



An Affiliate of Florida Blue

Membership has its **privileges**

2019 ENROLLMENT GUIDE

FHCP Medicare Premier Plus (HMO) H1035-011

**Brevard, Seminole
and St. Johns Counties**

**Your Partner in
Good Health**

Welcome

Congratulations for choosing **FHCP Medicare!**

This booklet will help make enrolling in your FHCP Medicare plan as easy as possible. It also explains what will happen immediately after you're enrolled, and how to start finding out just how FHCP Medicare is your Partner in Good Health.

This booklet contains:

A **summary of benefits** included in your plan



Information about your plan's **provider network** and how to find a doctor



Information on Medicare **prescription drug benefits** and how to save money on prescription drugs



Enrollment steps that will walk you through the process and explain what will happen during your first 90 days as a member



All the forms you need to enroll in your plan



A glossary of terms that defines Medicare Advantage health plan jargon



If you have questions...



Ask your agent for help or call us. We're here for you!
1-855-462-3427 (TTY: 1-800-955-8770)

8 a.m. - 8 p.m. local time, seven days a week from October 1 - March 31, except for Thanksgiving and Christmas. From April 1 - September 30, we are open Monday - Friday 8 a.m. - 8 p.m. local time.

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

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What is Medicare Advantage?

Medicare Advantage plans are health plans offered by private insurers that contract with Medicare.



These plans combine the benefits of:



Original Medicare Part A, Inpatient hospital and skilled nursing facility care



Original Medicare Part B, Outpatient services and physician care

And they usually include extras, such as:



Prescription drug coverage. (Our FHCP Medicare plans cover prescription drugs.)



Additional benefits, like dental, hearing and vision

With Original Medicare your out-of-pocket costs, like deductibles, coinsurance and copays, can add up. Medicare Advantage plans offer additional benefits and can help you pay fewer out-of-pocket costs than Original Medicare.



Important Medicare Enrollment Information

Medicare Advantage Open Enrollment Period (OEP), January 1–March 31

OEP runs January 1 through March 31. During this period if you are enrolled in a Medicare Advantage (MA) plan, you are allowed to make a one-time election to go to another MA plan or to Original Medicare. If you enroll in Original Medicare, you may also purchase a Medicare Supplement and/or a Prescription Drug Plan.

Note: There is no guaranteed-issue enrollment period for Medicare Supplement plans.

Annual Election Period (AEP), October 15–December 7

Every year, from October 15 through December 7, you can switch, drop or join the Medicare Advantage or Medicare Prescription Drug Plan of your choosing. You can also enroll in Original Medicare. Your plan selection becomes effective January 1 of the following year.



Initial Enrollment Period

When you become eligible for Medicare, you can enroll in Original Medicare or a Medicare health or Prescription Drug Plan three months before the month you turn 65, the month of your birthday, and the three months after the month of your birthday.

Special Election Period (SEP)

After certain events, such as a recent move or losing your employer or union coverage, you may be eligible for a Special Election Period. If you think you qualify, talk to your local sales agent.



How to make the most of your Medicare dollars



Use a Preferred Pharmacy

FHCP Medicare Plans give you a preferred pharmacy option. As an FHCP Medicare member you can fill your prescription drugs at an FHCP Preferred Pharmacy location to save even more on most prescriptions.



FHCP Medicare also provides standard retail pharmacies throughout our service area. These standard pharmacies supplement the FHCP Preferred pharmacies. These pharmacies offer covered drugs, generally at a higher cost-sharing than the FHCP Preferred pharmacies and **include the following locations:**

Walgreens

Winn-Dixie



Mail-Order Pharmacy

For certain kinds of drugs, we offer a mail-order pharmacy. Generally, the drugs provided through FHCP's mail-order pharmacy are drugs that you take on a regular basis, for a chronic or long-term medical condition.

How to Find Out Which Drugs Are Covered

You can find all covered drugs in the formulary, the list of drugs that your plan covers. It's also called a drug list. To see our formulary, visit FHCPMedicare.com.



