Florida Blue
MEDICARE
Your local Blue Cross Blue Shield

FHCP Medicare

2024 Enrollment Guide

St. Johns County

FHCP Medicare Flagler Advantage (HMO) H1035-016

Y0011_FHCP0276 2023_M

Welcome

Inside, there's everything you need to become a part of the FHCP Medicare community.

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

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

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

Enrollment steps that will walk you through the process

All the forms you need to enroll in your plan

Information on what happens **after you enroll** in your plan 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

92808 0720

Table of Contents

What is Medicare Advantage?

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

ORIGINAL MEDICARE

Provided by the federal government

Covers hospital stays, skilled nursing facilities and home health care

Covers doctor visits and many outpatient services, such as lab tests, X-rays and physical therapy

MEDICARE SUPPLEMENT PLAN

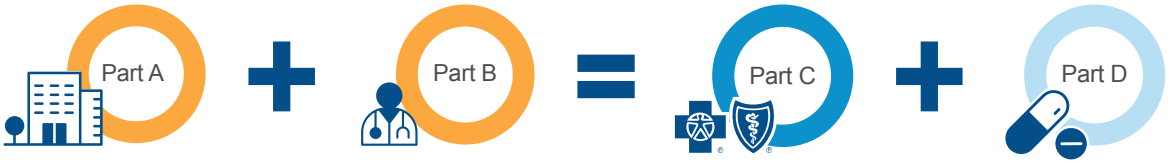
Covers some or all out-of-pocket costs not covered by Parts A and B, like deductibles, copays and coninsurance

MEDICARE PART D PLAN

Covers prescription drugs

MEDICARE ADVANTAGE PLAN

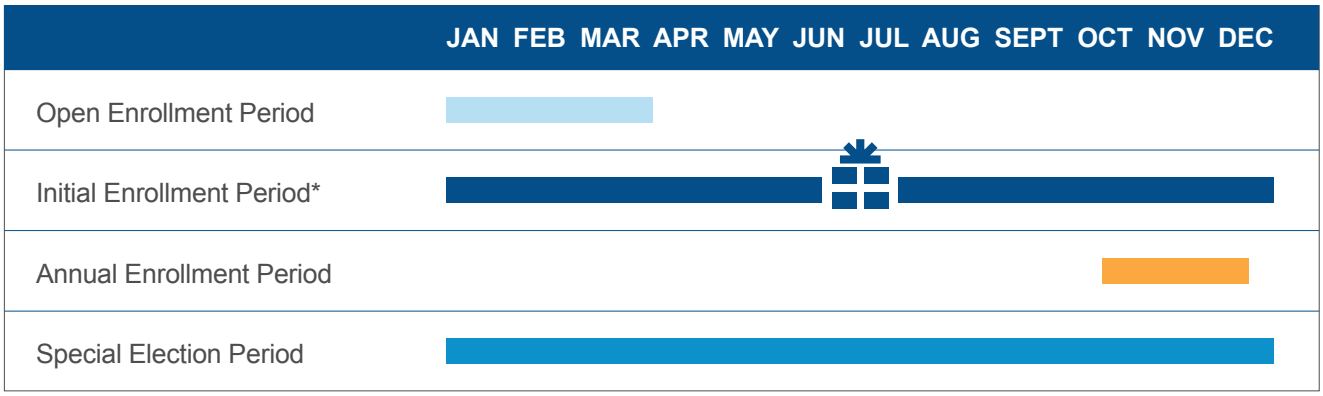
Offered by private insurance companies



Combines **Original Medicare** Part A and Part B in one plan

Many plans offer additional benefits not covered by Original Medicare, plus **MAPD plans** include prescription drug coverage.

Important Medicare Enrollment Information



* 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 Enrollment 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.

Florida Blue MEDICARE | FHCP Medicare

Benefits at-a-Glance

FHCP MEDICARE FLAGLER ADVANTAGE (HMO)

Plan Costs & Details

PBP Number	H1035-016
Service Area	St. Johns
How much is the monthly premium?	**$0** You must continue to pay your Medicare Part B premium.
How much is the deductible?	**$0** for health care services
Is there any limit on how much I will pay for my covered medical services?	**$3,650** for services you receive from In-Network providers.

Medical & Hospital Benefits

Doctor's Office Visits	**$0 copay** Primary Care Physician **$15 copay** Specialist
Preventive Care	**$0 copay**
Inpatient Hospital	Days 1-5: **$215 copay** per day. After the 5th day the plan pays 100% of covered expenses.
Outpatient Hospital	**$150 copay**
Outpatient Surgery	**$75 copay** in an Ambulatory Surgical Center **$150 copay** in an Outpatient Hospital Facility
Urgently Needed Services	**$0 copay** per visit at an FHCP Extended Hours Care Center **$10 copay** at an Urgent Care Center
Emergency Room	**$125 copay**

Part D Prescription Drug Benefits

Deductible	**$0 per year** for Part D prescription drugs.

