FHCP Medicare Rx Plus (HMO-POS) offered by FHCP Medicare

Annual Notice of Changes for 2019

You are currently enrolled as a member of FHCP's Medvantage Rx Plus Plan. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.1, 2.2 and 2.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit **https://go.medicare.gov/drugprices**. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at **https://www.medicare.gov** website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** FHCP Medicare Rx Plus, you don't need to do anything. You will stay in FHCP Medicare Rx Plus.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in FHCP's Medvantage Rx Plus Plan.
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- Please contact our Member Services number at 1-833-866-6559 for additional information. (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 Day and Christmas Day. However, from April 1 - September 30, our hours are 8:00 a.m. - 8:00 p.m. local time, Monday - Friday. You will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day.
- This document may be available in an alternate format, including large print, audio tapes, CDs and Braille. Please call Member Services at the number listed above if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

About FHCP Medicare Rx Plus

- FHCP Medicare is an HMO plan with a Medicare contract. Enrollment in FHCP Medicare depends on contract renewal.
- When this booklet says "we," "us," or "our," it means FHCP Medicare. When it says "plan" or "our plan," it means FHCP Medicare Rx Plus.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for FHCP Medicare Rx Plus in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
FHCP Medicare Rx Plus		
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$44	$44
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$4,700	$4,700
FHCP Medicare Rx Plus POS		
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$114	$114
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	**In-Network** $4,700 **Out-of-Network** $8,000	**In-Network** $4,700 **Out-of-Network** $8,000

Cost	2018 (this year)	2019 (next year)
IN-NETWORK MEDICAL BENEFITS		
Doctor office visits	Primary care visits: $0 Copayment per visit Specialist care visits: $30 Copayment per visit	Primary care visits: $0 Copayment per visit Specialist care visits: $30 Copayment per visit
Inpatient hospital stays	Days 1-6: $300 Copayment per day (per Medicare-covered stay). Days 7-90: $0 Copayment per day (per Medicare-covered stay). $0 Copayment for additional hospital days.	Days 1-6: $290 Copayment per day (per Medicare-covered stay). Days 7-90: $0 Copayment per day (per Medicare-covered stay). $0 Copayment for additional hospital days
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Standard Retail cost-sharing: $10 copayment Preferred Retail cost-sharing: $0 copayment • Drug Tier 2: Standard Retail cost-sharing: $20 copayment Preferred Retail cost-sharing: $4 copayment • Drug Tier 3: Standard Retail cost-sharing: $47 copayment Preferred Retail cost-sharing: $40 copayment • Drug Tier 4: Standard Retail cost-sharing: $100 copayment Preferred Retail cost-sharing: $80 copayment	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Standard Retail cost-sharing: $17 copayment Preferred Retail cost-sharing: $0 copayment • Drug Tier 2: Standard Retail cost-sharing: $20 copayment Preferred Retail cost-sharing: $4 copayment • Drug Tier 3: Standard Retail cost-sharing: $47 copayment Preferred Retail cost-sharing: $42 copayment • Drug Tier 4: Standard Retail cost-sharing: $100 copayment Preferred Retail cost-sharing: $92 copayment

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage *(continued)*	• Drug Tier 5: Standard Retail cost-sharing: 33% of the total cost Preferred Retail cost-sharing: 25% of the total cost • Drug Tier 6: Standard Retail cost-sharing: 33% of the total cost Preferred Retail cost-sharing: 33% of the total cost	• Drug Tier 5: Standard Retail cost-sharing: 33% of the total cost Preferred Retail cost-sharing: 33% of the total cost

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from FHCP's Medvantage Rx Plus Plan to FHCP Medicare Rx Plus.

If you have the optional supplemental point of service benefit added to your plan, then the plan name will change from FHCP's Medvantage Rx Plus with Optional Point of Service Plan to FHCP Medicare Rx Plus POS.