Click on
Get an Answer



Select
*Prescription Drug
Information & Documents*



Click on
*2019 Comprehensive
Formulary*



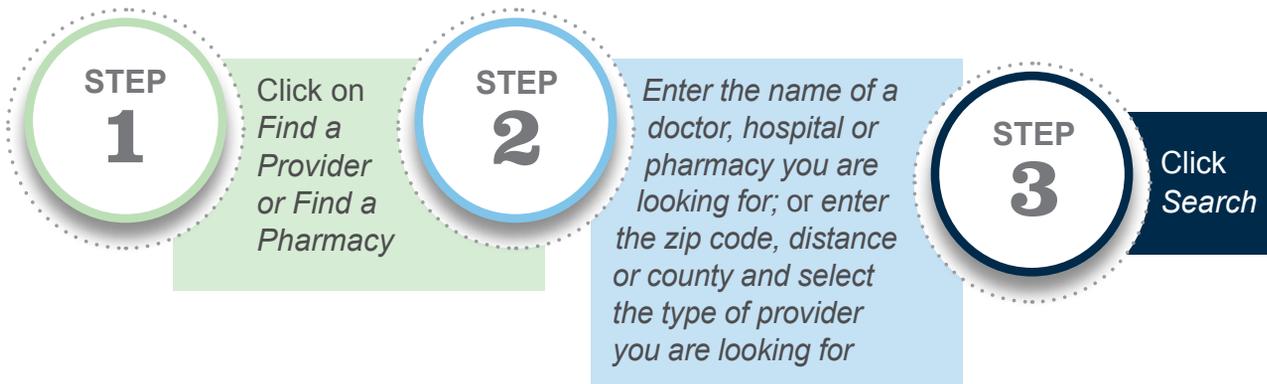
Stay in-network

Be sure to select a doctor in FHCP Medicare’s network. Except for emergency care, urgent care and dialysis services when you’re outside the plan’s service area, you must go to in-network doctors to be covered. This is true even when the care you receive is medically necessary. Avoid unpredictable costs and have peace of mind by staying in your network.



How to Find Out Which Doctors, Hospitals and Pharmacies Are in Your Plan’s Network

There are a few ways to find out which doctors, hospital and pharmacies are in a plan’s network. You can ask your agent for help, call Customer Service (see contact information on the Welcome page), or you can visit **FHCPMedicare.com** and follow these steps:



Choosing Your Primary Care Doctor Is Important

As a new member, one of your first—and most important—decisions is choosing a primary care doctor (PCP). Your PCP manages your overall health and coordinates specialized care and most covered services. Your PCP and any specialists you see work together as a team of professionals focused on you.

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 users, call 1-800-955-8770) or consult the online pharmacy directory at www.FHCPMedicare.com.

You get **more** with **FHCP Medicare**



Preferred Fitness Program

Unlimited visits to local fitness centers and gyms throughout our service area. Visit FHCPMedicare.com to find a participating location.



Transportation Services

Rides to your doctor, hospital or pharmacy. These services can accommodate wheelchairs, walkers, oxygen tanks and service animals.



Hearing Aids

Exams at no cost and coverage toward the purchase of hearing aids.



Routine Dental Check Up

Exams and cleanings at no cost.



Telemedicine

Appointments via a secure web based application on a smart phone, tablet or computer. Face to face visits allow the telemedicine physician or psychologist to treat common non-emergency medical issues, as well as behavioral health care.



Nurse Advice Line

Staffed 24 hours a day, 365 days a year, by experienced, bilingual Registered Nurses who are available to assist you in making the right choices involving health issues.



What you can expect the **first 90 days**

During your first 90 days of enrollment, you can get up and running quickly. Here are some things to look for.

To assure you that your application has been received and accepted, you will receive:

- ✓ **Notification of Receipt of Application**
- ✓ **Notice That You Have Been Enrolled**

You'll receive several items to keep all year:

- ✓ **2019 FHCP Medicare member ID card**
- ✓ **Evidence of Coverage (EOC)**, a complete description of your coverage
- ✓ **Formulary**, a list of the prescription drugs your plan covers

Throughout the year, we'll stay in touch. You'll receive:

- ✓ **Explanations of Benefits** to keep you up to date on any services and supplies you may have received during the previous month
- ✓ **Calls from our Care Team** from time to time to help you stay on top of your health needs
- ✓ **Surveys** to see how we are doing



Summary of benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

FHCP Medicare Premier Plus (HMO) H1035-011

January 1, 2019 – December 31, 2019

The plan's service area includes:

**Brevard, Seminole and
St. Johns Counties**



An Affiliate of Florida Blue

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. 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 these plans on our website, www.fhcpmedicare.com. The Evidence of Coverage includes a complete list of services we cover.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **FHCP Medicare Premier Plus (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **FHCP Medicare Premier Plus (HMO)** covers and what you pay.

- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at <http://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.

Sections in this booklet

- Things to Know About **FHCP Medicare Premier Plus (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available for free in other language. Please call us at 1-855-462-3427. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 – March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday – Friday, 8:00 a.m. – 8:00 p.m., local time.

Things to Know About FHCP Medicare Premier Plus (HMO)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. local time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. local time.

FHCP Medicare Premier Plus (HMO) Phone Numbers and Website

- 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.
- Our website: www.fhcpmedicare.com

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Who can join?

To join **FHCP Medicare Premier Plus (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: **Brevard, Seminole and St. Johns**.

Which doctors, hospitals, and pharmacies can I use?

FHCP Medicare Premier Plus (HMO) has 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 must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these preferred pharmacies.

You can see our plan's provider and pharmacy directories at our website (www.fhcpmedicare.com).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get *more than what* is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some other drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.fhcpmedicare.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five tiers. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact
FHCP Medicare for details.**

SECTION II - SUMMARY OF BENEFITS

FHCP Medicare Premier Plus (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

How much is the monthly premium?	You do not pay a separate monthly plan premium. You must continue to pay your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$4900 for services you receive from in-network providers. <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Note: Amounts you pay for Part D drugs and dental, hearing and vision services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.</p>

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Care	<p><i>Authorization is required for non-emergency Inpatient Hospital stays</i></p> <ul style="list-style-type: none"> • Days 1-7: \$255 Copay per day. • Days 8-90: \$0 Copay per day. • \$0 Copay for additional hospital days. <p>A deductible and/or other cost-sharing is charged for each inpatient stay.</p>
Outpatient Hospital Care	<p><i>Authorization may be required for Medicare-covered Outpatient Hospital Care</i></p> <p>Medicare-covered Outpatient Hospital Services and Medicare-covered Observation Services: \$200 Copay per visit.</p>
Doctor's Office Visits	<p>Primary care physician visit: \$0 Copay.</p> <p><i>Authorization is required for most Specialist visits</i></p> <p>Specialist visit: \$20 Copay.</p> <ul style="list-style-type: none"> • A copay will apply for no-show Specialist visits
Preventive Care	<p>You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care.</p> <p>\$90 Copay.</p> <p>Worldwide coverage.</p>

SECTION II - SUMMARY OF BENEFITS**FHCP Medicare Premier Plus (HMO)**

Urgently Needed Services	<p>Medicare Covered Urgently Needed Services</p> <p>\$20 Copay.</p> <p>Worldwide coverage.</p>
Diagnostic Services/Labs/Imaging	<p><i>Authorization may be required for certain services</i></p> <ul style="list-style-type: none"> • Diagnostic radiology services (CT Scans, MRIs, PET Scans, Nuclear Scans): \$10 - \$175 Copay. • Diagnostic tests and procedures: \$0 – \$200 Copay. • Lab services: \$0 Copay. • Outpatient x-rays: \$10 Copay. • Therapeutic radiology services (such as radiation treatment for cancer): \$10 - \$50 Copay
Hearing Services	<p>Medicare-Covered Hearing Services</p> <p>Exam to diagnose and treat hearing and balance issues: \$40 Copay.</p> <p>Additional Hearing Services</p> <ul style="list-style-type: none"> • Routine hearing exam (1 per year): \$0 Copay. • Up to 2 hearing aids per year for either a \$699 or \$999 Copay per aid • \$0 Copay for evaluation and fitting of hearing aids (1 per year)
Dental Services	<p><i>Authorization is required for Medicare-covered comprehensive dental services.</i></p> <p>Medicare-covered Dental Services (non-routine dental care such as setting fractures of the jaw or facial bones, jaw surgery, extraction of teeth to prepare for radiation therapy, services covered when provided by a physician) \$20 Copay.</p> <p>Additional Dental Services (cleanings, oral exams, X-rays, extraction of erupted tooth or exposed root, adjustment of complete or partial denture): \$0 Copay.</p>
Vision Services	<p>Medicare-Covered Vision Services</p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): <ul style="list-style-type: none"> - \$15 Copay when performed by an Optometrist - \$20 Copay when performed by an Ophthalmologist • One pair of eyeglasses or contact lenses after each cataract surgery: \$0 Copay <p>Additional Vision Services</p> <ul style="list-style-type: none"> • Routine eye exam (1 every year): \$15 Copay. • Plan pays up to \$90 every two years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist.
Mental Health Care	<p>Inpatient Mental Health Care</p> <p><i>Authorization is required for non-emergency inpatient mental health care.</i></p> <ul style="list-style-type: none"> • Days 1-6: \$255 Copay per day. • Days 7-90: \$0 Copay. <p>A deductible and/or other cost-sharing is charged for each inpatient stay.</p>

