



2021 Summary of Benefits Medicare Advantage Plans with Part D Prescription Drug Coverage

FHCP Medicare Choice (HMO-POS) H1035-044
1/1/2021 – 12/31/2021



The plans' service area includes:
Flagler and Volusia Counties

Y0011_FBM0140 2020_M

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 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: Flagler and Volusia

Which doctors, hospitals, and pharmacies can I use?

FHCP Medicare Choice (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, you may pay more 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.
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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.
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Important Information

Through this document you will see the symbols below.

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

If you do not get 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 prior authorization from the plan.

Monthly Premium, Deductible and Limits



FHCP Medicare Choice (HMO-POS) Flagler and Volusia H1035-044		
	In-Network	Out-of-Network
Monthly Plan Premium	\$0 You must continue to pay your Medicare Part B premium	
Deductible	\$900 per year for covered Out-of-Network medical services \$395 per year per year for Part D prescription drugs. Applies only to Part D drugs in Tier 3, Tier 4 and Tier 5.	
Maximum Out-of-Pocket Responsibility	\$7,550 is the most you pay for copays, coinsurance and other costs for Medicare-covered In-Network medical services from in-network providers for the year. \$9,000 is the most you pay for copays, coinsurance and other costs for Medicare-covered Out-of-Network medical services for the year. Note: Amounts you pay for Part D drugs and hearing services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.	

Medical and Hospital Benefits



FHCP Medicare Choice (HMO-POS) Flagler and Volusia H1035-044		
	In-Network	Out-of-Network
Inpatient Hospital Care ◇	<ul style="list-style-type: none"> ▪ \$500 copay per day, days 1-4 ▪ \$0 copay per day after day 4 	<ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible
Outpatient Hospital Care ◇	<ul style="list-style-type: none"> ▪ \$400 copay per visit for Medicare-covered services ▪ \$400 copay per visit for Observation services 	<ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible
Ambulatory Surgery Center ◇	<ul style="list-style-type: none"> ▪ \$300 copay for surgery services provided at an Ambulatory Surgery Center 	<ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible
Doctor's Office Visits	<ul style="list-style-type: none"> ▪ \$20 copay per primary care visit ▪ \$50 copay per specialist visit ◇ 	<ul style="list-style-type: none"> ▪ \$40 copay per primary care visit ▪ \$80 copay per specialist visit

**FHCP Medicare Choice
(HMO-POS)**

Flagler and Volusia
H1035-044

In-Network

Out-of-Network

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)
 - Cardiovascular disease screening and intensive behavioral therapy
 - Cervical and vaginal cancer screening
 - Colorectal cancer screening
 - Depression screening
 - Diabetes screening and self-management training
 - Hepatitis B and C screening
 - HIV screening
 - Intensive Behavioral Therapy for Obesity
 - Lung cancer screening
 - Medical nutrition therapy
 - Prostate cancer screening
 - Sexually transmitted infections – screening and high-intensity behavioral counseling to prevent them
 - Smoking and tobacco use cessation counseling
 - Vaccines for influenza, pneumonia and Hepatitis B
 - Welcome to Medicare preventive visit
- **50%** coinsurance after you pay your plan deductible

Any additional preventive services approved by Medicare during the contract year will be covered.

Emergency Care

Medicare-Covered Emergency Care

- **\$90** copay per visit, in- or out-of-network

This copay is waived if you are admitted to the hospital within 24 hours of an emergency room visit for the same condition.

Worldwide Emergency Care Services

- **\$90** copay for Worldwide Emergency Care
- **\$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Ambulance Services

Urgently Needed Services

Medicare-Covered Urgently Needed Services

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.


