2020 Enrollment Guide

FHCP Medicare Premier Plus (HMO) H1035-011
FHCP Medicare Premier Advantage (HMO) H1035-040

The plans’ service area includes:

Brevard & Seminole Counties
Welcome

Congratulations for choosing FHCP Medicare!

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

This booklet contains:

- **A summary of benefits** included in your plan
- **Enrollment steps** that will walk you through the process
- **All the forms** you need to enroll in your plan
- **Information about your plan’s provider network** and how to find a doctor
- **Information on Medicare prescription drug benefits** and how to save money on prescription drugs
- **Information on what happens after you enroll** and what to expect

If you have questions… We are available.

**1-855-462-3427 (TTY: 1-800-955-8770)**

*October 1 to March 31:* 7 days a week from 8 a.m. to 8 p.m. local time, except for Thanksgiving and Christmas and from *April 1 to September 30:* Monday through Friday, from 8 a.m. to 8 p.m. local time
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What is Medicare Advantage?

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

**ORIGINAL MEDICARE**

**Part A** covers inpatient hospital and skilled nursing facility care.

**Part B** covers outpatient services and physician care.

**PRESCRIPTION DRUGS**

**Part D** covers prescription drugs.

**MEDICARE ADVANTAGE**

**Part C** combines Part A, Part B and often Part D plus additional benefits like dental, hearing and vision. Our FHCP Medicare Advantage plans include Part D coverage.

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

<table>
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<tbody>
<tr>
<td>Open Enrollment Period</td>
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<tr>
<td>Initial Enrollment Period*</td>
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<td>Annual Election Period</td>
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<td>Special Election Period</td>
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</tbody>
</table>

* 3 months before/after and including the month of your 65th birthday.

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

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

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

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

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

**Brevard & Seminole Counties**

### Plan Costs

<table>
<thead>
<tr>
<th></th>
<th>FHCP Medicare Premier Plus (H1035-011)</th>
<th>FHCP Medicare Premier Advantage (H1035-040)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much is the monthly premium?</td>
<td>$0 You must continue to pay your Medicare Part B premium.</td>
<td>$20 You must continue to pay your Medicare Part B premium.</td>
</tr>
<tr>
<td>How much is the deductible?</td>
<td>This plan does not have a deductible.</td>
<td>This plan does not have a deductible.</td>
</tr>
<tr>
<td>Is there any limit on how much I will pay for my covered services?</td>
<td>$4,900 for services you receive from in-network providers.</td>
<td>$3,400 for services you receive from in-network providers.</td>
</tr>
</tbody>
</table>

### Medical & Hospital Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>FHCP Medicare Premier Plus</th>
<th>FHCP Medicare Premier Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor’s Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$20 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>Days 1-7: $270 copay per day After the 7th day the plan pays 100% of covered expenses.</td>
<td>Days 1-5: $205 copay per day After the 5th day the plan pays 100% of covered expenses.</td>
</tr>
<tr>
<td><strong>Outpatient Hospital</strong></td>
<td>$200 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$150 copay in an Ambulatory Surgical Center</td>
<td>$75 copay in an Ambulatory Surgical Center</td>
</tr>
<tr>
<td></td>
<td>$200 copay in an Outpatient Hospital Facility</td>
<td>$150 copay in an Outpatient Hospital Facility</td>
</tr>
<tr>
<td><strong>Urgently Needed Services</strong></td>
<td>$20 copay at an Urgent Care Center</td>
<td>$10 copay at an Urgent Care Center</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$90 copay</td>
<td>$120 copay</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>$295 copay</td>
<td>$265 copay</td>
</tr>
</tbody>
</table>

### Additional Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>FHCP Medicare Premier Plus</th>
<th>FHCP Medicare Premier Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Services</strong></td>
<td>$0 copay for routine hearing exam. Hearing aid coverage.¹</td>
<td>$0 copay for routine hearing exam. Hearing aid coverage.¹</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>$0 copay for cleanings and other services.¹</td>
<td>$0 copay for cleanings and other services.¹</td>
<td></td>
</tr>
</tbody>
</table>
### Additional Benefits (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 (Preferred Generic)</th>
<th>Tier 2 (Generic)</th>
<th>Tier 3 (Preferred Brand)</th>
<th>Tier 4 (Non-Preferred Brand)</th>
<th>Tier 5 (Specialty Tier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Services</td>
<td>$0 copay</td>
<td>$7 copay</td>
<td>$45 copay</td>
<td>$98 copay</td>
<td>33% coinsurance</td>
</tr>
<tr>
<td>Fitness Gym Membership</td>
<td>Preferred Fitness Program</td>
<td>Preferred Fitness Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over-the-Counter Items</td>
<td>Not Covered</td>
<td></td>
<td>$75 quarterly allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td></td>
</tr>
</tbody>
</table>

1 See Summary of Benefits for more details

### Part D Prescription Drug Benefits

#### What you pay at a Preferred Pharmacy for a 31-day Supply

<table>
<thead>
<tr>
<th>Tier 1 (Preferred Generic)</th>
<th>Tier 2 (Generic)</th>
<th>Tier 3 (Preferred Brand)</th>
<th>Tier 4 (Non-Preferred Brand)</th>
<th>Tier 5 (Specialty Tier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$0 copay</td>
<td>$7 copay</td>
<td>$45 copay</td>
<td>$98 copay</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$0 copay</td>
<td>$5 copay</td>
<td>$44 copay</td>
<td>$95 copay</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$0 copay</td>
<td>$5 copay</td>
<td>$44 copay</td>
<td>$95 copay</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$0 copay</td>
<td>$5 copay</td>
<td>$44 copay</td>
<td>$95 copay</td>
</tr>
</tbody>
</table>