What you pay at a Preferred Pharmacy for a 31-day supply

Tier 1 (Preferred Generic)	**$0 copay**
Tier 2 (Generic)	**$5 copay**
Tier 3 (Preferred Brand)	**$44 copay**
Tier 4 (Non-Preferred)	**$95 copay**
Tier 5 (Specialty)	**33% coinsurance**
Tier 6 (Vaccines)	**$0 copay**

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

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

Tier 1 (Preferred Generic)	**$0 copay**
Tier 2 (Generic)	**$12 copay**
Tier 3 (Preferred Brand)	**$129 copay**
Tier 4 (Non-Preferred)	**$282 copay**
Tier 5 (Specialty)	Not Applicable
Tier 6 (Vaccines)	Not Applicable

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Additional Benefits

Vision Services	**$0 copay** for annual routine eye exam. **$180 allowance** every two years towards the purchase of eyeglasses (lenses and frames) from a participating Optometrist.
Dental Services	**$0 copay** for the following services • Oral exams, cleanings, and X-rays • Non-surgical extractions • Adjustment of complete or partial denture Refer to the Evidence of Coverage for coverage limits and frequency.
Hearing Services and Hearing Aids	**$0 copay** for one routine hearing exam per year. **$0 copay** for evaluation and fitting of hearing aids. **$300 maximum allowance** for each hearing aid. Up to 2 hearing aids every year. Hearing aids must be purchased through our participating provider to have access to the benefit.
Over-the-Counter Items	**$60 quarterly allowance** for the purchase of non-prescription items, such as vitamins and aspirin. What you need to know: Any balance not used for a quarter will not carry over to the next quarter.
FHCP Medicare Rewards	Rewards for completing certain preventive health screenings.
Preferred Fitness Program	Free unlimited visits to participating fitness centers and gyms in FHCP Medicare's Service Area.

Florida Blue MEDICARE
Your local Blue Cross Blue Shield

FHCP Medicare

2024 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

FHCP Medicare Flagler Advantage (HMO) H1035-016

1/1/2024 – 12/31/2024

The plan's service area includes:

St. Johns County

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 *Medicare & You* 2024 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 **county in Florida: St. Johns**

Which doctors, hospitals, and pharmacies can I use?

We 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 on 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 this plan, call us at 1-833-866-6559, TTY: 1-800-955-8770.**
- **If you are not a member of this plan, call us at 1-855-462-3427, TTY: 1-800-955-8770.**
  - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
  - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- 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

Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	$0 per year for health care services $0 per year for Part D prescription drugs. There is no deductible for insulins.
Maximum Out-of-Pocket Responsibility	$3,650 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.

Medical and Hospital Benefits

Inpatient Hospital Coverage *◊	• $215 copay per day for days 1-5 • $0 copay per day, after day 5
Outpatient Hospital Coverage *◊	• $150 copay per visit for Medicare-covered services • $150 copay per stay for Medicare-covered Observation services
Ambulatory Surgical Center (ASC) Services *◊	• $75 copay for surgery services provided at an Ambulatory Surgical Center
Doctor Visits	• $0 copay per primary care visit • $15 copay per specialist visit *◊

Preventive Care	• $0 copay for Medicare-covered services
	  • Abdominal aortic aneurysm screening
	  • Annual wellness visit
	  • Bone mass measurement
	  • Breast cancer screening (mammograms)

	• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • "Welcome to Medicare" preventive visit
Emergency Care	**Medicare-Covered Emergency Care** • $125 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** • $125 copay for Worldwide Emergency Care • $25,000 combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services and Worldwide 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.

	• $0 copay per visit at an FHCP Extended Hours Care Center • $10 copay at an Urgent Care Center, in- or out-of-network **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 Worldwide Ambulance Services
Diagnostic Services/ Labs/Imaging *◊	**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 Tests and Procedures** • $0 - $200 copay **Radiation Therapy** • $10 - $50 copay
Hearing Services	**Medicare-Covered Hearing Services*** • $45 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 • $300 per ear. You pay a $0 copay for up to 2 hearing aids every year with a maximum benefit allowance of $300 per ear. • NOTE: Hearing aids must be purchased through our participating provider to have access to the benefit. • Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.
Dental Services	**Medicare-Covered Dental Services ◊** • $20 copay for non-routine dental care **Additional Dental Services** • $0 copay for covered preventive dental services • $0 copay for covered comprehensive dental services

