

FHCP Medicare Premier Plus (HMO) offered by FHCP Medicare

Annual Notice of Changes for 2019

You are currently enrolled as a member of FHCP's Premier 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 Premier Plus, you don’t need to do anything. You will stay in FHCP Medicare Premier 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 Premier 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, 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.
- 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 Premier 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 Premier Plus.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for FHCP Medicare Premier 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) |
|---|---|---|
| Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details. | \$24 | \$0 |
| Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.) | \$4,000 | \$4,900 |
| Doctor office visits | Primary care visits: \$0 Copayment per visit Specialist care visits: \$20 Copayment per visit | Primary care visits: \$0 Copayment per visit Specialist care visits: \$20 Copayment per visit |
| Inpatient hospital stays | Days 1-7: \$200 Copayment per day (per Medicare-covered stay). Days 8-90: \$0 Copayment per day (per Medicare-covered stay). \$0 Copayment for additional hospital days. | Days 1-7: \$255 Copayment per day (per Medicare-covered stay). Days 8-90: \$0 Copayment per day (per Medicare-covered stay). \$0 Copayment for additional hospital days. |

| Cost | 2018 (this year) | 2019 (next year) |
|--|---|--|
| Part D prescription drug coverage (See Section 2.6 for details.) | Deductible: \$0 Copayment/Coinsurance during the Initial Coverage Stage: <ul style="list-style-type: none"> • 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: \$7 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: \$90 copayment • 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 | Deductible: \$0 Copayment/Coinsurance during the Initial Coverage Stage: <ul style="list-style-type: none"> • 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: \$7 copayment • Drug Tier 3: Standard Retail cost-sharing: \$47 copayment Preferred Retail cost-sharing: \$44 copayment • Drug Tier 4: Standard Retail cost-sharing: \$100 copayment Preferred Retail cost-sharing: \$95 copayment • 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 Premier Plus Plan to FHCP Medicare Premier Plus.

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 (You must also continue to pay your Medicare Part B premium.) | \$24 | \$0 |

- 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) |
|---|------------------|--|
| Maximum out-of-pocket amount | \$4,000 | \$4,900 |
| Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | | Once you have paid \$4,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services 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) |
|---|--|--|
| <p>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:</p> <ul style="list-style-type: none"> • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) for Medicare-covered dental services. | <p>Authorization rules may apply.</p> <p>You pay a \$20 copayment per visit for Medicare-covered dental benefits</p> | <p>Prior authorization is required for Medicare-covered comprehensive dental services.</p> <p>You pay a \$20 copayment per visit for Medicare-covered dental services</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|---|--|--------------------------------|
| <p>Dental services <i>(continued)</i></p> | | |
| <p>We also cover the following additional dental services and supplies not covered by Medicare*:</p> | <p>Preventive Dental benefits (such as cleaning) are not covered</p> | |
| <p><u>Clinical Oral Evaluations</u> 1 evaluation every six months D0120 – Periodic oral evaluation D0180 – Comprehensive periodontal evaluation – new or established patient D0150 – Comprehensive oral evaluation – new or established patient</p> | | <p>You pay a \$0 copayment</p> |
| <p><i>Comprehensive oral evaluations (D0150) are limited to 1 per lifetime, per dentist but also counts against the 1 evaluation limit per year</i> As Necessary D0140 – Limited oral evaluation – problem focused</p> | | |
| <p><u>Diagnostic Imaging (X-rays)</u> 1 set per year D0270 – Bitewing – single radiographic image D0272 – Bitewing – two radiographic images D0273 – Bitewings – three radiographic images D0274 – Bitewings – four radiographic images D0277 – Vertical bitewings – 7-8 radiographic images <i>Any of the above codes constitute one set.</i></p> | | <p>You pay a \$0 copayment</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|--|------------------|-------------------------|
| Dental services <i>(continued)</i> | | |
| 1 set every 3 years | | |
| D0210 – Intraoral – complete series of radiographic images | | |
| D0330 – Panoramic radiographic image | | |
| As Necessary | | |
| D0220 – Intraoral periapical – first radiographic image | | |
| D0230 – Intraoral periapical – each additional radiographic image | | |
| D0240 – Intraoral – occlusal radiographic image | | |
| <i>Any of the above codes constitute one set. Intraoral and panoramic imaging services count against the 1 set per year limit.</i> | | |
| <u>Dental Prophylaxis (Cleanings)</u> | | You pay a \$0 copayment |
| 1 cleaning Every six months | | |
| D1110 – Prophylaxis – adult | | |
| <u>Extractions</u> | | You pay a \$0 copayment |
| 2 Every year | | |
| D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | | |
| <u>Denture Adjustments</u> | | You pay a \$0 copayment |
| Up to 2 every year | | |
| D5410 – Adjust complete denture – maxillary | | |
| D5411 – Adjust complete denture – mandibular | | |
| D5421 – Adjust partial denture – maxillary | | |
| D5422 – Adjust partial denture – mandibular | | |