#### What you pay at a FHCP Mail Order Pharmacy for a 93-day supply

<table>
<thead>
<tr>
<th>Tier 1 (Preferred Generic)</th>
<th>Tier 2 (Generic)</th>
<th>Tier 3 (Preferred Brand)</th>
<th>Tier 4 (Non-Preferred Brand)</th>
<th>Tier 5 (Specialty Tier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$0 copay</td>
<td>$18 copay</td>
<td>$132 copay</td>
<td>$291 copay</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$0 copay</td>
<td>$12 copay</td>
<td>$129 copay</td>
<td>$282 copay</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$0 copay</td>
<td>$12 copay</td>
<td>$129 copay</td>
<td>$282 copay</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$0 copay</td>
<td>$12 copay</td>
<td>$129 copay</td>
<td>$282 copay</td>
</tr>
<tr>
<td>Tier 5</td>
<td>$0 copay</td>
<td>$12 copay</td>
<td>$129 copay</td>
<td>$282 copay</td>
</tr>
</tbody>
</table>
2020

Summary of Benefits

Medicare Advantage Plans with Part D
Prescription Drug Coverage

FHCP Medicare Premier Plus (HMO) H1035-011
FHCP Medicare Premier Advantage (HMO) H1035-040
January 1, 2020 – December 31, 2020

The plans’ service area includes:

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

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

### Who Can Join?

To join, you must:

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

Our service area includes the following counties in Florida: Brevard and Seminole

### Which doctors, hospitals, and pharmacies can I use?

**FHCP Medicare Premier Plus (HMO) and FHCP Medicare Premier Advantage (HMO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

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

### Have Questions? Call Us

- If you are a member of one of these plans, call us at 1-833-866-6559, TTY: 1-800-955-8770.
- If you are not a member of one of these plans, call us at 1-855-462-3427, TTY: 1-800-955-8770.
  - We are available October 1 to March 31, 7 days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
  - From April 1 to September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time.
- Or visit our website at www.fhcpmedicare.com.

### Important Information

Through this document you will see the symbols below.

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

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

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

<table>
<thead>
<tr>
<th>Monthly Plan Premium</th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>You must continue to pay your Medicare Part B premium</td>
<td>$20 You must continue to pay your Medicare Part B premium</td>
</tr>
<tr>
<td>Deductible</td>
<td>This plan does not have a deductible</td>
<td>This plan does not have a deductible</td>
</tr>
</tbody>
</table>

### Maximum Out-of-Pocket Responsibility
- **FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011**
  - **$4,900** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.
  - **Note:** Amounts you pay for Part D drugs, dental, hearing, vision and routine foot care services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.

- **FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040**
  - **$3,400** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.
  - **Note:** Amounts you pay for Part D drugs, dental, hearing, vision and routine foot care services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.

## Medical and Hospital Benefits

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<thead>
<tr>
<th></th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
</table>
| **Inpatient Hospital Care *◊** | ▪ **$270** copay per day, days 1-7  
▪ **$0** copay per day after day 7 | ▪ **$205** copay per day, days 1-5  
▪ **$0** copay per day after day 5 |
| **Outpatient Hospital Care *◊** | ▪ **$200** copay per visit for Medicare-covered services  
▪ **$200** copay per visit for Observation services | ▪ **$150** copay per visit for Medicare-covered services  
▪ **$150** copay per visit for Observation services |
| **Ambulatory Surgery Center ◊** | ▪ **$150** copay for surgery services provided at an Ambulatory Surgery Center | ▪ **$75** copay for surgery services provided at an Ambulatory Surgery Center |
| **Doctor’s Office Visits** | ▪ **$0** copay per primary care visit  
▪ **$20** copay per specialist visit *◊ | ▪ **$0** copay per primary care visit  
▪ **$15** copay per specialist visit *◊ |
| **Preventive Care** | ▪ **$0** copay for Medicare-covered services  
▪ Abdominal aortic aneurysm screening  
▪ Alcohol misuse screening and counseling  
▪ Annual Wellness visit  
▪ Bone mass measurements  
▪ Breast cancer screening (mammograms) | ▪ **$0** copay for Medicare-covered services  
▪ Abdominal aortic aneurysm screening  
▪ Alcohol misuse screening and counseling  
▪ Annual Wellness visit  
▪ Bone mass measurements  
▪ Breast cancer screening (mammograms) |
<table>
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<tr>
<th>Emergency Care</th>
<th>Medicare-Covered Emergency Care</th>
<th>Medicare-Covered Emergency Care</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$90 copay per visit, in- or out-of-network</td>
<td>$120 copay per visit, in- or out-of-network</td>
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<tr>
<td></td>
<td>This copay is waived if you are admitted to the hospital within 24 hours of an emergency room visit for the same condition.</td>
<td>This copay is waived if you are admitted to the hospital within 24 hours of an emergency room visit for the same condition.</td>
</tr>
<tr>
<td>Worldwide Emergency Care Services</td>
<td>$90 copay for Worldwide Emergency Care</td>
<td>$120 copay for Worldwide Emergency Care</td>
</tr>
<tr>
<td></td>
<td>$25,000 combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Ambulance Services</td>
<td>$25,000 combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Ambulance Services</td>
</tr>
</tbody>
</table>