Vision Services	**Medicare-Covered Vision Services** • $0 copay for Optometrist services to diagnose and treat eye diseases and conditions • $15 copay for Ophthalmologist services to diagnose and treat eye diseases and conditions • $0 copay for glaucoma screening (once per year for members at high risk of glaucoma) • $0 copay for one diabetic retinal exam per year • $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery **Additional Vision Services** • $0 copay for an annual routine eye exam • Plan pays up to $180 every 2 years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist
Mental Health Services *◊	**Inpatient Mental Health Services** • $215 copay per day for days 1-5 • $0 copay per day for days 6-90 • 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** • $15 copay
Skilled Nursing Facility (SNF) *◊	• $0 copay per day for days 1-20 • $150 copay per day for days 21-100 Our plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required
Physical Therapy *◊	• $20 copay per visit
Ambulance ◊	**Medicare-Covered Ambulance Services** • $265 copay for each Medicare-covered trip (one-way) **Worldwide Ambulance Services** • $265 copay for Worldwide Emergency Ambulance services • $25,000 combined yearly limit for Worldwide Emergency Care, Worldwide Urgently Needed Services, and Worldwide Ambulance Services
Transportation	• Not Covered
Medicare Part B Drugs ◊	• 0% coinsurance for the following Part B drugs (albuterol, ipratropium, albuterol-ipratropium)

	• Up to 20% coinsurance for chemotherapy drugs, infusion drugs and all other Part B-covered drugs • 20% up to $35 per month for Insulin Drugs via DME

Additional Benefits

Diabetic Supplies	**Medicare-Covered Diabetes Monitoring supplies** • 20% of the total cost for 50 test strips/sensors • 20% of the total cost for lancets • 0% of the total cost for Glucometer
Podiatry	**Medicare-Covered Podiatry Services** • $15 copay for each Medicare-covered podiatry visit
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
Telehealth	**Telehealth via FHCP Medicare's contracted vendor:** • $10 copay for a PCP visit • $30 copay for a Psychologist visit **Telehealth visits with an FHCP Staff Provider:** • $0 copay per visit for Primary Care Physician; Specialist; Outpatient Mental Health & Psychiatric Services (Individual sessions only); Opioid Treatment Program Services; Outpatient Substance Abuse (Individual sessions only); Dietician Services and Diabetes Self-Management Training (through FHCP Medicare's Clinical staff by appointment only)
Over-the-Counter Items	• $60 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
FHCP Medicare Rewards	• Rewards for completing certain preventive health screenings.

Part D Prescription Drug Benefits

Deductible Stage
This plan does not have a deductible. There is no deductible for insulins.

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 (your payments plus any Part D plan's payments) reach **$5,030**. You may get your drugs at network retail pharmacies and mail order pharmacies.

See Evidence of Coverage for details.	**Preferred Retail (31-day supply)**	**Standard Retail/LTC (31-day supply)**	**Mail Order (93-day supply)**
Tier 1 - Preferred Generic	$0 copay	$10 copay	$0 copay
Tier 2 - Generic	$5 copay	$20 copay	$12 copay
Tier 3 - Preferred Brand	$44 copay $35 copay for Insulin	$47 copay $35 copay for Insulin	$129 copay $105 copay for Insulin
Tier 4 - Non-Preferred Drug	$95 copay $35 copay for Insulin	$100 copay $35 copay for Insulin	$282 copay $105 copay for Insulin
Tier 5 - Specialty Tier	33% coinsurance $35 copay for Insulin	33% coinsurance $35 copay for Insulin	Not Applicable
Tier 6 - Vaccines ($0 cost sharing)	$0 copay	$0 copay	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 your total year-to-date drug cost (your payments plus any Part D plan's payments) reaches **$5,030**. You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **$8,000**.

<u>During the Coverage Gap Stage</u>

- 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).
- For insulins, you won't pay more than $35 copay for a one-month supply of each insulin.

Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs reach $8,000, you pay:

- $0 copay for all Part D drugs in all tiers.

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 Drug) cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) 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.
- Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines. No cost vaccines are listed in FHCP Medicare's formulary under Tier 6.

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.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Visit fhcpmedicare.com/ndnotice_ENG for information on our free language assistance services.

Nosotros cumplimos con las leyes federales de derechos civiles aplicables y no discriminamos por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Para información sobre nuestros servicios gratuitos de asistencia lingüística, visite fhcpmedicare.com/ndnotice_SPA.

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-866-6559. (TTY users should call 1-800-955-8770). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-866-6559. (TTY: 1-800-955-8773). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电1-833-866-6559。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電1-833-866-6559。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-866-6559. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-866-6559. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-866-6559. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-866-6559. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-866-6559. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-866-6559. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول
على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-866-6559. سيقوم .
بمساعدتك. هذه خدمة مجانية شخص ما يتحدث العربية.

Form CMS-10802
(Expires 12/31/25)

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-866-6559. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-866-6559. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-866-6559. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-866-6559. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-866-6559. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-866-6559. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802
(Expires 12/31/25)

Notes

Florida Blue

MEDICARE

Your local Blue Cross Blue Shield

FHCP Medicare

Enrollment Forms

Steps that will walk you through the process and **all the forms** you need to enroll in your plan

Florida Blue MEDICARE | FHCP Medicare

Ready to sign up?