| Cost | 2018 (this year) | 2019 (next year) |
|--|---|---|
| <p>Dental services <i>(continued)</i></p> <p>*Amounts you pay for these additional dental services and supplies do not count toward your in-network out-of-pocket maximum amount.</p> | | |
| <p>Emergency care</p> <p><i>Coverage is available world-wide</i></p> | <p>You pay an \$80 copayment per Medicare-covered visit.</p> <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>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.</p> <p>You pay an \$80 copayment for plan covered emergency services received outside the US or its territories.</p> | <p>You pay a \$90 copayment per Medicare-covered visit.</p> <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>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.</p> <p>You pay a \$90 copayment for plan covered emergency services received outside the US or its territories.</p> |
| <p>Health and wellness education programs</p> <p>The education sessions must be provided by a certified health educator or other qualified health professional, such as a physician, licensed nurse, registered dietician, or nutritionist.</p> | | |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|--------------------------------|
| <p>Health and wellness education programs (continued)</p> | | |
| <p>➤ <u>ACUTE LOW BACK AND NECK PAIN</u> - This physical therapy program helps members manage acute or chronic low back or neck pain</p> | <p>You pay a \$20 copayment per visit</p> | <p>Not Covered</p> |
| <p>➤ <u>ASTHMA</u> - This program provides education materials to help members manage their asthma and follow their doctor’s treatment plan.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)</u> - This program provides education to members to help them more effectively manage COPD. In addition, members meeting certain criteria may qualify for the Medication Action Plan (MAP) program which targets early intervention through medication management.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>CONTROLLING HIGH BLOOD PRESSURE (HYPERTENSION)</u> – This program includes a tool kit that explains the health risks related to high blood pressure. It includes information on measuring blood pressure, the importance of routinely taking medications, diet tips, exercise, and other self-management tools.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|--|--------------------------------|--------------------------------|
| <p>Health and wellness education programs (continued)</p> | | |
| <p>➤ <u>DEPRESSION</u> – This program is for members recently prescribed antidepressant medications. Educational materials covering the basics of self-management include a discussion about depression, importance of taking prescribed medications, and methods of coping.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>DIABETES EDUCATION PROGRAM</u> - Recognized by the American Diabetes Association (ADA), and conducted by FHCP Medicare’s registered nurses and registered dietitians/Certified Diabetes Educators (CDEs), this free 10-hour diabetes education program covers: diabetes overview, complications, signs and symptoms of high and low blood sugar, lifestyle modifications, medications, nutrition, monitoring guidelines (HgbA1C, blood glucose meters, blood pressure, weight), and foot, skin, and dental care.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>DIABETES PREVENTION PROGRAM</u> is a two hour class that identifies risk factors for developing Diabetes.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|---|--------------------------------|--------------------------------|
| <p>Health and wellness education programs (continued)</p> | | |
| <p>➤ <u>NUTRITION GAME PLAN FOR DIABETES</u> - This two hour session is recommended for members who complete the ten-hour Diabetes Education Program. The class reinforces nutrition education and answers questions regarding diabetes.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>HEART DISEASE</u> - Members with elevated cholesterol levels who are at risk for heart disease will receive educational materials including self-management information, tips for controlling cholesterol levels and reducing risk factors.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>HEALTHY HEART NUTRITION PROGRAM</u> This class helps members identify risk factors for heart disease and provides tips for improving lifestyle choices to reduce those risks.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>HEART FAILURE</u> - Members with a history of heart failure will receive educational materials including self-management tools and education aimed at reducing emergency room and hospital admissions.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |
| <p>➤ <u>PREFERRED FITNESS PROGRAM</u> - Free unlimited visits to participating fitness centers and gyms in FHCP Medicare’s Service Area.</p> | <p>You pay a \$0 copayment</p> | <p>You pay a \$0 copayment</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|--|--|--|
| Hearing services <i>(continued)</i> | | |
| Evaluation and fitting for hearing aids: 1 per year | You pay a \$0 copayment per visit for Hearing Aid fitting/Evaluation | You pay a \$0 copayment for each evaluation and fitting for hearing aids. |
| <p>Hearing aids: Up to 2 TruHearing™ Flyte hearing aids per year (1 per ear, per year). Coverage is only for the TruHearing Flyte Advanced and Flyte Premium hearing aids, which are available in various styles and colors. You must use a TruHearing network provider to receive this benefit. Your hearing aid benefit includes the following:</p> <ul style="list-style-type: none"> • Up to 3 provider visits within 1 year of your purchase • 45-day trial period • 3-year extended warranty • 48 batteries per hearing aid | Hearing Aids are not covered | <p>You pay a \$699 copayment for each TruHearing Flyte Advanced hearing aid.</p> <p>You pay a \$999 copayment for each TruHearing Flyte Premium hearing aid.</p> |
| <p>The following services and supplies are not covered under your hearing aid benefit:</p> <ul style="list-style-type: none"> • Ear molds • Hearing aid accessories • Additional provider visits • Extra batteries • Hearing aid return fees • Loss and damage warranty claims | | |
| <p>You will be responsible for costs associated with excluded services and supplies.</p> | | |
| <p>*Amounts you pay for these additional hearing services and supplies do not count toward your in-network out-of-pocket maximum amount.</p> | | |