SECTION II - SUMMARY OF BENEFITS

FHCP Medicare Premier Plus (HMO)

<p>Mental Health Care, continued</p>	<p>Outpatient Mental Health Care Individual or Group therapy visits: \$20 Copay.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p><i>Authorization is required for SNF stays.</i> No prior hospital stay required. When admitted to a Skilled Nursing Facility (SNF), you're covered as defined by Original Medicare guidelines. FHCP Medicare does not cover custodial care. FHCP Medicare follows Original Medicare guidelines in determining authorization and benefit period for SNF services. Our plan covers up to 100 days in a SNF per benefit period.</p> <ul style="list-style-type: none"> • Days 1-20: \$0 Copay per day per benefit period. • Days 21-100: \$172 Copay per day per benefit period.
<p>Physical Therapy</p>	<p>Physical therapy: \$20 Copay per visit</p>
<p>Ambulance</p>	<p>\$175 Copay for each Medicare-covered trip (one way) Worldwide coverage.</p>
<p>Transportation (Routine)</p>	<p><i>Authorization is required for non-emergency transportation to a plan approved location for health related purposes only.</i> \$0 Copay for one-way trips (unlimited)</p>
<p>Medicare Part B Drugs</p>	<p><i>Prior Authorization and/or Step Therapy may be required for Medicare Part B-covered prescription drugs</i> 20% coinsurance for chemotherapy drugs and other Part B drugs Medicare Part B drugs when administered in a dialysis center require a 20% coinsurance. Part B drugs are available at FHCP Medicare's In-network preferred retail pharmacies only, up to a 31-day supply, OR when administered by an in-network physician or an out-of-network physician.</p>

SECTION II - SUMMARY OF BENEFITS

FHCP Medicare Premier Plus (HMO)

PRESCRIPTION DRUG BENEFITS

<p>Deductible Stage</p>	<p>This plan does not have a deductible.</p>																																																
<p>Initial Coverage Stage</p> <p>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.</p> <p>You remain in this stage until your total yearly drug costs (total drug costs paid by you <i>and</i> any Part D plan) reach \$3,820.</p> <p>You may get your drugs at Standard retail, Preferred retail pharmacies and mail order pharmacies.</p>	<p>Preferred Retail Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$0 Copay</td> <td>\$0 Copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$7 Copay</td> <td>\$21 Copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$44 Copay</td> <td>\$132 Copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Brand)</td> <td>\$95 Copay</td> <td>\$285 Copay</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>33% Coinsurance</td> <td>Not Applicable</td> </tr> </tbody> </table> <p>Standard Retail Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$17 Copay</td> <td>\$51 Copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$20 Copay</td> <td>\$60 Copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$47 Copay</td> <td>\$141 Copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Brand)</td> <td>\$100 Copay</td> <td>\$300 Copay</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>33% Coinsurance</td> <td>Not Applicable</td> </tr> </tbody> </table> <p>Mail Order</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$0 Copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$18 Copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$129 Copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Brand)</td> <td>\$282 Copay</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>Not Applicable</td> </tr> </tbody> </table> <p>Your cost-sharing may be different if you use a Long Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy. 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.</p> <p>If you request and the plan approves a formulary exception, you will pay Tier 4: Non-Preferred Brand Drug cost sharing.</p>	Tier	One-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	Tier 2 (Generic)	\$7 Copay	\$21 Copay	Tier 3 (Preferred Brand)	\$44 Copay	\$132 Copay	Tier 4 (Non-Preferred Brand)	\$95 Copay	\$285 Copay	Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Tier	One-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$17 Copay	\$51 Copay	Tier 2 (Generic)	\$20 Copay	\$60 Copay	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	Tier 4 (Non-Preferred Brand)	\$100 Copay	\$300 Copay	Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Tier	Three-month supply	Tier 1 (Preferred Generic)	\$0 Copay	Tier 2 (Generic)	\$18 Copay	Tier 3 (Preferred Brand)	\$129 Copay	Tier 4 (Non-Preferred Brand)	\$282 Copay	Tier 5 (Specialty Tier)	Not Applicable
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<p>Coverage Gap</p>	<p>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 the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,820.</p> <p>During the Coverage Gap Stage:</p> <ul style="list-style-type: none"> 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 37% of the cost, whichever is lower. For brand-name drugs, you pay 25% of the cost (plus a portion of the dispensing fee). <p>You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of \$5,100.</p>																																																