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

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

Paper: Use the paper enrollment form provided. 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

Pre-Enrollment Checklist	This form provides important information you need to know before purchasing a plan.
Individual Enrollment Form	This is the form you complete to enroll in a FHCP Medicare Advantage plan.
Protected Health Information Authorization for Customer Service Inquiries	Complete this form if you need to give us permission to release your health information to someone. Send the original, not a photocopy, with your enrollment form. Otherwise, we will protect this information and release it only to you.
Scope of Sales Appointment (SOA) Confirmation Form	According to Medicare guidelines, agents can talk to you only about products you choose to discuss. Medicare asks you to complete an SOA form that shows which Medicare Advantage and/or 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.
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.

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

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage, your current Medicare Advantage healthcare will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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, 2024.
- ☐ 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).

FHCP Medicare

OMB No. 0938-1378 Expires: 07/31/2024

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

You must complete all items unless they are indicated as optional. You can't be denied coverage for not including information that is marked as optional.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

FHCP Medicare
P.O. Box 45296
Jacksonville, FL 32232-5296

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call FHCP Medicare Flagler Advantage at 1-800-352-9824, Ext. 7160. TTY users can call 1-800-955-8770.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a FHCP Medicare Flagler Advantage al 1-800-352-9824, Ext. 7160 / TTY: 1-800-955-8773 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

This page intentionally left blank

FHCP Medicare

P.O. Box 45296 | Jacksonville, FL 32232-5296

A Medicare Advantage Health Care Plan

Individual Enrollment Form

Please check which plan you want to enroll in:

○ **FHCP Medicare Flagler Advantage** $0 per month

First Name:	Last Name:	Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
M M D D Y Y Y Y	○ M ○ F	( )	( )

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:

Please provide your Medicare insurance information:

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

Medicare Number:	Part A Effective Date:	Part B Effective Date:
	M M D D Y Y Y Y	M M D D Y Y Y Y

By providing the information above, you consent to receive calls and text messages (SMS/MMS) about your account, care, and non-marketing related calls to the number(s) provided from Florida Blue, DBA FHCP Medicare, its affiliates, and others acting on their behalf made to that phone number including calls and texts to your wireless device which may include an automated telephone dialing system and other related automated technologies, a prerecorded or artificial voice message, or both without regard to state or federal limitations on the frequency of calls or messages. If you do not wish to receive autodialed, prerecorded, or artificial voice calls to your mobile number, please contact us at 1-800-352-9824, Ext. 7160.

Ethnicity and Race (Optional)

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ○ No, not of Hispanic, Latino/a, or Spanish origin
- ○ Yes, Puerto Rican
- ○ Yes, another Hispanic, Latino/a, or Spanish origin
- ○ **I choose not to answer.**
- ○ Yes, Mexican, Mexican American, Chicano/a
- ○ Yes, Cuban

What's your race? Select all that apply.

- ○ American Indian or Alaska Native
- ○ Chinese
- ○ Japanese
- ○ Other Asian
- ○ Vietnamese
- ○ **I choose not to answer.**
- ○ Asian Indian
- ○ Filipino
- ○ Korean
- ○ Other Pacific Islander
- ○ White
- ○ Black or African American
- ○ Guamanian or Chamorro
- ○ Native Hawaiian
- ○ Samoan

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 ○ Large print

Please contact FHCP Medicare Flagler 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.

Please read and answer these important questions (Questions 2–5 are optional):

1. Will you have other **prescription** drug coverage (like VA, TRICARE) in addition to FHCP Medicare Flagler Advantage?
   ○ Yes ○ No

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

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

   Name of Institution: _____ Phone Number: (_____) _____ – _____

   Address (number and street): _____

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

   Medicaid number: _____

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

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

Paying Your Plan Premium:

For those members enrolling in FHCP Medicare Flagler Advantage, 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.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

○ 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.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay FHCP Medicare the Part D-IRMAA.

Attestation of Eligibility for an Enrollment Period

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

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

- ○ I am new to Medicare.
- ○ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ○ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): M M D D Y Y Y Y
- ○ I recently was released from incarceration. I was released on (insert date): M M D D Y Y Y Y
- ○ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): M M D D Y Y Y Y
- ○ I recently obtained lawful presence status in the United States. I got this status on (insert date): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ I recently left a PACE program on (insert date): M M D D Y Y Y Y
- ○ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): M M D D Y Y Y Y
- ○ I am leaving employer or union coverage on (insert date): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ○ I was enrolled in a plan that is experiencing financial difficulties to such an extent that a State or territorial regulatory authority has placed the organization in receivership.
- ○ I was enrolled in a plan identified with the low performing icon (LPI).