| Cost | 2018 (this year) | 2019 (next year) |
|--|--|---|
| <p>Inpatient hospital care</p> | <p>Authorization rules may apply.</p> <p>For each Medicare-covered hospital stay, you pay a:</p> <ul style="list-style-type: none"> • \$200 copayment per day (days 1-7) • \$0 copayment per day (days 8-90) • \$0 copayment for additional hospital days <p>No limit to the number of days covered by the plan each hospital stay.</p> <p>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.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>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.</p> | <p>Authorization is required for non-emergency inpatient hospital stays.</p> <p>For each Medicare-covered hospital stay, you pay a:</p> <ul style="list-style-type: none"> • \$255 copayment per day (days 1-7) • \$0 copayment per day (days 8-90) • \$0 copayment for additional hospital days <p>No limit to the number of days covered by the plan each hospital stay.</p> <p>A deductible and/or other cost-sharing is charged for each inpatient stay.</p> <p>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.</p> |
| <p>Inpatient mental health care</p> | <p>Authorization rules may apply.</p> <p>For Medicare-covered hospital days, you pay a:</p> <ul style="list-style-type: none"> • \$200 copayment per day | <p>Authorization is required for non-emergency inpatient mental health care.</p> <p>For Medicare-covered hospital days, you pay a:</p> <ul style="list-style-type: none"> • \$255 copayment per day |

| Cost | 2018 (this year) | 2019 (next year) |
|---|--|---|
| <p>Inpatient mental health care <i>(continued)</i></p> | <p>(days 1-7)</p> <ul style="list-style-type: none"> • \$0 copayment per day (days 8-90) • \$0 copayment for additional days <p>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.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | <p>(days 1-6)</p> <ul style="list-style-type: none"> • \$0 copayment per day (days 7-90) • \$0 copayment for additional days <p>A deductible and/or other cost-sharing is charged for each inpatient stay.</p> |
| <p>Medicare Part B prescription drugs</p> | <p>Prior Authorization and/or Step Therapy requirements do not apply to any Medicare Part B prescription drugs.</p> | <p>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.</p> <p>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.</p> |
| <p>Services to treat kidney disease</p> | <p>Authorization rules may apply.</p> <ul style="list-style-type: none"> • You pay a \$0 copayment for renal dialysis • You pay a \$0 copayment for kidney disease education services | <ul style="list-style-type: none"> • You pay 20% of the total cost for renal dialysis • You pay a \$0 copayment for kidney disease education services |