FHCP Medicare Premier Plus (HMO)

Catastrophic Amount	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay the greater of:</p> <ul style="list-style-type: none"> • \$3.40 copay for generic (including brand drugs treated as generic) and a \$8.50 copayment for all other drugs, or • 5% of the cost.
ADDITIONAL MEDICAL BENEFITS	
Wellness Programs	<p>Preferred Fitness Program</p> <ul style="list-style-type: none"> • \$0 copay per visit <p>Telemedicine</p> <ul style="list-style-type: none"> • Primary Care: \$10 copay per visit • Psychologist: \$30 copay per visit

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 user 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 Health Options, Inc., DBA FHCP Medicare, an affiliate of Florida Blue.

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Enrollment Forms



An Affiliate of Florida Blue



Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-462-3427 (TTY: 1-800-955-8770).

UNDERSTANDING THE BENEFITS

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.fhcpmedicare.com or call 1-855-462-3427 (TTY: 1-800-955-8770) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If your pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

UNDERSTANDING IMPORTANT RULES

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Forms Used for Enrollment

Pre-Enrollment Checklist

This form helps you locate resources and provides important information you need to know before purchasing a plan.

Individual Enrollment Form

This is the form you complete to enroll in a an FHCP Medicare plan. This booklet contains two forms.

Protected Health Information Authorization for Customer Service Inquiries

Complete this form if you need to give us permission to release your health information to someone. Send the original, not a photocopy, with your enrollment form. Otherwise, we will protect this information and release it only to you.

Scope of Sales Appointment (SOA) Confirmation Form

According to Medicare guidelines, agents can talk to you only about products you choose to discuss. Medicare asks you to complete an SOA form that shows which Medicare Advantage and/or Part D products you wish to discuss. The form is intended to protect you. Completing the form does not mean you have enrolled in a plan. Your agent can complete this form with you by phone instead of using a paper copy.

Enrollment Verification Checklist

When you meet with an agent to enroll in a plan, the agent will look up how your plan covers medications that you take (including cost, tier and requirements/limitations). Your agent will also look up providers you use to see if they are in your network. Your agent will fill out this information on an enrollment verification checklist they provide and that you can take with you.



Ready to **sign up?**

Have your Medicare ID card handy, and let's get started!

Choose the way to enroll that's best for you.



Paper: Use the paper enrollment form that is included in this enrollment kit. Once you are done filling it out, you can mail the form to FHCP Medicare. (One form must be filled out for each person who enrolls.)



Online: Use the online form at [FHCPMedicare.com](https://www.fhcpmedicare.com). You'll be guided through the process of completing and submitting the enrollment form and the system will prompt you if you left anything missing or incomplete.



Licensed Sales Agent: An agent can help you choose the best plan for YOU and can also offer you help in filling out and submitting the enrollment form. The agent will be employed by or contracted with FHCP Medicare and may be paid based on your enrollment in a plan.

- Visit your local FHCP Welcome Center or agent; or
- Call and speak with one of our agents at **1-855-462-3427**. (TTY users should call 1-800-955-8770.)

Helpful tips for filling out your enrollment form.