If none of these statements applies to you or you're not sure, please contact FHCP Medicare Flagler 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:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in FHCP Medicare Flagler Advantage.
- I understand that my response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my FHCP Medicare Flagler Advantage coverage begins, I must get all of my medical and prescription drug benefits from FHCP Medicare Flagler Advantage. Benefits and services provided by FHCP Medicare Flagler Advantage and contained in my FHCP Medicare Flagler Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor FHCP Medicare Flagler Advantage will pay for benefits or services that are not covered.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Flagler 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 Flagler Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I understand that my signature (or the signature of the person legally 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: |M|M| |D|D| |Y|Y|Y|Y|

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

Name: _____

Address: _____

Phone Number: (_____) _____ – _____ **Relationship to Enrollee:** _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Text Messages

Text messages are a great way to stay in touch, manage your account, and learn more about your plan and benefits.

We may send you a confirmation text message after you are enrolled to complete your registration to receive member messages and alerts. By opting in, you consent to receive text messages which may include but not be limited to financial matters and marketing from Florida Blue, DBA FHCP Medicare, its affiliates, and others acting on their behalf. This may include an automated technologies without regard to state or federal limitations on the frequency of calls or messages. I understand that my consent is not required as a condition of making a purchase. Message frequency varies and message and data rates may apply. These communications may contain Protected Health Information (PHI) that is protected by applicable law and by opting-in you agree and understand that communications may be unencrypted, and you agree to accept the risk that unencrypted electronic communications may be intercepted and/or read by a third party. You can cancel the SMS service for subscribed messages at any time.

○ **I want to receive text messages and alerts and agree to the terms and conditions stated and referenced above.**

Mobile Number: (_____) _____ – _____

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. By enrolling in paperless communications, you agree to receive messages electronically, which may include but not limited to, the Evidence of Coverage, Summary of Benefits, Notice of Privacy Practices, Proxy Statements, financial matters, and marketing. You understand and acknowledge that electronic communications may not be secure, you are responsible for and accept the risk you agree to accept the risk that electronic communications may be intercepted and/or read by a third party. By agreeing to receive electronic communications you agree to indemnify and hold Florida Blue, DBA FHCP Medicare and its affiliates harmless from any claim or cause of action against Florida Blue, DBA FHCP Medicare and its affiliates for delivering or other information to the address, phone number, or other contact information that you provide.

E-mail: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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 #: _____

This page intentionally left blank

FHCP Medicare

OMB No. 0938-1378 Expires: 07/31/2024

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

You must complete all items unless they are indicated as optional. You can't be denied coverage for not including information that is marked as optional.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

FHCP Medicare
P.O. Box 45296
Jacksonville, FL 32232-5296

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call FHCP Medicare Flagler Advantage at 1-800-352-9824, Ext. 7160. TTY users can call 1-800-955-8770.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a FHCP Medicare Flagler Advantage al 1-800-352-9824, Ext. 7160 / TTY: 1-800-955-8773 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

This page intentionally left blank

FHCP Medicare
P.O. Box 45296 | Jacksonville, FL 32232-5296

A Medicare Advantage Health Care Plan

Individual Enrollment Form

Please check which plan you want to enroll in:

○ **FHCP Medicare Flagler Advantage** $0 per month

First Name:	Last Name:	Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
M M D D Y Y Y Y	○ M ○ F	( )	( )

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:

Please provide your Medicare insurance information:

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

Medicare Number:	Part A Effective Date:	Part B Effective Date:
	M M D D Y Y Y Y	M M D D Y Y Y Y

By providing the information above, you consent to receive calls and text messages (SMS/MMS) about your account, care, and non-marketing related calls to the number(s) provided from Florida Blue, DBA FHCP Medicare, its affiliates, and others acting on their behalf made to that phone number including calls and texts to your wireless device which may include an automated telephone dialing system and other related automated technologies, a prerecorded or artificial voice message, or both without regard to state or federal limitations on the frequency of calls or messages. If you do not wish to receive autodialed, prerecorded, or artificial voice calls to your mobile number, please contact us at 1-800-352-9824, Ext. 7160.

Ethnicity and Race (Optional)

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

○ No, not of Hispanic, Latino/a, or Spanish origin
○ Yes, Puerto Rican
○ Yes, another Hispanic, Latino/a, or Spanish origin
○ **I choose not to answer.**
○ Yes, Mexican, Mexican American, Chicano/a
○ Yes, Cuban

What's your race? Select all that apply.

○ American Indian or Alaska Native
○ Chinese
○ Japanese
○ Other Asian
○ Vietnamese
○ **I choose not to answer.**
○ Asian Indian
○ Filipino
○ Korean
○ Other Pacific Islander
○ White
○ Black or African American
○ Guamanian or Chamorro
○ Native Hawaiian
○ Samoan

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 ○ Large print

Please contact FHCP Medicare Flagler 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.