| Cost | 2018 (this year) | 2019 (next year) |
|--|---|--|
| Services to treat kidney disease <i>(continued)</i> | Out-of-area Renal Dialysis is covered only when you are traveling outside of FHCP's service area | Out-of-network Renal Dialysis is covered only when you are traveling outside of FHCP Medicare's service area |
| Skilled nursing facility (SNF) care | <p>Authorization may rules apply.</p> <p>For SNF stays, you pay:</p> <ul style="list-style-type: none"> • \$0 copayment per day (days 1-20) • \$160 copayment per day (days 21-100) <p>NOTE: No prior hospital stay required.</p> <p>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.</p> | <p>Authorization rules apply.</p> <p>For SNF stays, you pay:</p> <ul style="list-style-type: none"> • \$0 copayment per day (days 1-20) per benefit period • \$172 copayment per day (days 21-100) per benefit period <p>NOTE: No prior hospital stay required.</p> <p>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.</p> <p>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.</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|--------------------------------|------------------|--|
| 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 transitional 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 | Your cost for a one-month supply at a network pharmacy: | Your cost for a one-month supply at a network pharmacy: |
| During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. | Tier 1 (Preferred Generic): <i>Standard Retail cost-sharing:</i> You pay \$10 copayment per prescription <i>Preferred Retail cost-sharing:</i> You pay \$0 copayment per prescription | Tier 1 (Preferred Generic): <i>Standard Retail cost-sharing:</i> You pay \$17 copayment per prescription <i>Preferred Retail cost-sharing:</i> You pay \$0 copayment per prescription |
| 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 <i>Evidence of Coverage</i> . | Tier 2 (Generic): <i>Standard Retail cost-sharing:</i> You pay \$20 copayment per prescription <i>Preferred Retail cost-sharing:</i> You pay \$7 copayment per prescription | Tier 2 (Generic): <i>Standard Retail cost-sharing:</i> You pay \$20 copayment per prescription <i>Preferred Retail cost-sharing:</i> You pay \$7 copayment per prescription |

| Stage | 2018 (this year) | 2019 (next year) |
|--|--|---|
| <p>Stage 2: Initial Coverage Stage <i>(continued)</i></p> <p>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.</p> | <p>Tier 3 (Preferred Brand):</p> <p><i>Standard Retail cost-sharing:</i> You pay \$47 copayment per prescription</p> <p><i>Preferred Retail cost-sharing:</i> You pay \$42 copayment per prescription</p> <p>Tier 4 (Non-Preferred Brand):</p> <p><i>Standard Retail cost-sharing:</i> You pay \$100 copayment per prescription</p> <p><i>Preferred Retail cost-sharing:</i> You pay \$90 copayment per prescription</p> <p>Tier 5 (Injectable Drugs):</p> <p><i>Standard Retail cost-sharing:</i> You pay 33% of the total cost</p> <p><i>Preferred Retail cost-sharing:</i> You pay 25% of the total cost</p> <p>Tier 6 (Specialty Tier):</p> <p><i>Standard Retail cost-sharing:</i> You pay 33% of the total cost</p> <p><i>Preferred Retail cost-sharing:</i> You pay 33% of the total cost</p> <p>Once your total drug costs have reached \$3,750, you will move to the next stage (the Coverage Gap Stage).</p> | <p>Tier 3 (Preferred Brand):</p> <p><i>Standard Retail cost-sharing:</i> You pay \$47 copayment per prescription</p> <p><i>Preferred Retail cost-sharing:</i> You pay \$44 copayment per prescription</p> <p>Tier 4 (Non-Preferred Brand):</p> <p><i>Standard Retail cost-sharing:</i> You pay \$100 copayment per prescription</p> <p><i>Preferred Retail cost-sharing:</i> You pay \$95 copayment per prescription</p> <p>Injectable Drugs are no longer on a separate tier.</p> <p>Tier 5 (Specialty Tier):</p> <p><i>Standard Retail cost-sharing:</i> You pay 33% of the total cost</p> <p><i>Preferred Retail cost-sharing:</i> You pay 33% of the total cost</p> <p>Once your total drug costs have reached \$3,820, you will move to the next stage (the Coverage Gap Stage).</p> |