- ✓ No matter which way you choose to enroll, make sure you don't skip any sections. If you leave out information, it may delay your start date.
- ✓ When choosing a plan, select only ONE plan name.
- ✓ Where requested, be sure to fill in the Part A and Part B effective dates from your Medicare ID card.
- ✓ If you choose an HMO plan, write in your choice for a primary care physician (PCP). If you do not write in your choice for a PCP, one will be assigned to you.
- ✓ If you are not signing up between October 15 and December 7, be sure to complete the "Attestation of Eligibility for an Enrollment Period" section.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill.
- Electronic Funds Transfer (EFT) from your bank account each month. (FHCP Medicare will send you a letter with further instructions on how to set this up.)
- Credit Card (FHCP Medicare will send you a letter with further instructions on how to set this up.)
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check

I get monthly benefits from: Social Security RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise we may need to contact you to obtain additional information.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
Will you have other **prescription** drug coverage in addition to FHCP Medicare Premier Plus? Yes No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If "yes," please provide the following information:
Name of Institution: _____
Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid program? Yes No
If "yes," please provide your Medicaid number: _____
5. Do you or your spouse work? Yes No

Please choose the name of a Primary Care Physician (PCP), clinic or health center: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: Spanish Braille Audio tape Large print

Please contact FHCP Medicare Premier Plus at 1-800-352-9824, Ext. 7160 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. – 5 p.m. local time, Monday through Friday. TTY users should call 1-800-955-8770.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining FHCP Medicare Premier Plus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FHCP Medicare Premier Plus. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):
- I recently was released from incarceration. I was released on (insert date):
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- I recently obtained lawful presence status in the United States. I got this status on (insert date):
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date):
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date):
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):
- I recently left a PACE program on (insert date):
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):
- I am leaving employer or union coverage on (insert date):
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):
- I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____

AEP: _____

SEP (type): _____

Not Eligible: _____

PCP Provider ID# : _____

Entity Name:

Five digit Entity ID number (if known):

|_|_|_|_|_|

Date Received by agent: _____

FHCP Medicare Agent ID #: _____

Agent State License #: _____

Agent Confirmation #: _____

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People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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I get monthly benefits from: Social Security RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to FHCP Medicare Premier Plus? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid program? Yes No

If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please choose the name of a Primary Care Physician (PCP), clinic or health center: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: Spanish Braille Audio tape Large print

Please contact FHCP Medicare Premier Plus at 1-800-352-9824, Ext. 7160 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. – 5 p.m. local time, Monday through Friday. TTY users should call 1-800-955-8770.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining FHCP Medicare Premier Plus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FHCP Medicare Premier Plus. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):
- I recently was released from incarceration. I was released on (insert date):
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- I recently obtained lawful presence status in the United States. I got this status on (insert date):
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date):
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date):
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):
- I recently left a PACE program on (insert date):
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):
- I am leaving employer or union coverage on (insert date):
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):
- I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____

AEP: _____

SEP (type): _____

Not Eligible: _____

PCP Provider ID# : _____

Entity Name:

Five digit Entity ID number (if known):

|_|_|_|_|_|

Date Received by agent: _____

FHCP Medicare Agent ID #: _____

Agent State License #: _____

Agent Confirmation #: _____

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Protected Health Information **Authorization** for Customer Service Inquiries

PURPOSE

I am the member listed in Section I.

This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc., and Florida Health Care Plan, Inc. (together, "FHCP Medicare") to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

SECTION I

Please provide the following information regarding the person whose Protected Health Information is to be released.

Member Name: _____

Member Number: _____

Group Number: _____ Date of Birth: _____

SECTION II

I authorize FHCP Medicare to release, orally and/or in writing, the following Protected Health Information concerning me:

- Identifying information (e.g., name, address, age, gender);
- Health care coverage information (i.e., general & plan-specific benefit information);
- Past, present and future claims information (except for any period of time during which a Confidential Communication address¹ was in effect); and
- Coordination of Benefit Information.

SECTION III

Please identify the person(s) to whom the member's Protected Health Information may be released and their relationship, i.e., sales agent, employer health benefit representative, parent, family member, friend, corporation, organization, law firm, vendor.

My information may be given to the person(s) listed below.

Please Print:

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

SECTION IV

By law, this authorization must indicate that persons other than FHCP Medicare receiving member's Protected Health Information may not have to obey federal health information privacy laws and member's Protected Health Information may be further released by those persons.

Please complete this entire form and return to:

FHCP Medicare
c/o Florida Blue
Access Authorization Unit
P.O. Box 45296
Jacksonville, FL 32232

Protected Health Information **Authorization** for Customer Service Inquiries *(continued)*

I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, FHCP Medicare will have no further liability as to the further release of my Protected Health Information by those designated persons.

