days each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

	Benefit Category	Original Medicare
4	Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above). 190 day lifetime limit in a Psychiatric Hospital.
5	Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day 100 days for each benefit period. 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.
6	Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.
7	Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.

HEALTH PLUS ELITE	
In-Network Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care”) You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	
General Authorizaton rules may apply.	
In-Network In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day You will not be charged additional cost sharing for professional services. Plan covers up to 100 days each benefit period 3-day prior hospital stay is required.	
General Authorization rules may apply.	
In-Network \$0 copay for Medicare-covered home health visits.	
General You must get care from a Medicare-certified hospice.	

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

	<i>Benefit Category</i>	<i>Original Medicare</i>
	OUTPATIENT CARE	
8	Doctor Office Visits	20% coinsurance
9	Chiropractic Services	Routine care not covered 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.
10	Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.
11	Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.
12	Outpatient Substance Abuse Care	20% coinsurance
13	Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges

HEALTH PLUS ELITE	
General See “Physical Exams,” for more information. Authorization rules may apply.	
In-Network 20% of the cost for each primary care doctor visit for Medicare-covered benefits. 20% of the cost for each specialist visit for Medicare-covered benefits.	
General Authorization rules may apply. In-Network 20% coinsurance for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	
General Authorization rules may apply. In-Network 20% of the cost for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	
General Authorization rules may apply. In-Network 50% of the cost for each Medicare-covered individual or group therapy visit.	
General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered individual or group visits.	
General Authorization rules may apply. In-Network 20% of the cost for each Medicare-covered ambulatory surgical center visit. 20% of the cost for each Medicare-covered outpatient hospital facility visit.	

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

	Benefit Category	Original Medicare
14	Ambulance Services (medically necessary ambulance services)	20% coinsurance
15	Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit 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. NOT covered outside the U.S. except under limited circumstances.
16	Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.
17	Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18	Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance
19	Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance

HEALTH PLUS ELITE
General Authorization rules may apply.
In-Network 20% of the cost for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.
In-Network \$50 copay for Medicare-covered emergency room visits.
Out-of-Network Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.
In and Out-of-Network If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit
General \$50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.
General Authorization rules may apply.
In-Network 20% of the cost for Medicare-covered Occupational Therapy visits. 20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.
General Authorization rules may apply.
In-Network 20% of the cost for Medicare-covered items.
General Authorization rules may apply.
In-Network 20% of the cost for Medicare-covered items.

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

	Benefit Category	Original Medicare
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.
21	Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and x-rays \$0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.
PREVENTIVE SERVICES		
22	Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
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.
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.

HEALTH PLUS ELITE	
General Authorization rules may apply.	
In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.	
General Authorization rules may apply.	
In-Network 0% of the cost for Medicare-covered lab services. 20% of the cost for Medicare-covered diagnostic procedures and tests. 20% of the cost for Medicare-covered X-rays. 20% of the cost for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services.	
In-Network \$0 copay for Medicare-covered bone mass measurement	
In-Network \$0 copay for Medicare-covered colorectal screenings.	
In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

	Benefit Category	Original Medicare
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.
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 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.
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 registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

HEALTH PLUS ELITE	
	In-Network \$0 copay for Medicare-covered screening mammograms.
	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.
	In-Network \$0 copay for Medicare-covered prostate cancer screening.
	General Authorization rules may apply.
	In-Network \$0 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

Benefit Category**Prescription Drugs****Original Medicare**

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.

HEALTH PLUS ELITE**Drugs covered under Medicare Part B****General**

20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).

20% of the cost for Part B-covered chemotherapy drugs.

Drugs Covered under Medicare Part D**General**

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <https://mp.medimpact.com/pharmacyportal/public/Login.jsp?viewtype=mi> on the web.

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

-have limited incomes,

-live in long term care facilities,

or

-have access to Indian/Tribal/Urban (Indian Health Service).

The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

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

Some drugs have quantity limits.

Your provider must get prior authorization from Health Plus Elite for certain drugs.

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.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

In-Network

\$295 yearly deductible.

Initial Coverage

After you pay your yearly deductible, you pay 25% until total yearly drug costs reach \$2,700.

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

Benefit Category

Original Medicare

Prescription Drugs - Cont'd

HEALTH PLUS ELITE

Retail Pharmacy

You can get drugs the following way(s):

- one-month (30-day) supply
- three-month (90-day) supply

Long Term Care Pharmacy

You can get drugs the following way(s):

- one-month (31-day) supply

Mail Order

You can get drugs the following way(s):

- three-month (90-day) supply

Coverage Gap

After your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of:-

- A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or
- 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Plus Elite.

You can get drugs the following way:

- one-month (30-day) supply

Out-of-Network Initial Coverage

After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until your total yearly drug costs reach \$2,700.

Out-of-Network Coverage Gap

After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Health Plus Elite for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to HealthPlus Elite so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:

- A \$2.40 copay for generic (including brand drugs treated as generic) and a \$ 6.00 copay for all other drugs, or
- 5% coinsurance.