You should be receiving a new ID card reflecting the new plan name in the mail at the end of this year.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium for FHCP Medicare Rx Plus (You must also continue to pay your Medicare Part B premium.)	$44	$44
Monthly premium for FHCP Medicare Rx Plus POS (You must also continue to pay your Medicare Part B premium.)	$114	$114

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,700	$4,700 Once you have paid $4,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Out-of-network maximum out-of-pocket amount (for FHCP Medicare Rx Plus POS only) Your costs for covered medical services (such as copays) from out-of-network providers count toward your out-of-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your out-of-network maximum out-of-pocket amount.	$8,000	$8,000 Once you have paid $8,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from out-of-network providers for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at **www.fhcpmedicare.com**. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at **www.fhcpmedicare.com**. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Limited Medicare-covered dental services only. (covered services include: Extraction of teeth to prepare jaw for radiation treatment of neoplastic disease; Dental exams prior to kidney transplantation; and Certain non-routine dental services rendered in a hospital when incidental to a Medicare-covered service)	Authorization rules may apply You pay a $30 copayment per visit for Medicare-covered dental benefits	Prior authorization is required for Medicare-covered comprehensive dental services. You pay a $30 copayment per visit for Medicare-covered dental services
We also cover the following additional dental services and supplies not covered by Medicare*:	Preventive Dental benefits (such as cleaning) are not covered	
<u>Clinical Oral Evaluations</u> **1 per lifetime for new patients** D0150 - Comprehensive oral evaluation **1 evaluation every six months for established patients** D0120 – Periodic oral evaluation		You pay a $0 copayment per Oral Exam

Cost	2018 (this year)	2019 (next year)
Dental services *(continued)* *Comprehensive oral evaluations (D0150) are limited to **1 per lifetime, per dentist** but also counts against the 1 evaluation **limit per year*** **<u>Diagnostic Imaging (X–rays)</u>** **1 every 60 months** D0210 – Intraoral – complete series of radiographic images **-OR-** D0330 – Panoramic radiographic image D0277 – Vertical bitewings – 7-8 radiographic images when done with ***D0330*** and instead of ***D0210*** D0350 - 2D Oral/Facial photographic images **1 every 12 months** D0274 – Bitewings – four radiographic images **<u>Dental Prophylaxis (Cleanings)</u>** **1 cleaning Every six months** D1110 – Prophylaxis – adult *Amounts you pay for these additional dental services and supplies do not count toward your in-network out-of-pocket maximum amount.		You pay a $0 copayment per dental x-ray You pay a $0 copayment per Cleaning

Cost	2018 (this year)	2019 (next year)
Emergency care	You pay an $80 copayment per Medicare-covered visit. 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. If you receive emergency care at an out-of- network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.	You pay a $90 copayment per Medicare-covered visit. 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. If you receive emergency care at an out-of- network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Coverage is available world-wide	You pay an $80 copayment for plan covered emergency services received outside the US or its territories.	You pay a $90 copayment for plan covered emergency services received outside the US or its territories.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. **We also cover the following additional hearing services and supplies not covered by Medicare*:**	You pay a $0 copayment per visit for Medicare-covered exams to diagnose and treat hearing and balance issues	You pay a $30 copayment per visit for Medicare-covered exams to diagnose and treat hearing and balance issues
Routine hearing exams: 1 per year	You pay a $0 copayment for routine hearing exam	You pay a $0 copayment for routine hearing exam

Cost	2018 (this year)	2019 (next year)
Hearing services *(continued)* **Fitting/Evaluation for hearing aids:** • Adjustment visits during the first 30 day trial period • Adjustments visits needed during the first year beginning on day 31 (after the 30 day trial period has ended).	You pay a $0 copayment per visit for Hearing Aid fitting/Evaluation (1 every year)	You pay a $0 copayment per visit You pay a $25 copayment per visit
Hearing aids: We cover up to two hearing aids per year (1 per ear, per year). Coverage is only for the **Standard Digital** and **Advanced Digital** Hearing Aids provided by FHCP Medicare's participating audiology and hearing centers throughout Volusia and Flagler counties. *Amounts you pay for these additional hearing services and supplies do not count toward your in-network out-of-pocket maximum amount.	Hearing aids are not covered	**Standard Digital** Hearing Aid including Behind the Ear (BTE) fitting and ear molds: - You pay a $610 per each Aid, or $1220 per pair **Advanced Digital** Hearing Aids including Behind the Ear (BTE) fitting and ear molds. - Tier 1 = you pay a $1,630 per each Aid or $3,260 per pair - Tier 3 = you pay a $2,055 per each Aid or $4,110 per pair - Tier 5 = you pay a $2,505 per each Aid or $5,010 per pair - Tier 7 = you pay a $2,905 per each Aid or $5,810 per pair - Tier 9 = you pay a $3,355 per each Aid or $6,710 per pair
Inpatient hospital care	Authorization rules may apply For each Medicare-covered hospital stay, you pay a: • $300 copayment per day	Authorization is required for non-emergency inpatient hospital stays. For each Medicare-covered hospital stay, you pay a: • $290 copayment per day