Please read and answer these important questions (Questions 2–5 are optional):

1. Will you have other **prescription** drug coverage (like VA, TRICARE) in addition to FHCP Medicare Flagler Advantage?
   ○ Yes ○ No

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

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

   Name of Institution: _____ Phone Number: (_____) _____ – _____

   Address (number and street): _____

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

   Medicaid number: _____

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

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

Paying Your Plan Premium:

For those members enrolling in FHCP Medicare Flagler Advantage, 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.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

○ 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.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay FHCP Medicare the Part D-IRMAA.

Attestation of Eligibility for an Enrollment Period

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

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

- ○ I am new to Medicare.
- ○ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ○ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): M M D D Y Y Y Y
- ○ I recently was released from incarceration. I was released on (insert date): M M D D Y Y Y Y
- ○ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): M M D D Y Y Y Y
- ○ I recently obtained lawful presence status in the United States. I got this status on (insert date): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ I recently left a PACE program on (insert date): M M D D Y Y Y Y
- ○ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): M M D D Y Y Y Y
- ○ I am leaving employer or union coverage on (insert date): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ 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): M M D D Y Y Y Y
- ○ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ○ I was enrolled in a plan that is experiencing financial difficulties to such an extent that a State or territorial regulatory authority has placed the organization in receivership.
- ○ I was enrolled in a plan identified with the low performing icon (LPI).

If none of these statements applies to you or you're not sure, please contact FHCP Medicare Flagler 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:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in FHCP Medicare Flagler Advantage.
- I understand that my response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my FHCP Medicare Flagler Advantage coverage begins, I must get all of my medical and prescription drug benefits from FHCP Medicare Flagler Advantage. Benefits and services provided by FHCP Medicare Flagler Advantage and contained in my FHCP Medicare Flagler Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor FHCP Medicare Flagler Advantage will pay for benefits or services that are not covered.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Flagler 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 Flagler Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I understand that my signature (or the signature of the person legally 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: |M|M| |D|D| |Y|Y|Y|Y|

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

Name: _____

Address: _____

Phone Number: (_____) _____ – _____ **Relationship to Enrollee:** _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Text Messages

Text messages are a great way to stay in touch, manage your account, and learn more about your plan and benefits.

We may send you a confirmation text message after you are enrolled to complete your registration to receive member messages and alerts. By opting in, you consent to receive text messages which may include but not be limited to financial matters and marketing from Florida Blue, DBA FHCP Medicare, its affiliates, and others acting on their behalf. This may include an automated technologies without regard to state or federal limitations on the frequency of calls or messages. I understand that my consent is not required as a condition of making a purchase. Message frequency varies and message and data rates may apply. These communications may contain Protected Health Information (PHI) that is protected by applicable law and by opting-in you agree and understand that communications may be unencrypted, and you agree to accept the risk that unencrypted electronic communications may be intercepted and/or read by a third party. You can cancel the SMS service for subscribed messages at any time.

○ **I want to receive text messages and alerts and agree to the terms and conditions stated and referenced above.**

Mobile Number: (_____) _____ – _____

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. By enrolling in paperless communications, you agree to receive messages electronically, which may include but not limited to, the Evidence of Coverage, Summary of Benefits, Notice of Privacy Practices, Proxy Statements, financial matters, and marketing. You understand and acknowledge that electronic communications may not be secure, you are responsible for and accept the risk you agree to accept the risk that electronic communications may be intercepted and/or read by a third party. By agreeing to receive electronic communications you agree to indemnify and hold Florida Blue, DBA FHCP Medicare and its affiliates harmless from any claim or cause of action against Florida Blue, DBA FHCP Medicare and its affiliates for delivering or other information to the address, phone number, or other contact information that you provide.

E-mail: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

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 #: _____

This page intentionally left blank

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.

Please complete this entire form and return to:

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

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[1] 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.

Protected Health Information Authorization for Customer Service Inquiries

(continued)

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

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

Section V

This authorization will expire:

_____/_____/_____
Month Day Year

OR

_____
The date member's FHCP Medicare health coverage ends

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

Section VI

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

Section VII

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

Section VIII

Signature

Member Signature:

_____

Date: _____

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

Legal Representative's Name[2]:

_____

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.

Please complete this entire form and return to:

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

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[1] 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.

Protected Health Information Authorization for Customer Service Inquiries

(continued)

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

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

Section V

This authorization will expire:

_____/_____/_____
Month Day Year

OR

_____

The date member's FHCP Medicare health coverage ends

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

Section VI

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

Section VII

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

Section VIII

Signature

Member Signature:

_____

Date: _____

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

Legal Representative's Name[2]:

_____

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.