- **\$20** copay per visit at an FHCP Extended Hours Care Center
- **\$50** copay at an Urgent Care Center, in- or out-of-network

Worldwide Urgently Needed Services

- **\$50** copay for Worldwide Urgently Needed Services
- **\$25,000** combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Ambulance Services

**FHCP Medicare Choice
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	In-Network	Out-of-Network
Diagnostic Services/ Labs/Imaging	<p>Laboratory Services ◇</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>X-Rays</p> <ul style="list-style-type: none"> ▪ \$10 - \$50 copay <p>Diagnostic Radiology Services ◇ Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan</p> <ul style="list-style-type: none"> ▪ \$10 - \$200 copay <p>Diagnostic Test and Procedures ◇</p> <ul style="list-style-type: none"> ▪ \$0 - \$300 Copay <p>Radiation Therapy ◇</p> <ul style="list-style-type: none"> ▪ \$10 - \$50 copay 	<p>Laboratory Services</p> <ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible <p>X-Rays</p> <ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible <p>Diagnostic Radiology Services Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan</p> <ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible <p>Diagnostic Test and Procedures</p> <ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible <p>Radiation Therapy</p> <ul style="list-style-type: none"> ▪ 50% coinsurance after you pay your plan deductible
<p>Hearing Services</p> 	<p>Medicare-Covered Hearing Services</p> <ul style="list-style-type: none"> ▪ \$50 copay for exams to diagnose and treat hearing and balance issues <p>Additional Hearing Services</p> <ul style="list-style-type: none"> ▪ \$0 copay for one routine hearing exam per year ▪ \$0 copay for evaluation and fitting of hearing aids within the first 30-day trial period ▪ \$25 copay for evaluation and fitting of hearing aids after the 30-day trial has ended ▪ \$610 copay per Standard Digital aid (two hearing aids per year, one per ear) ▪ \$1,630 - \$3,355 copay per Advanced Digital aid (two hearing aids per year, one per ear) 	<ul style="list-style-type: none"> ▪ Not Covered Out-of-Network

**FHCP Medicare Choice
(HMO-POS)**

Flagler and Volusia
H1035-044

In-Network

Out-of-Network

Dental Services



Medicare-Covered Dental Services ◇

- **\$50** copay for extraction of teeth to prepare jaw for radiation treatment of neoplastic disease; dental exams prior to kidney transplantation; and certain non-routine dental services rendered in a hospital when incidental to a Medicare-covered service

Additional Dental Services

- Not covered

Medicare-Covered Dental Services

- **\$80** copay for extraction of teeth to prepare jaw for radiation treatment of neoplastic disease; dental exams prior to kidney transplantation; and certain non-routine dental services rendered in a hospital when incidental to a Medicare-covered service

Additional Dental Services

- Not covered

Vision Services



Medicare-Covered Vision Services

Exam to diagnose and treat disease and conditions of the eye (including yearly glaucoma screening):

- **\$50** copay when performed by an Optometrist
- **\$50** copay when performed by an Ophthalmologist

One pair of eyeglasses or contact lenses after each cataract surgery:

- **\$0** copay

Additional Vision Services

- Not covered

- **Not Covered Out-of-Network**

Mental Health Care

Inpatient Mental Health Services ◇

- **\$465** copay per day for days 1-4
- **\$0** copay per day for days 5-90

Outpatient Mental Health Services ◇

- **\$40** copay

Inpatient Mental Health Services ◇

- **50%** coinsurance after you pay your plan deductible

Outpatient Mental Health Services

- **\$80** copay

Skilled Nursing Facility (SNF) ◇

- **\$0** copay per day for days 1-20
- **\$172** copay per day days 21-100

Our plan covers up to 100 days in a SNF per benefit period

- No prior hospital stay is required

- **50%** coinsurance per stay after you pay your plan deductible

- No prior hospital stay is required

Physical Therapy

- **\$40** copay per visit

- **\$40** copay per visit

Ambulance ◇

- **\$300** copay for each Medicare-covered trip (one-way)

Worldwide Ambulance Services

- **\$300** copay for Worldwide Emergency Ambulance services
- **\$25,000** combined yearly limit for Worldwide Emergency Care, Urgently Needed Services, and Ambulance Services

FHCP Medicare Choice (HMO-POS) Flagler and Volusia H1035-044		
	In-Network	Out-of-Network
Medicare Part B Drugs ◇	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 50% coinsurance for chemotherapy drugs, infusion drugs, and all other drugs covered under Medicare Part B after you pay your plan deductible.

Part D Prescription Drug Benefits



Deductible Stage

After you pay your **\$395** deductible, you pay the cost sharing amounts in the table below. The deductible applies to the following tiers:

- Tier 3 – Preferred Brand
- Tier 4 – Non-Preferred Brand
- Tier 5 – Specialty Tier

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your Tier 1 and Tier 2 drugs and you pay your share of the costs.