Any additional preventive services approved by Medicare during the contract year will be covered.
| Urgently Needed Services | Medicare-Covered Urgently Needed Services  
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.  
- **$20** copay at an Urgent Care Center, in- or out-of-network  
| FHCP Medicare Premier Plus (HMO)  
Brevard and Seminole  
H1035-011 | Medicare-Covered Urgently Needed Services  
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.  
- **$10** copay at an Urgent Care Center, in- or out-of-network  
| FHCP Medicare Premier Advantage (HMO)  
Brevard and Seminole  
H1035-040 |

| Worldwide Urgently Needed Services  
- **$20** copay for Worldwide Urgently Needed Services  
- **$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Ambulance Services | Worldwide Urgently Needed Services  
- **$10** copay for Worldwide Urgently Needed Services  
- **$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Ambulance Services |

| Diagnostic Services/ Labs/Imaging | Laboratory Services  
- **$0** copay  
X-Rays  
- **$10** copay  
Diag nostic Radiology Services  
Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan  
- **$10 - $175** copay  
Di agnostic Test and Procedures  
- **$0 - $200** Copay  
Radiation Therapy  
- **$10 - $50** copay | Laboratory Services  
- **$0** copay  
X-Rays  
- **$10** copay  
Diagnostic Radiology Services  
Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan  
- **$10 - $175** copay  
Diagnostic Test and Procedures  
- **$0 - $200** Copay  
Radiation Therapy  
- **$10 - $50** copay |

| Hearing Services | Medicare-Covered Hearing Services  
- **$40** copay for exams to diagnose and treat hearing and balance issues  
Additional Hearing Services  
- **$0** copay for one routine hearing exam per year  
- **$0** copay for evaluation and fitting of hearing aids  
- **$699 - $999** copay per aid (two hearing aids per year, one per ear) | Medicare-Covered Hearing Services  
- **$40** copay for exams to diagnose and treat hearing and balance issues  
Additional Hearing Services  
- **$0** copay for one routine hearing exam per year  
- **$0** copay for evaluation and fitting of hearing aids  
- **$699 - $999** copay per aid (two hearing aids per year, one per ear) |
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Medicare-Covered Dental Services</th>
<th>Medicare-Covered Vision Services</th>
<th>Medicare-Covered Inpatient Mental Health Services</th>
<th>Medicare-Covered Outpatient Mental Health Services</th>
<th>Medicare-Covered Skilled Nursing Facility (SNF)</th>
<th>Medicare-Covered Physical Therapy</th>
<th>Medicare-Covered Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services</td>
<td>$20 copay for non-routine dental care</td>
<td>* Exam to diagnose and treat disease and conditions of the eye (including yearly glaucoma screening):</td>
<td>$270 copay per day for days 1-6</td>
<td>$20 copay</td>
<td>$0 copay per day for days 1-20</td>
<td>$20 copay per visit</td>
<td>$295 copay for each Medicare-covered trip (one-way)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* $15 copay when performed by an Optometrist</td>
<td></td>
<td></td>
<td>$172 copay per day 21-100</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>* $20 copay when performed by an Ophthalmologist</td>
<td></td>
<td></td>
<td>$0 copay per day for days 1-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>One pair of eyeglasses or contact lenses after each cataract surgery:</td>
<td></td>
<td></td>
<td>$150 copay per day 21-100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* $0 copay</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Vision Services</td>
<td>* $15 copay for an annual routine eye examination</td>
<td>* Plan pays up to $90 every two years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist</td>
<td>* $205 copay per day for days 1-5</td>
<td>$15 copay</td>
<td>$0 copay per day for days 1-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* $0 copay every two years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist</td>
<td></td>
<td></td>
<td>$150 copay per day 21-100</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mental Health Care</td>
<td></td>
<td></td>
<td>* $205 copay per day for days 1-5</td>
<td>$15 copay</td>
<td>$0 copay per day for days 1-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* $0 copay per day for days 1-20</td>
<td></td>
<td></td>
<td>$150 copay per day 21-100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* $0 copay per day for days 6-90</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>$295 copay for each Medicare-covered trip (one-way)</td>
<td>$265 copay for each Medicare-covered trip (one-way)</td>
<td>$20 copay per visit</td>
<td>$20 copay per visit</td>
<td>$20 copay per visit</td>
<td>$20 copay per visit</td>
<td>$295 copay for each Medicare-covered trip (one-way)</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Worldwide Ambulance Services</strong></td>
<td>- $295 copay for Worldwide Emergency Ambulance services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transportation◊</strong></td>
<td>- $0 copay for six one-way trips per year for medically necessary, non-emergency transportation to a plan-approved location from a participating transportation provider for health-related purposes only.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Part B Drugs◊</strong></td>
<td>- 0% coinsurance for the following Part B drugs (albuterol, ipratropium, albuterol-ipratropium)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Part B Drugs◊</strong></td>
<td>- 20% coinsurance for chemotherapy drugs, infusion drugs and all other Part B-covered drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FHCP Medicare Premier Plus (HMO)**
Brevard and Seminole
H1035-011

**FHCP Medicare Premier Advantage (HMO)**
Brevard and Seminole
H1035-040

**Worldwide Ambulance Services**
- $265 copay for Worldwide Emergency Ambulance services
- $25,000 combined yearly limit for Worldwide Emergency Care, Urgently Needed Services, and Ambulance Services

**Transportation◊**
- $0 copay for six one-way trips per year for medically necessary, non-emergency transportation to a plan-approved location from a participating transportation provider for health-related purposes only.