Cost	2018 (this year)	2019 (next year)
Inpatient hospital care *(continued)*	(days 1-6) • $0 copayment per day (days 7-90) • $0 copayment for additional hospital days No limit to the number of days covered by the plan each hospital stay. You pay the Inpatient Hospital copayments each time you're admitted to a hospital, no matter how many days have passed since your last admission. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.	(days 1-6) • $0 copayment per day (days 7-90) • $0 copayment for additional hospital days No limit to the number of days covered by the plan each hospital stay. A deductible and/or other cost-sharing is charged for each inpatient stay. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.
Inpatient mental health care	Authorization rules may apply For Medicare-covered hospital days, you pay a: • $300 copayment per day (days 1-5) • $0 copayment per day (days 6-90) • $0 copayment for additional days	Authorization is required for non-emergency inpatient mental health care. For Medicare-covered hospital days, you pay a: • $290 copayment per day (days 1-5) • $0 copayment per day (days 6-90) • $0 copayment for additional days

Cost	2018 (this year)	2019 (next year)
Inpatient mental health care *(continued)*	You pay the Inpatient Hospital Psychiatric copayments each time you're admitted to a hospital, no matter how many days have passed since your last admission. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	A deductible and/or other cost-sharing is charged for each inpatient stay.
Medicare Part B prescription drugs	Prior Authorization and/or Step Therapy requirements do not apply to any Medicare Part B prescription drugs.	Medicare Part B prescription drugs may be subject to prior authorization and/or step therapy requirements. For more information about these requirements, see Chapter 5, Section 4.2 of the Evidence of Coverage. **Exception:** Medicare-covered inpatient stays are subject only to the per-day copayment; any Medicare Part B drugs are included. Contact Member Services for more information.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	Authorization rules may apply. For Medicare-covered outpatient services received at a Hospital Outpatient Department or Provider-based department of a hospital/clinic, you pay: • $200 copayment per visit for Surgical services • $200 copayment per stay for Surgery with Outpatient Monitoring Services; Stand-alone Outpatient Monitoring	Authorization rules apply. For Medicare-covered outpatient services received at a Hospital Outpatient Department or Provider-based department of a hospital/clinic, you pay: • $200 copayment per visit for Surgical services • $200 copayment per stay for Surgery with Outpatient Monitoring Services; Stand-alone Outpatient Monitoring

Cost	2018 (this year)	2019 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *(continued)*	Services; and Other Interventional Services combined with Outpatient Monitoring Services. (Examples of Other Interventional Services: Cardiac Cath., Angioplasties, Vascular and Arterial Studies, and Other Cardiac procedures/studies) For Medicare-covered Ambulatory Surgical Center Services (free-standing facility), you pay: • $100 copayment per visit	Services; and Other Interventional Services combined with Outpatient Monitoring Services. (Examples of Other Interventional Services: Cardiac Cath., Angioplasties, Vascular and Arterial Studies, and Other Cardiac procedures/studies) For Medicare-covered Ambulatory Surgical Center Services (free-standing facility), you pay: • $150 copayment per visit
Services to treat kidney disease	Authorization rules may apply. • You pay a$0 copayment for renal dialysis • You pay a$0 copayment for kidney disease education services Out-of-area Renal Dialysis is covered only when you are traveling outside of FHCP's service area	 • You pay 20% of the total cost for renal dialysis • You pay a$0 copayment for kidney disease education services Out-of-network Renal Dialysis is covered only when you are traveling outside of FHCP Medicare's service area
Skilled nursing facility (SNF) care	Authorization may rules apply. For SNF stays, you pay: • $0 copayment per day (days 1-20) • $160 copayment per day (days 21-100)	Authorization rules apply. For SNF stays, you pay: • $0 copayment per day (days 1-20) per benefit period • $172 copayment per day (days 21-100) per benefit period

Cost	2018 (this year)	2019 (next year)
Skilled nursing facility (SNF) care *(continued)*	**NOTE:** No prior hospital stay required. When admitted to a Skilled Nursing Facility (SNF), you're covered as defined by Original Medicare guidelines. FHCP does not cover custodial care. FHCP follows Original Medicare guidelines in determining authorization and benefit period for SNF services.	**NOTE:** 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. A "**benefit period"** starts the day you go into a SNF. It ends when you go for 60 days in a row without an inpatient admission. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
Transportation services	Not Covered	Authorization rules apply for non-emergency transportation to a plan approved location. You pay a $0 copayment for one-way trips (unlimited)