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

_____ ☐	**Medicare Advantage Plans (Part C) and Cost Plans**
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).	
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.	
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.	
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.	
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.	
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.	

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

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

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

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

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

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

Scope of Appointment documentation is subject to CMS record retention requirements

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

Scope of Sales Appointment Confirmation Form (continued)

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:

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

This page intentionally left blank

Scope of Sales Appointment Confirmation Form

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

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

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

_____ ☐	**Medicare Advantage Plans (Part C) and Cost Plans**
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).	
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.	
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.	
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.	
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.	
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.	

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

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

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

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

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

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

Scope of Appointment documentation is subject to CMS record retention requirements

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

Scope of Sales Appointment Confirmation Form (continued)

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:

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

This page intentionally left blank

Enrollment Checklist

Applicant's Last Name: _____ **Applicant's First Name:** _____

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.

For Medicare Advantage plans

Yes ☐	No ☐	Do you understand that you have applied for a Medicare Advantage plan? This plan is **not a** Medicare Supplement "Medigap" plan. This plan replaces Original Medicare.
Yes ☐	No ☐	Do you understand that to enroll you must be "entitled" to Part A and enrolled in Part B?
Yes ☐	No ☐	Do you understand you must continue to pay your Medicare Part B premium (unless it is paid for you by Medicaid or another third party)?

For Medicare Advantage-Prescription Drug plans

Yes ☐	No ☐	Did the sales agent fully explain the prescription deductible associated with the plan (if applicable), and the amount?
Yes ☐	No ☐	Did the sales agent tell you about the Preferred pharmacies in the network?
Yes ☐	No ☐	Do you understand you have applied for a Medicare Advantage-Prescription Drug plan?
Yes ☐	No ☐	Do you understand to enroll you must have Medicare Part A **and/or** Part B?
Yes ☐	No ☐	Did the sales agent explain the plan's drug list (also referred to as a formulary) and drug tiers?
Yes ☐	No ☐	Did the sales agent explain the coverage gap, sometimes referred to as the doughnut hole?
Yes ☐	No ☐	Do you understand that in most cases you must use a pharmacy in our drug plan network?
Yes ☐	No ☐	Did the sales agent confirm that your prescription drugs are covered under the plan's drug list?

For All plans

Yes ☐	No ☐	Did the sales agent fully explain your premium, benefits, copays, and coinsurance amounts?
Yes ☐	No ☐	Did the sales agent show you the Summary of Benefits and give you a copy?
Yes ☐	No ☐	Did the sales agent give you their contact information? (name, phone or business card)
Yes ☐	No ☐	Do you understand if you enroll in a Medicare Advantage plan and later decide to make a change, under most circumstances you are able to do so during the Annual Enrollment Period, October 15 -December 7 each year?

For All plans *(continued)*

Yes ☐	No ☐	Did the sales agent fully explain the medical deductible associated with the plan, (if applicable), and the amount?
Yes ☐	No ☐	Do you understand that you must use in-network health care providers to get the in-network benefits, copays and coinsurances?
Yes ☐	No ☐	Do you understand that if you use out-of-network health care providers you will likely pay higher out-of-pocket costs? (**Note:** HMO members are not covered out-of-network, except in emergencies, urgent care and out-of-area dialysis.)
Yes ☐	No ☐	Did the sales agent confirm that your doctor(s) is(are) in-network for the plan that you selected?

Drug Name	Covered		Tier	Cost	B vs. D*	PA	Qty Limits	Step Therapy
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						

**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.*

Provider's Name	Par/Non-Par	Provider's Complete Address

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 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 _____

Agent's Signature_____ Date _____

FHCP Medicare is an HMO plan with a Medicare contract. Enrollment in FHCP Medicare depends on contract renewal. HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

34349 0719

This page intentionally left blank

Enrollment Checklist

Applicant's Last Name: _____ **Applicant's First Name:** _____

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.

For Medicare Advantage plans

Yes ☐	No ☐	Do you understand that you have applied for a Medicare Advantage plan? This plan is **not a** Medicare Supplement "Medigap" plan. This plan replaces Original Medicare.
Yes ☐	No ☐	Do you understand that to enroll you must be "entitled" to Part A and enrolled in Part B?
Yes ☐	No ☐	Do you understand you must continue to pay your Medicare Part B premium (unless it is paid for you by Medicaid or another third party)?

For Medicare Advantage-Prescription Drug plans

Yes ☐	No ☐	Did the sales agent fully explain the prescription deductible associated with the plan (if applicable), and the amount?
Yes ☐	No ☐	Did the sales agent tell you about the Preferred pharmacies in the network?
Yes ☐	No ☐	Do you understand you have applied for a Medicare Advantage-Prescription Drug plan?
Yes ☐	No ☐	Do you understand to enroll you must have Medicare Part A **and/or** Part B?
Yes ☐	No ☐	Did the sales agent explain the plan's drug list (also referred to as a formulary) and drug tiers?
Yes ☐	No ☐	Did the sales agent explain the coverage gap, sometimes referred to as the doughnut hole?
Yes ☐	No ☐	Do you understand that in most cases you must use a pharmacy in our drug plan network?
Yes ☐	No ☐	Did the sales agent confirm that your prescription drugs are covered under the plan's drug list?

