FHCP Medicare

An Affiliate of Florida Blue

2023 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

FHCP Medicare Flagler Advantage (HMO) H1035-016

1/1/2023 – 12/31/2023

The plan's service area includes:
St. Johns County

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You may also view the "Evidence of Coverage" for this plan on our website, **www.fhcpmedicare.com**.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You* 2023 handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

To join, you must:

- be entitled to Medicare Part A; and
- be enrolled in Medicare Part B; and
- live in **our service area.**

Our service area includes the following county in Florida: St. Johns

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Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

- You can see our plan's provider and pharmacy directory on our website (**www.fhcpmedicare.com**). Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- If you are a member of this plan, call us at 1-833-866-6559, TTY: 1-800-955-8770.
- If you are not a member of this plan, call us at 1-855-462-3427, TTY: 1-800-955-8770.
    - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
    - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at **www.fhcpmedicare.com**.

Important Information

Through this document you will see the symbols below.

* Services with this symbol may require approval in advance (a referral) from your Primary Care Doctor (PCP) in order for the plan to cover them.

◊ Services with this symbol may require prior authorization from the plan before you receive services.

If you do not get a referral or prior authorization when required, you may have to pay the full cost of the services. Please contact your PCP or refer to the Evidence of Coverage (EOC) for more information about services that require a referral and/or prior authorization from the plan.

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$0** You must continue to pay your Medicare Part B premium.
Deductible	**$0** per year for health care services **$0** per year for Part D prescription drugs.
Maximum Out-of-Pocket Responsibility	**$3,650** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.

Medical and Hospital Benefits

Inpatient Hospital Coverage *◊	• **$215** copay per day for days 1-5 • **$0** copay per day, after day 5
Outpatient Hospital Coverage *◊	• **$150** copay per visit for Medicare-covered services • **$150** copay per stay for Medicare-covered Observation services
Ambulatory Surgical Center (ASC) Services *◊	• **$75** copay for surgery services provided at an Ambulatory Surgical Center
Doctor Visits	• **$0** copay per primary care visit • **$15** copay per specialist visit *◊

Preventive Care	• **$0** copay for Medicare-covered services
	  • Abdominal aortic aneurysm screening
	  • Annual wellness visit
	  • Bone mass measurement
	  • Breast cancer screening (mammograms)
	  • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
	  • Cardiovascular disease testing
	  • Cervical and vaginal cancer screening
	  • Colorectal cancer screening

	• Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision Care: Glaucoma screening • "Welcome to Medicare" preventive visit
Emergency Care	**Medicare-Covered Emergency Care** • **$125** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 24 hours of an emergency room visit for the same condition. **Worldwide Emergency Care Services** • **$125** copay for Worldwide Emergency Care • **$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Worldwide Ambulance Services
Urgently Needed Services	**Medicare-Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. • **$0** copay per visit at an FHCP Extended Hours Care Center • **$10** copay at an Urgent Care Center, in- or out-of-network **Worldwide Urgently Needed Services** • **$10** copay for Worldwide Urgently Needed Services

	• **$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Worldwide Ambulance Services
Diagnostic Services/ Labs/Imaging *◊	**Laboratory Services** • **$0** copay **X-Rays** • **$10** copay **Diagnostic Radiology Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan. • **$20 - $175** copay **Diagnostic Tests and Procedures** • **$0 - $200** copay **Radiation Therapy** • **$10 - $50** copay
Hearing Services	**Medicare-Covered Hearing Services*** • **$45** copay for exams to diagnose and treat hearing and balance issues **Additional Hearing Services** • **$0** copay for one routine hearing exam per year • **$0** copay for evaluation and fitting of hearing aids • **$300 per ear.** You pay a **$0** copay for up to 2 hearing aids every year with a maximum benefit allowance of **$300** per ear. NOTE: Hearing aids must be purchased through our participating provider to have access to the benefit. • Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.
Dental Services	**Medicare-Covered Dental Services ◊** • **$20** copay for non-routine dental care **Additional Dental Services** • **$0** copay for covered preventive dental services • **$0** copay for covered comprehensive dental services

Vision Services	**Medicare-Covered Vision Services** • **$0** copay for Optometrist services to diagnose and treat eye diseases and conditions • **$15** copay for Ophthalmologist services to diagnose and treat eye diseases and conditions • **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) • **$0** copay for one diabetic retinal exam per year • **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery **Additional Vision Services** • **$0** copay for an annual routine eye examination • Plan pays up to **$180** every two years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist
Mental Health Services *◊	**Inpatient Mental Health Services** • **$215** copay per day for days 1-5 • **$0** copay per day for days 6-90 • 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** • **$15** copay
Skilled Nursing Facility (SNF) *◊	• **$0** copay per day for days 1-20 • **$150** copay per day for days 21-100 Our plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required
Physical Therapy *	• **$20** copay per visit
Ambulance ◊	**Medicare-Covered Ambulance Services** • **$265** copay for each Medicare-covered trip (one-way) **Worldwide Ambulance Services** • **$265** copay for Worldwide Emergency Ambulance services • **$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services, and Worldwide Ambulance Services
Transportation	• Not Covered
Medicare Part B Drugs ◊	• **0%** coinsurance for the following Part B drugs (albuterol, ipratropium, albuterol-ipratropium)