**Medicare Part B Drugs◊**
- 0% coinsurance for the following Part B drugs (albuterol, ipratropium, albuterol-ipratropium)
- 20% coinsurance for chemotherapy drugs, infusion drugs and all other Part B-covered drugs
Part D Prescription Drug Benefits

Deductible Stage
These plans do not have a deductible.

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

You remain in this stage until your total yearly drug costs (total drug costs paid by you and any Part D plan) reach $4,020. You may get your drugs at network retail pharmacies and mail order pharmacies.

## Tier 1 – Preferred Generic

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Retail (One-month (31-day) supply)</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Standard Retail (One-month (31-day) supply)</td>
<td>$17 Copay</td>
<td>$17 Copay</td>
</tr>
<tr>
<td>Mail Order (Three-month (93-day) supply)</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
</tr>
</tbody>
</table>

## Tier 2 – Generic

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Retail (One-month (31-day) supply)</td>
<td>$7 Copay</td>
<td>$7 Copay</td>
</tr>
<tr>
<td>Standard Retail (One-month (31-day) supply)</td>
<td>$20 Copay</td>
<td>$20 Copay</td>
</tr>
<tr>
<td>Mail Order (Three-month (93-day) supply)</td>
<td>$18 Copay</td>
<td>$18 Copay</td>
</tr>
</tbody>
</table>

## Tier 3 – Preferred Brand

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Retail (One-month (31-day) supply)</td>
<td>$45 Copay</td>
<td>$45 Copay</td>
</tr>
<tr>
<td>Standard Retail (One-month (31-day) supply)</td>
<td>$47 Copay</td>
<td>$47 Copay</td>
</tr>
<tr>
<td>Mail Order (Three-month (93-day) supply)</td>
<td>$132 Copay</td>
<td>$132 Copay</td>
</tr>
</tbody>
</table>

## Tier 4 – Non-Preferred Brand

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Retail (One-month (31-day) supply)</td>
<td>$98 Copay</td>
<td>$98 Copay</td>
</tr>
<tr>
<td>Standard Retail (One-month (31-day) supply)</td>
<td>$100 Copay</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Mail Order (Three-month (93-day) supply)</td>
<td>$291 Copay</td>
<td>$291 Copay</td>
</tr>
</tbody>
</table>

## Tier 5 – Specialty Tier

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>33%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Coverage Gap Stage
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug costs (including what our plan has paid and what you have paid) reach $4,020. You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of $6,350.

During the Coverage Gap Stage:
- You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 2 (Generic) – or 25% of the cost, whichever is lower
- For generic drugs in all other tiers, you pay 25% of the cost.
- For brand-name drugs, you pay 25% of the cost (plus a portion of the dispensing fee).
Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs reach $6,350, you pay the greater of:

- $3.60 copay for generic drugs in all tiers (including brand drugs treated as generic) and a $8.95 copay for all other drugs in all tiers, or 5% of the cost.

Additional Drug Coverage

- Please call us or see the plan’s “Evidence of Coverage” on our website (www.fhcpmedicare.com) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4: Non-Preferred Brand cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 93 days) of a drug.

Additional Benefits

<table>
<thead>
<tr>
<th></th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Supplies</td>
<td>Medicare-covered Diabetes Monitoring supplies</td>
<td>Medicare-covered Diabetes Monitoring supplies</td>
</tr>
<tr>
<td></td>
<td>$10 copay for 50 test strips/sensors</td>
<td>$10 copay for 50 test strips/sensors</td>
</tr>
<tr>
<td></td>
<td>$10 copay for lancets</td>
<td>$10 copay for lancets</td>
</tr>
<tr>
<td></td>
<td>$0 copay for Glucometer</td>
<td>$0 copay for Glucometer</td>
</tr>
<tr>
<td>Podiatry</td>
<td>$20 copay for each Medicare-covered podiatry visit</td>
<td>$15 copay for each Medicare-covered podiatry visit</td>
</tr>
<tr>
<td></td>
<td>$10 copay per routine visit. Limited to 6 visits per year</td>
<td>$10 copay per routine visit. Limited to 6 visits per year</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$20 copay for each Medicare-covered chiropractic visit</td>
<td>$20 copay for each Medicare-covered chiropractic visit</td>
</tr>
<tr>
<td>Medical Equipment and Supplies ◊</td>
<td>20% of the cost for plan-approved Medicare-covered durable medical equipment</td>
<td>20% of the cost for plan-approved Medicare-covered durable medical equipment</td>
</tr>
<tr>
<td>Outpatient Occupational and Speech Therapy *</td>
<td>$20 copay per visit</td>
<td>$20 copay per visit</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>Medical Telemedicine via FHCP Medicare’s contracted vendor.</td>
<td>Medical Telemedicine via FHCP Medicare’s contracted vendor.</td>
</tr>
<tr>
<td></td>
<td>$10 copay for a PCP visit</td>
<td>$10 copay for a PCP visit</td>
</tr>
<tr>
<td></td>
<td>$30 copay for a Psychologist visit</td>
<td>$30 copay for a Psychologist visit</td>
</tr>
<tr>
<td></td>
<td>Medical Telemedicine via ZOOM with an FHCP Staff Physician.</td>
<td>Medical Telemedicine via ZOOM with an FHCP Staff Physician.</td>
</tr>
<tr>
<td></td>
<td>$0 copay for a PCP visit</td>
<td>$0 copay for a PCP visit</td>
</tr>
<tr>
<td></td>
<td>$20 copay for a Specialist visit</td>
<td>$15 copay for a Specialist visit</td>
</tr>
</tbody>
</table>

FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011

FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040

Diabetic Supplies

- Medicare-covered Diabetes Monitoring supplies
  - $10 copay for 50 test strips/sensors
  - $10 copay for lancets
  - $0 copay for Glucometer

Podiatry

- $20 copay for each Medicare-covered podiatry visit
  - $10 copay per routine visit. Limited to 6 visits per year

Chiropractic

- $20 copay for each Medicare-covered chiropractic visit

Medical Equipment and Supplies ◊

- 20% of the cost for plan-approved Medicare-covered durable medical equipment

Outpatient Occupational and Speech Therapy *

- $20 copay per visit

Telemedicine

- Medical Telemedicine via FHCP Medicare’s contracted vendor.
  - $10 copay for a PCP visit
  - $30 copay for a Psychologist visit
- Medical Telemedicine via ZOOM with an FHCP Staff Physician.
  - $0 copay for a PCP visit
  - $20 copay for a Specialist visit

- Medical Telemedicine via FHCP Medicare’s contracted vendor.
  - $10 copay for a PCP visit
  - $30 copay for a Psychologist visit
- Medical Telemedicine via ZOOM with an FHCP Staff Physician.
  - $0 copay for a PCP visit
  - $15 copay for a Specialist visit
You Get More with FHCP Medicare

<table>
<thead>
<tr>
<th></th>
<th>FHCP Medicare Premier Plus (HMO) Brevard and Seminole H1035-011</th>
<th>FHCP Medicare Premier Advantage (HMO) Brevard and Seminole H1035-040</th>
</tr>
</thead>
</table>
| Over-the-Counter Items    | ▪ Not Covered                                                 | ▪ $75 quarterly allowance for the purchase of non-prescription items, such as vitamins and aspirin  
|                           |                                                               | ▪ Any balance not used for a quarter will not carry over to the next quarter |
| Preferred Fitness Program | ▪ Free unlimited visits to participating fitness centers and gyms in FHCP Medicare’s service area | ▪ Free unlimited visits to participating fitness centers and gyms in FHCP Medicare’s service area |
| FHCP Medicare Rewards     | ▪ Rewards for completing certain preventive health screenings. | ▪ Rewards for completing certain preventive health screenings. |

Disclaimers

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

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

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

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

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

Steps that will walk you through the process and all the forms you need to enroll in your plan
Choose the way to enroll that’s best for you.

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

**Online:** Use the online form at fhcpmedicare.com. You’ll be guided through the process of completing and submitting the enrollment form and the system will prompt you if you left anything missing or incomplete.

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

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

**Helpful tips for filling out your enrollment form.**

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

<table>
<thead>
<tr>
<th></th>
<th>Form Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-Enrollment Checklist This form provides important information you need to know before purchasing a plan.</td>
</tr>
<tr>
<td>2</td>
<td>Individual Enrollment Form This is the form you complete to enroll in a FHCP Medicare Advantage plan. This booklet contains two enrollment forms.</td>
</tr>
<tr>
<td>3</td>
<td>Protected Health Information Authorization for Customer Service Inquiries Complete this form if you need to give us permission to release your health information to someone. Send the original, not a photocopy, with your enrollment form. Otherwise, we will protect this information and release it only to you.</td>
</tr>
<tr>
<td>4</td>
<td>Scope of Sales Appointment (SOA) Confirmation Form According to Medicare guidelines, agents can talk to you only about products you choose to discuss. Medicare asks you to complete an SOA form that shows which Medicare Advantage and/or Medicare Prescription Drug plans you wish to discuss. The form is intended to protect you. Completing the form does not mean you have enrolled in a plan. Your agent can complete this form with you by phone instead of using a paper copy.</td>
</tr>
<tr>
<td>5</td>
<td>Enrollment Verification Checklist When you meet with an agent to enroll in a plan, the agent will look up how your plan covers medications that you take (including cost, tier and requirements/limitations). Your agent will also look up providers you use to see if they are in your network. Your agent will fill out this information on an enrollment verification checklist they provide and that you can take with you.</td>
</tr>
</tbody>
</table>
Pre-Enrollment Checklist

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

Understanding the Benefits

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for services you routinely receive from a doctor. Visit www.fhcpmedicare.com or call 1-855-462-3427 (TTY:1-800-955-8770) to view a copy of the EOC.

☐ Review the provider directory (or ask your doctors) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select new doctors.

☐ Review the pharmacy directory to make sure the pharmacy you use for prescription medicines is in the network. If your pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.