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days of medication rather than the amount provided in 2018 (90 days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Any existing formulary, tiering or utilization management exception authorization you may have will not automatically renew for the 2019 plan year. In order to ensure your current exception authorization does not expire, please contact our Member Services number for assistance. If your exception authorization does expire, you will be eligible for a transitionary fill of your currently approved medication according to the transition policy. Your doctor may have to submit a new request for continued authorization of the exception. See Chapter 5, Section 5 of the Evidence of Coverage for more information about exception requests.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 31-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2018 please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 8.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the separately mailed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you	Because we have no deductible, this payment stage does not apply to you

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard Retail cost-sharing:* You pay $10 copayment per prescription *Preferred Retail cost-sharing* You pay $0 copayment per prescription **Tier 2 (Generic):** *Standard Retail cost-sharing:* You pay $20 copayment per prescription *Preferred Retail cost-sharing* You pay $4 copayment per prescription **Tier 3 (Preferred Brand):** *Standard Retail cost-sharing:* You pay $47 copayment per prescription *Preferred Retail cost-sharing* You pay $40 copayment per prescription	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard Retail cost-sharing:* You pay $17 copayment per prescription *Preferred Retail cost-sharing* You pay $0 copayment per prescription **Tier 2 (Generic):** *Standard Retail cost-sharing:* You pay $20 copayment per prescription *Preferred Retail cost-sharing* You pay $4 copayment per prescription **Tier 3 (Preferred Brand):** *Standard Retail cost-sharing:* You pay $47 copayment per prescription *Preferred Retail cost-sharing* You pay $42 copayment per prescription

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage *(continued)*	**Tier 4 (Non-Preferred Brand):** *Standard Retail cost-sharing:* You pay $100 copayment per prescription *Preferred Retail cost-sharing* You pay $80 copayment per prescription	**Tier 4 (Non-Preferred Brand):** *Standard Retail cost-sharing:* You pay $100 copayment per prescription *Preferred Retail cost-sharing* You pay $92 copayment per prescription
	Tier 5 (Injectable Drugs): *Standard Retail cost-sharing:* You pay 33% of total cost *Preferred Retail cost-sharing* You pay 25% of total cost	**Injectable Drugs are no longer on a separate tier.**
	Tier 6 (Specialty Tier): *Standard Retail cost-sharing:* You pay 33% of total cost *Preferred Retail cost-sharing* You pay 33% of total cost	**Tier 5 (Specialty Tier):** *Standard Retail cost-sharing:* You pay 33% of total cost *Preferred Retail cost-sharing* You pay 33% of total cost
	Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 3 Administrative Changes

Cost	2018 (this year)	2019 (next year)
Ways you can pay your monthly plan premium	**Option 1: You can pay by cash, check, cashier's check or money order** You may pay your monthly plan premium directly to Florida Health Care Plans with cash, check, cashier's check, or money order. Payment of your plan premiums are due monthly and must be received by FHCP on or before the fifth of each month. You may pay your plan premium in person at one of our business offices or by mail. Monthly premium payments made by check, cashier's check, or money order should be made payable to Florida Health Care Plans and mailed directly to the plan along with your coupon at the following address: Florida Health Care Plans Attn: Cashier P.O. Box 9910 Daytona Beach, FL 32120 Upon enrollment FHCP will issue each member coupons within 30 days to facilitate payment of plan premiums. Payment of the member premium must be received by FHCP on or before the fifth day of the month. FHCP reserves the right to charge up to $30 for any returned bank items. If you have misplaced your coupons, please contact Member Services to have replacement coupons ordered.	**Option 1: You can pay by check** If you choose this option, you will be billed (invoiced) for your plan premium each month. Your monthly plan premium payment is due on the first day of each month. You may mail your premium payments to the following address: FHCP Medicare, PO Box 660289, Dallas, TX 75266-0289. You may mail overnight premium payments to: FHCP Medicare, Attn: CCR, BLDG. 100, 3rd Floor, 4800 Deerwood Campus Pkwy, Jacksonville, FL 32246-6498. Be sure to make checks payable to FHCP Medicare, not to the Centers for Medicare & Medicaid Services (CMS), the federal agency in charge of Medicare, nor to CMS' parent agency, the Department of Health and Human Services (HHS).