For All plans

Yes ☐	No ☐	Did the sales agent fully explain your premium, benefits, copays, and coinsurance amounts?
Yes ☐	No ☐	Did the sales agent show you the Summary of Benefits and give you a copy?
Yes ☐	No ☐	Did the sales agent give you their contact information? (name, phone or business card)
Yes ☐	No ☐	Do you understand if you enroll in a Medicare Advantage plan and later decide to make a change, under most circumstances you are able to do so during the Annual Enrollment Period, October 15 -December 7 each year?

For All plans *(continued)*

Yes ☐	No ☐	Did the sales agent fully explain the medical deductible associated with the plan, (if applicable), and the amount?
Yes ☐	No ☐	Do you understand that you must use in-network health care providers to get the in-network benefits, copays and coinsurances?
Yes ☐	No ☐	Do you understand that if you use out-of-network health care providers you will likely pay higher out-of-pocket costs? (**Note:** HMO members are not covered out-of-network, except in emergencies, urgent care and out-of-area dialysis.)
Yes ☐	No ☐	Did the sales agent confirm that your doctor(s) is(are) in-network for the plan that you selected?

Drug Name	Covered		Tier	Cost	B vs. D*	PA	Qty Limits	Step Therapy
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						

**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.*

Provider's Name	Par/Non-Par	Provider's Complete Address

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 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 _____

Agent's Signature_____ Date _____

FHCP Medicare is an HMO plan with a Medicare contract. Enrollment in FHCP Medicare depends on contract renewal. HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

34349 0719

This page intentionally left blank

Florida Blue
MEDICARE
Your local Blue Cross Blue Shield

FHCP
Medicare

What's Next?

Information on what happens
after you enroll in your plan
and what to expect

Florida Blue MEDICARE | FHCP Medicare

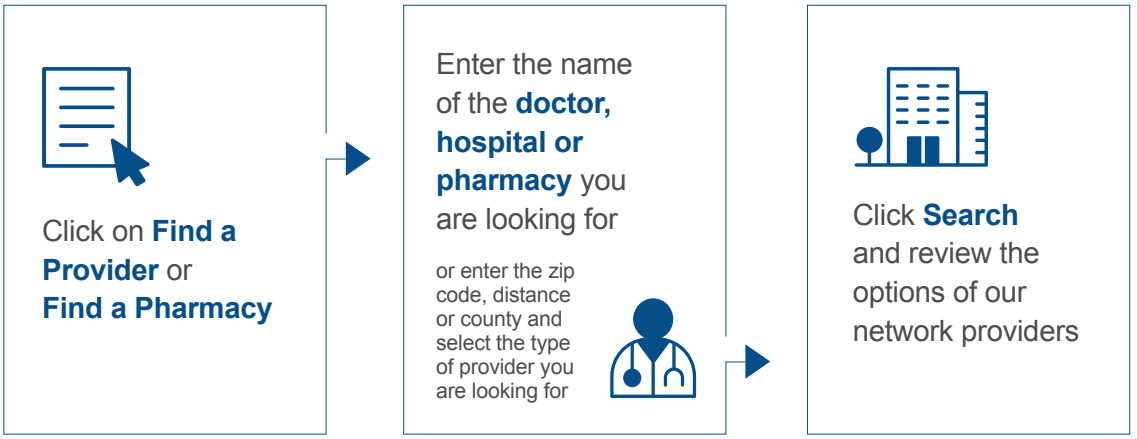
How to make the most of your Medicare Dollars

Use In-Network Doctors

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

How to find out which doctors, hospitals and pharmacies are in your plan's network:

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



Choosing Your Primary Care Doctor Is Important

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

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 *2024 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**
- ✓ **Information** on how to use your plan and locate plan documents

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

Want less mail?

Sign up for a secure member account at **fhcpmedicare.com**. You'll need your FHCP Medicare ID card to get started. Access your plan documents, check your out-of-pocket spending, and do more with your secure member account.

IMPORTANT INFORMATION:

2023 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Florida Blue HMO - H1035

For 2023, Florida Blue HMO - H1035 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
Drug Services Rating:	★★★½☆

FHCP Medicare
An Affiliate of Florida Blue

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact Florida Blue HMO 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 855-462-3427 (toll-free) or 800-955-8770 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time. Current members please call 833-866-6559 (toll-free) or 800-955-8770 (TTY).

This page intentionally left blank

This page intentionally left blank

This page intentionally left blank

Notes