☐ Except in emergency or urgent situations, we do not cover services provided by out-of-network providers (doctors who are not listed in the provider directory).
A Medicare Advantage Health Care Plan

Individual Enrollment Form

FHCP Medicare **Premier Plus** (HMO)  

FHCP Medicare **Premier Advantage** (HMO)

Please contact FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage if you need information in another language or format (Braille).

To Enroll in FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage please provide the following information:

Please check which plan you want to enroll in:

- **FHCP Medicare Premier Plus** (HMO) $0 per month
- **FHCP Medicare Premier Advantage** (HMO) $20 per month

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Sex:</th>
<th>Home Phone Number:</th>
<th>Alternate Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M/F</td>
<td>(               )</td>
<td>(                     )</td>
</tr>
</tbody>
</table>

Permanent Residence Street Address (P.O. Box is not allowed):

<table>
<thead>
<tr>
<th>City:</th>
<th>County:</th>
<th>State:</th>
<th>ZIP Code:</th>
</tr>
</thead>
</table>

Mailing Address (only if different from your Permanent Residence Address):

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
<th>State:</th>
<th>ZIP Code:</th>
</tr>
</thead>
</table>

E-mail Address: ____________________________

Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- **OR**-

• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

____________________________________

Medicare Number:

____________________________________

Is Entitled To  

**HOSPITAL** (PART A)  
**MEDICAL** (PART B)  

You must have Medicare Part A and Part B to join a Medicare Advantage plan.
Paying Your Plan Premium:

- **For those members enrolling in FHCP Medicare Premier Plus**, if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or Credit Card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay FHCP Medicare the Part D-IRMAA.

- **For those members enrolling in FHCP Medicare Premier Advantage**, you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or Credit Card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay FHCP Medicare the Part D-IRMAA.

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

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

**Please select a premium payment option:**

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

I get monthly benefits from:  
- Social Security
- RRB

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

**Please read and answer these important questions:**

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

If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis; otherwise we may need to contact you to obtain additional information.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

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

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

<table>
<thead>
<tr>
<th>Name of other coverage</th>
<th>ID # for this coverage</th>
<th>Group # for this coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>______________________</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

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

If “yes,” please provide the following information:

Name of Institution:________________________________________________________

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

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

If “yes,” please provide your Medicaid number: ___________________________________

5. Do you or your spouse work?  
☐ Yes  ☐ No

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

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

☐ Spanish  ☐ Braille  ☐ Audio tape  ☐ Large print

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

STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Attestation of Eligibility for an Enrollment Period

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

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

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I am new to Medicare.

I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):  

I recently was released from incarceration. I was released on (insert date):  

I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):  

I recently obtained lawful presence status in the United States. I got this status on (insert date):  

I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). on (insert date):  

I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):  

I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.  

I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):  

I recently left a PACE program on (insert date):  

I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):  

I am leaving employer or union coverage on (insert date):  

I belong to a pharmacy assistance program provided by my state.  

My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.  

I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):  

I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):  

I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you’re not sure, please contact FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage at 1-800-352-9824, Ext. 7160. (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 5 p.m. local time, Monday through Friday.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage serves a specific service area. If I move out of the area that FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage serves, I need to notify the plan so I can disenroll and find

Y0011_34981_M 0819 CMS Accepted
a new plan in my new area. Once I am a member of FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage Plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage coverage begins, I must get all of my health care from FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage and other services contained in my FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FHCP MEDICARE PREMIER PLUS OR FHCP MEDICARE PREMIER ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage, he/she may be paid based on my enrollment in FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage.

**Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: ___________________________

Today's Date: ____________

If you are the authorized representative, you must sign above and provide the following information:

Name: ___________________________

Address: ___________________________

Phone Number: ______________________

Relationship to Enrollee: ___________________________

**Office Use Only:**

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

Plan ID #: ___________________________

Effective Date of Coverage: ___________________________

ICEP/IEP: ___________________________

AEP: ___________________________

SEP (type): ___________________________

Not Eligible: ___________________________

PCP Provider ID#: ___________________________

Entity Name: ___________________________

Five digit Entity ID number (if known): ___________________________

Date Received by agent: ___________________________

FHCP Medicare Agent ID #: ___________________________

Agent State License #: ___________________________

Agent Confirmation #: ___________________________
A Medicare Advantage Health Care Plan

Individual Enrollment Form

FHCP Medicare Premier Plus (HMO)          FHCP Medicare Premier Advantage (HMO)

Please contact FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage if you need information in another language or format (Braille).

To Enroll in FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage please provide the following information:

Please check which plan you want to enroll in:
- FHCP Medicare Premier Plus (HMO) $0 per month
- FHCP Medicare Premier Advantage (HMO) $20 per month

Last Name:                                           First Name:                                                    Middle Initial:   ○ Mr.  ○ Mrs.  ○ Ms.

Birth Date:                                                          Sex:          ○ M  ○ F

Home Phone Number: (            )
Alternate Phone Number: (            )

Permanent Residence Street Address (P.O. Box is not allowed):

City:                                                                 County:                        State:                  ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address:                                                     City:                     State:                  ZIP Code:

E-mail Address: ______________________________________________________

Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

• Fill out this information as it appears on your Medicare card.
- OR -

• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To           Effective Date
HOSPITAL (PART A)       __________________
MEDICAL (PART B)        __________________

You must have Medicare Part A and Part B to join a Medicare Advantage plan.
Paying Your Plan Premium:

- **For those members enrolling in FHCP Medicare Premier Plus,** if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or Credit Card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay FHCP Medicare the Part D-IRMAA.