Cost	2018 (this year)	2019 (next year)
	Option 2: You can pay by automatic bank withdrawal after you have enrolled in the plan You may have your monthly premium automatically withdrawn from your bank account after you are a member of the plan. You can change to this method of payment by printing an Authorization Agreement for Direct Debit (ACH Debits) form at *www.fhcp.com/documents/medicare/2018/ACH_Medicare.pdf*. The completed form, along with a voided check, should be mailed to the following address: Florida Health Care Plans Attn: Finance P.O. Box 9910 Daytona Beach, FL 32120 If you need more information about or assistance with starting automatic bank withdrawal, you may call Florida Health Care Plans at 386-615-4066 or 1-800-352-9824, ext. 4066, Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. The automatic bank draft deduction will be made from your bank account between the 7th and 10th day of each month.	**Option 2: You can pay by automatic bank withdrawal after you have enrolled in the plan** You may have your monthly plan premium automatically withdrawn from your bank account after you are a member of the plan. Your payments will be withdrawn monthly. Deductions are made by the third day of the month. To enroll in the Automatic Payment Option (APO): • Go to **www.fhcpmedicare.com** and select the Member Portal link in the tool bar at the top of page. • Once in the member portal, click on the "Pay my bill" link in either the My Quick Links or My Resources sections at the top of the page. If you have any questions, please call FHCP Medicare's Finance Department at 1-386-615-4066 or 1-800-352-9824, Ext. 4066 (TTY Users should call 1-800-955-8770). Hours are Monday through Friday, 8:00 a.m. to 4:30 p.m., local time.
	Option 3: You can pay by a recurring monthly credit card charge after you have enrolled in the plan You may have your monthly premium automatically charged to your credit card after you are a member of the plan. You can change to this method of payment by printing a Credit Card Authorization Form at	**Option 3: You can pay by a recurring monthly credit card charge after you have enrolled in the plan** You may have your monthly plan premium automatically charged to your credit card after you are a member of the plan. Your payments will be withdrawn

Cost	2018 (this year)	2019 (next year)
	www.fhcp.com/documents/medicare/2018/Credit_Card_Info_Form.pdf. The completed form should be mailed to the following address: Florida Health Care Plans Attn: Finance P.O. Box 9910 Daytona Beach, FL 32120 If you need more information about or assistance with starting automatic credit card payments, you may call Florida Health Care Plans at 386-615-4066 or 1-800-352-9824, ext. 4066, Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. The automatic credit card charge will be charged to your card on or around the 8th day of each month.	monthly. Deductions are made by the third day of the month. To enroll in the Automatic Payment Option (APO): • Go to **www.fhcpmedicare.com** and select the Member Portal link in the tool bar at the top of page. • Once in the member portal, click on the "Pay my bill" link in either the My Quick Links or My Resources sections at the top of the page. If you have any questions, please call FHCP Medicare's Finance Department at 1-386-615-4066 or 1-800-352-9824, Ext. 4066 (TTY Users should call 1-800-955-8770). Hours are Monday through Friday, 8:00 a.m. to 4:30 p.m., local time. **Option 4: You can pay by telephone** You can pay the bill for your monthly plan premium by telephone by calling FHCP Medicare's Finance Department at 1-386-615-4066 or 1-800-352-9824, Ext. 4066 (TTY Users should call 1-800-955-8770). Hours are Monday through Friday, 8:00 a.m. to 4:30 p.m., EST. You can pay using your checking or savings account, along with your financial institutions nine digit routing number, or debit or credit card.

Cost	2018 (this year)	2019 (next year)
		Option 5: You can pay online You can also pay your monthly plan premium on our plan website. To make a payment online: • Go to **www.fhcpmedicare.com** and select the Member Portal link in the tool bar at the top of page. • Once in the member portal, click on the "Pay my bill" link in either the My Quick Links or My Resources sections at the top of the page. If you have any questions, please call FHCP Medicare's Finance Department at 1-386-615-4066 or 1-800-352-9824, Ext. 4066 (TTY Users should call 1-800-955-8770). Hours are Monday through Friday, 8:00 a.m. to 4:30 p.m., local time. **Option 6: You can have the plan premium taken out of your monthly Railroad Retirement Board check** You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) check. Contact FHCP Medicare's Enrollment Department for more information on how to pay your penalty this way. We will be happy to help you set this up. The Enrollment Department can be reached at 1-386-676-7160 or 1-800-352-9824, Ext. 7160 (TTY Users should call 1-800-955-8770). Hours are Monday through Friday, 8:00 a.m. to 5:00 p.m., local time.