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

	Benefit Category	Original Medicare
30	Dental Services	Preventive dental services (such as cleaning) not covered.
31	Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.
32	Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.
33	Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage 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.
34	Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.
35	Transportation (Routine)	Not covered
36	Acupuncture	Not covered

HEALTH PLUS ELITE	
	<p>In-Network \$0 copay for Medicare-covered dental benefits \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - up to 1 oral exam(s) every six months - up to 1 cleaning(s) every six months - up to 1 dental x-ray(s) every year <p>Plan offers additional comprehensive dental benefits.</p>
	<p>In-Network Hearing aids not covered.</p> <p>\$0 copay for Medicare-covered</p> <ul style="list-style-type: none"> - up to 1 routine hearing test(s) every year
	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair(s) of glasses every year - 20% of the cost for exams to diagnose and treat diseases and conditions of the eye. - 0% of the cost for up to 1 routine eye exam(s) every year <p>\$100 limit for eye wear every year.</p>
	<p>In-Network 20% of the cost for routine exams</p> <p>Limited to 1 exam(s) every year.</p> <p>20% of the cost for Medicare-covered benefits.</p>
	<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional benefit - Nursing Hotline - Smoking Cessation: Same coverage as Medicare.
	<p>In-Network This plan does not cover routine transportation.</p>
	<p>In-Network This plan does not cover Acupuncture.</p>

If you have questions about the Health Plus Elite plan, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

Section 3

Good Health is Your Most Important Asset

At Health Plus, your good health is our greatest concern. We work with you and your doctor to ensure that you receive the most appropriate care. Since your good health is our priority, we provide our members with preventive health care benefits, such as annual physical exams and screenings for cancer and other diseases, to help you stay well.

Your Primary Care Physician

When you join the Health Plus Elite plan, you select a primary care physician (PCP) from our listing of Health Plus participating providers in your area. Your PCP will provide all preventive services and help to coordinate your overall health care. Health Plus recognizes the following as primary care: family practice, general practice, internal medicine and geriatrics. With the **Health Plus Elite plan** you must use Health Plus participating plan providers for all routine services.

With the **Health Plus Elite plan**, you may also receive service from out-of-network providers but prior authorization is required for non-emergent services. You will be responsible for paying 20% coinsurance, for the out-of-network physician office visit.

Services from a Specialist

With Health Plus, you need a referral from your Primary Care Physician before visiting a network Specialist. Your PCP will help you find the right Specialist for your condition, and will make sure you receive the most appropriate medical care. Health Plus physicians are capable of providing virtually all of your medical needs. If you are a member of the **Health Plus Elite plan** and you choose to receive medical care from a physician or provider who does not participate with Health Plus, neither Health Plus nor Original Medicare will pay for these services.

Emergency and Urgent Care

Health Plus covers you for emergency care anywhere in the United States. If you are admitted to the hospital within 24 hours for the same condition, the copayment is waived.

All Health Plus members are covered for urgent care anywhere in the United States. You will be covered in full after you pay your urgent care \$50 copayment. If you are admitted to the hospital, the copayment is waived.

Member Services Department:

Dedicated to Health Plus Members

When a Health Plus member calls with a question or concern, his or her call is answered by a member service representative dedicated to the Health Plus Elite plan. The representatives in this unit are trained on Medicare managed care and the Health Plus Elite plan benefits.

Our Health Plus Member Service Representatives can:

- Answer questions concerning your benefits
- Help you select a Primary Care Physician
- Verify if a physician or provider currently participates with the Health Plus Elite plan
- Order new identification cards
- Assist with any required authorizations
- Perform claims inquiries and research

The programs are not subject to the Medicare appeals process. Any disputes regarding these programs may be subject to the Health Plus grievance process.

Should a problem arise with these programs, please call Member Services at 1-800-300-8181, Monday-Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. TTY/TDD users should call 1-800-421-1220.

Personal Health Advisor — Members can access a Personal Health Advisor 24 hours a day, 7 days a week by calling a nurse advice line. The Personal Health Advisor provides telephone access to registered nurses who provide health care triage, advice, and educational materials. Services for the hearing impaired and interpreters are also available.

- **Disease Management Programs** – For those members facing the challenges of diabetes, congestive heart disease, asthma and other chronic conditions, Health Plus offers education and care management programs to help members better manage their health.

Smoking Cessation:

Health Plus Elite covers 2 types of counseling:

* Intermediate cessation counseling is 3 to 10 minutes per session; and

* Intensive cessation counseling is greater than 10 minutes per session.

Health Plus Elite will cover 2 quit attempts per year. Each quit attempt may include a maximum of 4 intermediate or intensive counseling sessions, with the total annual benefit covering up to 8 sessions in a 12-month period. The health care provider and patient have the flexibility to choose between intermediate and intensive counseling.

To be eligible to receive this benefit, a beneficiary must have a condition that is adversely affected by smoking or tobacco use, or that the metabolism or dosing of a medication that is being used to treat a condition the beneficiary has is being adversely affected by his or her smoking or tobacco use.

In addition, Medicare Part D will also cover smoking cessation treatments prescribed by a physician beginning in January 2006.

For Your Satisfaction

We are confident that you will be completely satisfied with the health coverage you receive with Health Plus. If for any reason you decide to return to Original Medicare, simply notify Health Plus in writing, or call **1 (800) MEDICARE (1 (800) 633-4227)**. TTY/TDD users should call **1 (877) 486-2048**. You can call this number 24 hours a day, 7 days a week. You will have no lapse in coverage.

Once you enroll, you may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 – December 31 of every year), or under certain special circumstances.

If you currently have health coverage from an employer or union, joining Health Plus Elite could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Health Plus Elite may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Privacy Matters

Health Plus believes in treating our members with respect and in ensuring your privacy. We are committed to safeguarding the privacy of medical records and personal information. To ensure confidentiality, we:

- Obtain a voluntary, signed consent form before releasing confidential information
- Train our employees on how to protect your privacy rights, and require employees to sign confidentiality statements
- Restrict access to sensitive medical information to key staff on a need-to-know basis
- Require all physicians and providers to adhere to our written confidentiality policy.