- **For those members enrolling in FHCP Medicare Premier Advantage,** you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or Credit Card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay FHCP Medicare the Part D-IRMAA.

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

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

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

Please select a premium payment option:

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

I get monthly benefits from:  
- Social Security  
- RRB  

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

Please read and answer these important questions:

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

If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis; otherwise we may need to contact you to obtain additional information.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

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

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

<table>
<thead>
<tr>
<th>Name of other coverage</th>
<th>ID # for this coverage:</th>
<th>Group # for this coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

If “yes,” please provide the following information:

Name of Institution: ____________________________________________

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

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

If “yes,” please provide your Medicaid number: ____________________________

5. Do you or your spouse work?  ○ Yes  ○ No

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

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

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

STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Attestation of Eligibility for an Enrollment Period

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Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.
I am new to Medicare.
I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):  
I recently was released from incarceration. I was released on (insert date):  
I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):  
I recently obtained lawful presence status in the United States. I got this status on (insert date):  
I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). I got this status on (insert date):  
I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):  
I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven’t had a change.  
I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):  
I recently left a PACE program on (insert date):  
I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (insert date):  
I am leaving employer or union coverage on (insert date):  
I belong to a pharmacy assistance program provided by my state.  
My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.  
I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):  
I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):  
I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you’re not sure, please contact FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage at 1-800-352-9824, Ext. 7160. (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 5 p.m. local time, Monday through Friday.

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FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage serves a specific service area. If I move out of the area that FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage, I
have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage Plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage coverage begins, I must get all of my health care from FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage and other services contained in my FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR FHCP MEDICARE PREMIER PLUS OR FHCP MEDICARE PREMIER ADVANTAGE WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage, he/she may be paid based on my enrollment in FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage.

**Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that FHCP Medicare Premier Plus or FHCP Medicare Premier Advantage will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

**Signature:** __________________________  **Today's Date:** ________________

If you are the authorized representative, you must sign above and provide the following information:

**Name:** __________________________________________

**Address:** _________________________________________

**Phone Number:** ________________________________

**Relationship to Enrollee:** __________________________

---

**Office Use Only:**

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

---

**Entity Name:** _____________________________

**Five digit Entity ID number (if known):** ____________

**Date Received by agent:** _______________________

**FHCP Medicare Agent ID #:** ___________________

**Agent State License #:** _______________________

**Agent Confirmation #:** _______________________

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Protected Health Information Authorization for Customer Service Inquiries

Purpose
I am the member listed in Section I. This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Florida Blue Medicare, Inc., and Florida Health Care Plan, Inc. (together, “FHCP Medicare”) to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

Section I
Please provide the following information regarding the person whose Protected Health Information is to be released.
Member Name: ______________________________________________________
Member Number: ____________________________________________________
Group Number: ______________________ Date of Birth: _____________________

Section II
I authorize FHCP Medicare to release, orally and/or in writing, the following Protected Health Information concerning me:
• Identifying information (e.g., name, address, age, gender);
• Health care coverage information (i.e., general & plan-specific benefit information);
• Past, present and future claims information (except for any period of time during which a Confidential Communication address was in effect); and
• Coordination of Benefit Information.

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

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

Please Print:
Name: _________________________ Relationship to Member: _______________
Name: _________________________ Relationship to Member: _______________
Name: _________________________ Relationship to Member: _______________

Section IV
By law, this authorization must indicate that persons other than FHCP Medicare receiving member’s Protected Health Information may not have to obey federal health information privacy laws and member’s Protected Health Information may be further released by those persons.
I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, FHCP Medicare will have no further liability as to the further release of my Protected Health Information by those designated persons.

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

**Section V**

This authorization will expire:

____________/___________/__________

Month   Day   Year

OR

____________________________________________

The date member’s FHCP Medicare health coverage ends

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

**Section VI**

Copy of Authorization

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

**Section VII**

Right to Withdraw Authorization

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

**Section VIII**

Signature

Member Signature:

____________________________________________

Date: _________________

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

Legal Representative’s Name:

____________________________________________

Date Signed: _________________

Relationship to the member:

____________________________________________

---

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

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

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an independent licensee of the Blue Cross and Blue Shield Association
Protected Health Information Authorization for Customer Service Inquiries

Purpose
I am the member listed in Section I. This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Florida Blue Medicare, Inc., and Florida Health Care Plan, Inc. (together, “FHCP Medicare”) to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

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• Identifying information (e.g., name, address, age, gender);
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• Past, present and future claims information (except for any period of time during which a Confidential Communication address
  was in effect); and
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Name: _________________________ Relationship to Member: _________________________
Name: _________________________ Relationship to Member: _________________________
Name: _________________________ Relationship to Member: _________________________

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By law, this authorization must indicate that persons other than FHCP Medicare receiving member’s Protected Health Information may not have to obey federal health information privacy laws and member’s Protected Health Information may be further released by those persons.
I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, FHCP Medicare will have no further liability as to the further release of my Protected Health Information by those designated persons.