Cost	2018 (this year)	2019 (next year)
	Option 4: You can have the plan premium taken out of your monthly Social Security check You can have the plan premium taken out of your monthly Social Security check. Contact Florida Health Care Plans' Enrollment Department for more information on how to pay your plan premium this way. We will be happy to help you set this up. The Enrollment Department can be reached at 386-676-7160, Monday through Friday, 8 a.m. – 5 p.m.	**Option 7: You can have the plan premium taken out of your monthly Social Security check** You can have the plan premium taken out of your monthly Social Security check. Contact FHCP Medicare's Enrollment Department for more information on how to pay your penalty this way. We will be happy to help you set this up. The Enrollment Department can be reached at 386-676-7160 (TTY Users should call 1-800-955-8770). Hours are Monday through Friday, 8:00 a.m. to 5:00 p.m., local time.
Dropping the Optional Point of Service benefit throughout the year	**Electing the Optional Point of Service Benefit** 1. Application Process, Effective Date, Premiums a. At the time of **initial enrollment** a Medicare Eligible Beneficiary may elect to add the Optional Point of Service benefit to their plan for an additional $70 premium per month. This is in addition to your monthly plan premium. b. During the **Annual Election Period** you may elect to add the Optional Point of Service benefit to your plan for an additional premium per month. This is in addition to your monthly plan premium. The effective date for this election would be January 1 of each year. 2. After the **initial enrollment or annual election period**, you will **NOT** be allowed to **add** the	**Electing the Optional Point of Service Benefit** 1. Application Process, Effective Date, Premiums a. At the time of **initial enrollment** a Medicare Eligible Beneficiary may elect to add the Optional Point of Service benefit to their plan for an additional $70 premium per month. This is in addition to your monthly plan premium. b. During the **Annual Election Period** you may elect to add the Optional Point of Service benefit to your plan for an additional premium per month. This is in addition to your monthly plan premium. The effective date for this election would be January 1 of each year. **2.** After the **initial enrollment or annual election period**, you

Cost	2018 (this year)	2019 (next year)
	Optional Point of Service benefit during the year. During the contract year if you choose to discontinue the Optional Point of Service Benefit you MUST notify FHCP in writing by the end of the month for the change to take effect the first of the following month (i.e., written notification received August 31. The effective date of change will be September 1). Once FHCP has received this notification then you will not be responsible for any further monthly premiums for the Optional Point of Service benefit.	will **NOT** be allowed to **add or drop** the Optional Point of Service benefit during the year.
Failure to Pay Premiums for the Optional Point of Service Benefit	**Failure to Pay Premiums for the Optional Point of Service Benefit** If you enrolled in the Optional Point of Service benefit and you fail to pay your Optional Point of Service premium within 30 days after we notify you that premiums are overdue, we will downgrade you to the FHCP's Medvantage Rx Plus plan. Once FHCP has downgraded you to the FHCP's Medvantage Rx Plus plan you will not be permitted to add the Optional Point of Service benefit on to your plan until next Annual Election Period and any past due premiums have been paid.	**Failure to Pay Premiums for the Optional Point of Service Benefit** If you enrolled in the Optional Point of Service benefit and you fail to pay your Optional Point of Service premium by the first day of the month we will send you a notice telling you that your plan membership will end if we do not receive your premium within six calendar months after we notify you that premiums are overdue

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in FHCP Medicare Rx Plus

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to **https://www.medicare.gov** and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from FHCP Medicare Rx Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from FHCP Medicare Rx Plus.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a

change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

Note: If you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Florida, the SHIP is called *Serving Health Insurance Needs of Elders (SHINE)*.

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *SHINE* counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call *SHINE* at 1-800-963-5337. You can learn more about *SHINE* by visiting their website (**www.floridashine.org**).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with

HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida ADAP Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *the Florida ADAP Program by calling 1-800-352-2437. The hearing impaired may call 1-888-503-7118.*

SECTION 8 Questions?

Section 8.1 – Getting Help from FHCP Medicare Rx Plus

Questions? We're here to help. Please call Member Services at 1-833-866-6559. (TTY only, call 1-800-955-8770). We are available for phone calls 8:00 a.m. - 8:00 p.m. local time, seven days a week from October 1 - March 31, except for Thanksgiving Day and Christmas Day. However, from April 1 - September 30, our hours are 8:00 a.m. - 8:00 p.m. local time, five days a week, you will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for FHCP Medicare Rx Plus. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* will be separately mailed to you.

Visit our Website

You can also visit our website at **www.fhcpmedicare.com**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (**https://www.medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **https://www.medicare.gov** and click on "Find health & drug plans").

Read *Medicare & You 2019*

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**https://www.medicare.gov**) or 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.