This authorization is voluntary and is not a condition of enrollment in a health plan, eligibility for benefits or payment of claims.

SECTION V

This authorization will expire:

_____/_____/_____
Month Day Year

OR

The date member's FHCP Medicare health coverage ends

It is advised that you place a specific expiration date on this authorization if you are designating a sales agent or employer as an authorized representative, or any other person for whom you may have designated to assist you with a specific, short-term task.

SECTION VI

Copy of Authorization

Please keep a copy of your signed authorization. A photocopy is as valid as the original.

SECTION VII

Right to Withdraw Authorization

I understand that I may withdraw this authorization at any time by giving written notice to the address listed on page 1 of this form. I further understand that withdrawal of this authorization will not affect any action taken by FHCP Medicare in reliance on this authorization prior to receiving my written notice of withdrawal.

SECTION VIII

Signature

Member Signature:

Date: _____

If a legal representative signs this authorization form on behalf of the member, please complete the following information:

Legal Representative's Name²:

Date Signed: _____

Relationship to the member:

¹A Confidential Communication address is one specified by an adult (age 18 or older) that is different than the address where the subscriber receives his or her mail.

²Please provide written documentation to support your status as a guardian or other legal representative.

HMO coverage is offered by Health Options, Inc., D/B/A FHCP Medicare, an affiliate of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

_____ **Stand-alone Medicare Prescription Drug Plans (Part D)**

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

_____ **Medicare Advantage Plans (Part C) and Cost Plans**

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare approved doctor, hospital and provider that accepts the plan’s payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan’s network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
Plan Use Only:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	

Scope of Appointment documentation is subject to CMS record retention requirements

HMO coverage is offered by Health Options, Inc., DBA FHCP Medicare, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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Glossary of **terms**

Annual Election Period (AEP)	This is the time each year when you can sign up for or change your Medicare plan. AEP occurs October 15 to December 7.
Beneficiary	A beneficiary is someone who is eligible for Medicare.
Coinsurance	The percentage of costs of a covered health care service or prescription drug you pay (20%, for example) after you've paid your deductible.
Copayment (copay)	A fixed amount (\$20, for example) you pay for a covered health care service or prescription drug after you've paid your deductible (if applicable).
Deductible	The amount you pay for a covered health care service or prescription drug before your insurance plan starts to pay. With a \$500 deductible, for example, you pay the first \$500 of covered health care services or prescription drugs yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care services or prescription drugs. Your insurance company pays the rest.
Formulary	A list of prescription drugs covered by a prescription drug plan or a health plan that includes prescription drug benefits. Also called a drug list.
Network	The facilities, providers, pharmacies and suppliers your Medicare health plan has contracted with to provide health care and prescription drug services.
Provider	Anyone who provides health care for you is a provider. Doctors, nurses and pharmacists are all providers. A place where you receive care, like a hospital, is a provider, too.
Service Area	This is the geographical area where your plan covers your health care.
Tier	A tier is a category. Medicare Advantage Plans that include prescription drug coverage put covered drugs into different categories, called tiers, often based on how much they cost. For example, generic drugs are in one tier, while brand-name drugs are in another tier.



Section 1557 Notification: Discrimination is Against the Law

FHCP Medicare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FHCP Medicare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FHCP Medicare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified Interpreters
 - Information written in other languages

If you need these services, contact:

- FHCP Medicare : 1-833-866-6559

If you believe that FHCP Medicare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

FHCP Medicare
Civil Rights Coordinator
1340 Ridgewood Avenue
Holly Hill, FL 32117
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-833-866-6559. (TTY: 1-800-955-8770)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-866-6559 (TTY: 1-800-955-8770).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-833-866-6559 (TTY: 1-800-955-8770).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-866-6559 (TTY: 1-800-955-8770).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-833-866-6559 (TTY: 1-800-955-8770).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-866-6559 (TTY: 1-800-955-8770)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-866-6559 (ATS : 1-800-955-8770).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-866-6559 (TTY: 1-800-955-8770).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-866-6559 (телетайп: 1-800-955-8770).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-833-866-6559 (رقم هاتف الصم والبكم: 1-800-955-8770).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-833-866-6559 (TTY: 1-800-955-8770).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-866-6559 (TTY: 1-800-955-8770).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-866-6559 (TTY: 1-800-955-8770)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-833-866-6559 (TTY: 1-800-955-8770).

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