	• **20%** coinsurance for chemotherapy drugs, infusion drugs and all other Part B-covered drugs

Additional Benefits

Diabetic Supplies	**Medicare-Covered Diabetes Monitoring supplies** • **$10** copay for 50 test strips/sensors • **$10** copay for lancets • **$0** copay for Glucometer
Podiatry	**Medicare-Covered Podiatry Services** • **$15** copay for each Medicare-covered podiatry visit **Additional Podiatry Services** • **$10** copay per routine visit. Limited to 6 visits per year.
Chiropractic	• **$20** copay for each Medicare-covered chiropractic visit
Medical Equipment and Supplies ◊	• **20%** of the cost for plan-approved Medicare-covered durable medical equipment
Outpatient Occupational and Speech Therapy *	• **$20** copay per visit
Telehealth	**Telehealth via FHCP Medicare's contracted vendor:** • **$10** copay for a PCP visit • **$30** copay for a Psychologist visit **Telehealth visits with an FHCP Staff Provider:** • **$0** copay per visit for Primary Care Physician; Specialist; Outpatient Mental Health (Individual sessions only); Opioid Treatment Program Services; Outpatient Substance Abuse (Individual sessions only); Dietician Services and Diabetes Self-Management Training (through FHCP Medicare's Clinical staff by appointment only)
Over-the-Counter Items	• **$75** quarterly allowance for the purchase of non-prescription items, such as vitamins and aspirin • Any balance not used for a quarter will not carry over to the next quarter
Preferred Fitness Program	• Free unlimited visits to participating fitness centers and gyms in FHCP Medicare's service area

FHCP Medicare Rewards	• Rewards for completing certain preventive health screenings.

Part D Prescription Drug Benefits

Deductible Stage
This plan does not have a deductible.

Initial Coverage Stage
You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (your payments plus any Part D plan's payments) reach **$4,660**. You may get your drugs at network retail pharmacies and mail order pharmacies.

	Preferred Retail (31-day supply)	**Standard Retail/LTC (31-day supply)**	**Mail Order (93-day supply)**
Tier 1 - Preferred Generic	**$0** copay	**$10** copay	**$0** copay
Tier 2 - Generic	**$5** copay	**$20** copay	**$12** copay
Tier 3 - Preferred Brand	**$44** copay	**$47** copay	**$129** copay
Tier 4 - Non-Preferred Brand	**$95** copay	**$100** copay	**$282** copay
Tier 5 - Specialty Tier	**33%** coinsurance	**33%** coinsurance	Not Applicable

Coverage Gap Stage
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after your total year-to-date drug cost (your payments plus any Part D plan's payments) reaches **$4,660**. You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **$7,400**.

<u>During the Coverage Gap Stage</u>

- You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 2 (Generic) – or **25%** of the cost, whichever is lower.
- For generic drugs in all other tiers, you pay **25%** of the cost.
- For brand-name drugs, you pay **25%** of the cost (plus a portion of the dispensing fee).

Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs reach **$7,400**, you pay the *greater* of:

- **$4.15** copay for generic drugs in all tiers (including brand drugs treated as generic) and a **$10.35** copay for all other drugs in all tiers, or **5%** of the cost.

Additional Drug Coverage

- Please call us or see the plan's "Evidence of Coverage" on our website (**www.fhcpmedicare.com**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (Non-Preferred Brand) cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 93 days) of a drug.
- **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.
- **Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Disclaimers

FHCP Medicare is an HMO plan with a Medicare contract. Enrollment in FHCP Medicare depends on contract renewal.

This information is not a complete description of benefits. Call our Service Center at 1-855-462-3427 (TTY users call 1-800-955-8770) for more information.

FHCP Medicare's pharmacy network includes limited lower-cost, preferred pharmacies in Brevard, Flagler, Seminole, St. Johns and Volusia counties, Florida. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-833-866-6559 (TTY user call 1-800-955-8770) or consult the online pharmacy directory at **www.fhcpmedicare.com**.

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Visit fhcpmedicare.com/ndnotice_ENG for information on our free language assistance services.

Nosotros cumplimos con las leyes federales de derechos civiles aplicables y no discriminamos por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Para información sobre nuestros servicios gratuitos de asistencia lingüística, visite fhcpmedicare.com/ndnotice_SPA.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-866-6559. (TTY users should call 1-800-955-8770). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-866-6559. (TTY: 1-800-955-8773). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电1-833-866-6559. (TTY: 1-800-955-8770)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電1-833-866-6559. (TTY: 1-800-955-8770)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-866-6559. (TTY: 1-800-955-8770). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-866-6559. (TTY: 1-800-955-8770). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-866-6559. (TTY: 1-800-955-8770). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-866-6559. (TTY: 1-800-955-8770). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-866-6559. (TTY: 1-800-955-8770). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться

услугами переводчика, позвоните нам по телефону 1-833-866-6559. (TTY: 1-800-955-8770). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-866-6559. (TTY: 1-800-955-8770). سيقوم بمساعدتك. هذه خدمة مجانية شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-866-6559. (TTY: 1-800-955-8770). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-866-6559. (TTY: 1-800-955-8770). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-866-6559. (TTY: 1-800-955-8770). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-866-6559. (TTY: 1-800-955-8770). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-866-6559. (TTY: 1-800-955-8770). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-866-6559. (TTY: 1-800-955-8770). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。