After you (or others on your behalf) have met your Tier 3, Tier 4 and Tier 5 deductible, the plan pays its share of the costs of your Tier 3, Tier 4 and Tier 5 drugs and you pay your share.

You stay in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **\$4,130**.

You may get your drugs at network retail pharmacies and mail order pharmacies.

	Preferred Retail (One-month (31-day) supply)	Standard Retail (One-month (31-day) supply)	Mail Order (Three-month (93-day) supply)
Tier 1 – Preferred Generic	\$4 Copay	\$17 Copay	\$9 Copay
Tier 2 – Generic	\$10 Copay	\$20 Copay	\$27 Copay
Tier 3 – Preferred Brand	\$45 Copay	\$47 Copay	\$132 Copay
Tier 4 – Non-Preferred Brand	\$98 Copay	\$100 Copay	\$291 Copay
Tier 5 – Specialty Tier	25% Coinsurance	25% Coinsurance	Not Applicable

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug costs (including what our plan has paid and what you have paid) reach **\$4,130**. You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **\$6,550**.

During the Coverage Gap Stage:

- For generic drugs, 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 \$6,550, you pay the *greater of*:

- \$3.70 copay for generic drugs in all tiers (including brand drugs treated as generic) and a \$9.20 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

FHCP Medicare Choice (HMO-POS) Flagler and Volusia H1035-044		
	In-Network	Out-of-Network
Diabetic Supplies	Medicare-covered Diabetes Monitoring supplies <ul style="list-style-type: none"> ▪ \$10 copay for 50 test strips/sensors ▪ \$10 copay for lancets ▪ \$0 copay for Glucometer 	<ul style="list-style-type: none"> ▪ 50% coinsurance for Medicare-covered Diabetes Monitoring supplies (i.e. test strips/sensors, lancets, Glucometer) after you pay your plan deductible
Podiatry	<ul style="list-style-type: none"> ▪ \$50 copay for each Medicare-covered podiatry visit ▪ Routine foot care – Not covered 	<ul style="list-style-type: none"> ▪ \$80 copay for each Medicare-covered podiatry visit ▪ Routine foot care – Not covered
Chiropractic	<ul style="list-style-type: none"> ▪ \$20 copay for each Medicare-covered chiropractic visit 	<ul style="list-style-type: none"> ▪ \$40 copay for each Medicare-covered chiropractic visit
Medical Equipment and Supplies	<ul style="list-style-type: none"> ▪ 20% of the cost for plan-approved Medicare-covered durable medical equipment ◇ 	<ul style="list-style-type: none"> ▪ 50% of the cost for plan-approved Medicare-covered durable medical equipment after you pay your plan deductible
Outpatient Occupational and Speech Therapy	<ul style="list-style-type: none"> ▪ \$40 copay per visit 	<ul style="list-style-type: none"> ▪ \$40 copay per visit
Telemedicine	Medical Telemedicine via FHCP Medicare's contracted vendor. <ul style="list-style-type: none"> ▪ \$10 copay for a PCP visit ▪ \$30 copay for a Psychologist visit Medical Telemedicine via ZOOM with an FHCP Staff Physician. <ul style="list-style-type: none"> ▪ \$0 copay for a PCP visit ▪ \$0 copay for a Specialist visit 	<ul style="list-style-type: none"> ▪ Not covered Out-of-network

You Get More with FHCP Medicare

FHCP Medicare Choice (HMO-POS) Flagler and Volusia H1035-044		
	In-Network	Out-of-Network
Preferred Fitness Program 	<ul style="list-style-type: none"> Free unlimited visits to participating fitness centers and gyms in FHCP Medicare's service area 	<ul style="list-style-type: none"> Not Covered out-of-network
FHCP Medicare Rewards	<ul style="list-style-type: none"> Rewards for completing certain preventive health screenings. 	<ul style="list-style-type: none"> Not Covered out-of-network

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.

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
P.O. Box 9910,
Daytona Beach, FL 32120.
Phone: 1-844-219-6137,
TTY: 1-800-955-8770
Fax: 386-676-7149,
Email: rights@fhcp.com.

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

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

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

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

सुचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-833-866-6559 (TTY: 1-800-955-8770).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-833-866-6559 (TTY: 1-800-955-8770).