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This authorization will expire:

Month / Day / Year

OR

The date member’s FHCP Medicare health coverage ends

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

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

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

Section VIII
Signature
Member Signature:

Date: ________________

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

Legal Representative’s Name:

Date Signed: ________________

Relationship to the member:

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

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

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an independent licensee of the Blue Cross and Blue Shield Association.
Scope of Sales Appointment Confirmation Form

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

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

<table>
<thead>
<tr>
<th></th>
<th>Stand-alone Medicare Prescription Drug Plans (Part D)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Medicare Advantage Plans (Part C) and Cost Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).</td>
</tr>
<tr>
<td></td>
<td>Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.</td>
</tr>
<tr>
<td></td>
<td>Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare approved doctor, hospital and provider that accepts the plan’s payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.</td>
</tr>
<tr>
<td></td>
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<td>Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.</td>
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<td>Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan’s network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.</td>
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By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: ____________________________________________

Signature Date: ____________________________________________

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

Representative’s Name: ____________________________________________

Your Relationship to the Beneficiary: ____________________________________________

To be completed by Agent:

<table>
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<tr>
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Scope of Appointment documentation is subject to CMS record retention requirements

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an independent licensee of the Blue Cross and Blue Shield Association
Agent, if the form was signed by the beneficiary at the time of appointment, provide a written explanation below why SOA was not documented prior to meeting:

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### Stand-alone Medicare Prescription Drug Plans (Part D)

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

### Medicare Advantage Plans (Part C) and Cost Plans

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

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

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

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

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

- **Medicare Cost Plan** — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan’s network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
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Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

**Beneficiary or Authorized Representative Signature and Signature Date:**

Signature: _____________________________________________

Signature Date: ________________________________________

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

Representative’s Name: __________________________________

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**Enrollment Checklist**

FHCP Medicare is required by Medicare to contact you within 15 days of receiving your enrollment application. Within the next 15 days you will receive a letter from FHCP Medicare to verify that the Medicare Advantage-Prescription Drug Plan was fully explained. This will not affect your ability to enroll in the plan.

Your sales agent will review the following questions with you to verify that the Medicare Advantage-Prescription Drug Plan was fully explained. Check Yes or No as appropriate.

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<tr>
<th>Yes □ No □</th>
<th>Do you understand that you have applied for a Medicare Advantage-Prescription Drug Plan? This plan is <strong>not a</strong> Medicare Supplement “Medigap” plan. This plan replaces Original Medicare.</th>
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<td>Yes □ No □</td>
<td>Do you understand that HMO members are not covered out-of-network, except in emergencies, urgent care and out-of-area dialysis?</td>
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*Some drugs may be covered under Medicare Part B or Part D. To determine coverage under the appropriate Medicare benefit, your doctor is required to submit a Medicare Part B vs. D coverage determination form to FHCP Medicare to obtain prior approval for these medications before the prescription is filled.*
### Acknowledgement

My agent and I have reviewed all my doctor(s), hospital(s) and prescription drug(s) that I have provided today. We have discussed each provider’s participating status within my plan as well as my cost share and any requirements or limits regarding my prescription drug(s). I understand that some network providers may be added or removed from the network at any time. For any additional providers or to get the most up-to-date information about my plan’s network providers for my area or my prescription drugs, I will visit [www.fhcpmedicare.com](http://www.fhcpmedicare.com) or call Member Services at 1-833-866-6559 from 8 a.m. to 8 p.m. local time, seven days a week from October 1 – March 31, except for Thanksgiving and Christmas. From April 1 – September 30, we are open Monday – Friday, 8 a.m. – 8 p.m. local time, except for Federal holidays. (TTY users should call 1-800-955-8770).

Applicant’s Signature_________________________________ Date ______________________

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Provider’s Name | Par/Non-Par | Provider’s Complete Address
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What’s Next?

Information on what happens after you enroll and what to expect
How to find out which doctors, hospitals and pharmacies are in your plan’s network:

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

- Click on Find a Provider or Find a Pharmacy
- Enter the name of the doctor, hospital or pharmacy you are looking for
- or enter the zip code, distance or county and select the type of provider you are looking for
- Click Search and review the options of our network providers
Choosing Your Primary Care Doctor Is Important

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

Use a Preferred Pharmacy

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

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

Walgreens  Winn-Dixie  Publix

Mail-Order Pharmacy

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

How to find out which drugs are covered:

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

Click on Get an Answer  Select Prescription Drug Information & Documents  Click on 2020 Comprehensive Formulary

FHCP Medicare’s pharmacy network includes limited lower-cost, preferred pharmacies in Brevard, Flagler, Seminole, St. Johns and Volusia counties, Florida. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-833-866-6559 (TTY users, call 1-800-955-8770) or consult the online pharmacy directory at www.fhcpmedicare.com.
What you can expect in the first 90 days

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

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

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

You’ll receive several items to keep all year:

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

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

✓ Explanations of Benefits to keep you up to date on any services and supplies you may have received during the previous month
✓ Calls from our Care Team from time to time to help you stay on top of your health needs
✓ Surveys to see how we are doing
Section 1557 Notification: Discrimination is Against the Law

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

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

**If you need these services, contact:**
- FHCP Medicare: 1-833-866-6559

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

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

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

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-833-866-6559. (TTY: 1-800-955-8770)


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


10100-065 0718
HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an affiliate of Florida Blue and an Independent Licensee of the Blue Cross and Blue Shield Association.