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) |
|--|---|---|
| <p>Ways you can pay your Part D Late Enrollment Penalty</p> | <p>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:</p> <p style="text-align: center;">Florida Health Care Plans Attn: Cashier P.O. Box 9910 Daytona Beach, FL 32120</p> <p>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</p> | <p>Option 1: You can pay by check If you choose this option, you will be billed (invoiced) for your Part D late enrollment penalty each month. Your monthly Part D late enrollment penalty payment is due on the first day of each month. You may mail your penalty payments to the following address:</p> <p style="text-align: center;">FHCP Medicare, PO Box 660289, Dallas, TX 75266-0289.</p> <p>You may mail overnight penalty payments to:</p> <p style="text-align: center;">FHCP Medicare, Attn: CCR, BLDG. 100, 3rd Floor, 4800 Deerwood Campus Pkwy, Jacksonville, FL 32246-6498.</p> <p>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).</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|------|--|---|
| | <p>bank items. If you have misplaced your coupons, please contact Member Services to have replacement coupons ordered.</p> <p>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:</p> <p style="text-align: center;">Florida Health Care Plans Attn: Finance P.O. Box 9910 Daytona Beach, FL 32120</p> <p>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.</p> | <p>Option 2: You can pay by automatic bank withdrawal after you have enrolled in the plan You may have your monthly Part D late enrollment penalty 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.</p> <p>To enroll in the Automatic Payment Option (APO):</p> <ul style="list-style-type: none"> • 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. <p>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.</p> |

| Cost | 2018 (this year) | 2019 (next year) |
|------|--|---|
| | <p>Option 3: You can pay by a recurring monthly credit card charge after you have enrolled in the plan</p> <p>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 www.fhcp.com/documents/medicare/2018/Credit_Card_Info_Form.pdf. The completed form should be mailed to the following address:</p> <p style="text-align: center;">Florida Health Care Plans Attn: Finance P.O. Box 9910 Daytona Beach, FL 32120</p> <p>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.</p> | <p>Option 3: You can pay by a recurring monthly credit card charge after you have enrolled in the plan</p> <p>You may have your monthly Part D late enrollment penalty automatically charged to your credit card after you are a member of the plan. Your payments will be withdrawn monthly. Deductions are made by the third day of the month.</p> <p>To enroll in the Automatic Payment Option (APO):</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Option 4: You can pay by telephone</p> <p>You can pay the bill for your monthly Part D late enrollment penalty 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> |

| Cost | 2018 (this year) | 2019 (next year) |
|------|--|--|
| | <p>p.m., local time. You can pay using your checking or savings account, along with your financial institutions nine digit routing number, or debit or credit card.</p> | <p>Option 5: You can pay online You can also pay your monthly Part D late enrollment penalty on our plan website.</p> |
| | <p>To make a payment online:</p> <ul style="list-style-type: none"> • 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. | <p>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.</p> |
| | <p>Option 6: You can have the Part D late enrollment penalty taken out of your monthly Railroad Retirement Board check You can have the Part D late enrollment penalty 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</p> | |

| Cost | 2018 (this year) | 2019 (next year) |
|------|--|---|
| | <p>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.</p> | <p>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.</p> <p>Option 7: You can have the Part D late enrollment penalty taken out of your monthly Social Security check You can have the Part D late enrollment penalty 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 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.</p> |

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in FHCP Medicare Premier 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 Premier 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 Premier 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. (TTY: 1-888-503-7118.)*

SECTION 8 Questions?

Section 8.1 – Getting Help from FHCP Medicare Premier 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 Premier 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.