

FHCP Medicare Rx Plus (HMO-POS) offered by Florida Blue Medicare, Inc. (DBA FHCP Medicare)

Annual Notice of Change for 2026

You're enrolled as a member of FHCP Medicare Rx Plus (HMO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in FHCP Medicare Rx Plus (HMO-POS).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.fhcpmedicare.com or call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) for more information. Hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays. This call is free.
- This information is available in an alternate format, including large print, audio and braille. Please call Member Services at the number listed above if you need plan information in another format.

About FHCP Medicare Rx Plus (HMO-POS)

- FHCP Medicare is an HMO plan with a Medicare contract. Enrollment in FHCP Medicare depends on contract renewal.
- When this material says "we," "us," or "our," it means Florida Blue Medicare, Inc. (DBA FHCP Medicare). When it says "plan" or "our plan," it means FHCP Medicare Rx Plus (HMO-POS).

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in FHCP Medicare Rx Plus (HMO-POS).** Starting January 1, 2026 you'll get your medical and drug coverage through FHCP Medicare Rx Plus (HMO-POS). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
FHCP Medicare Rx Plus		
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$49.00	\$49.00
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	\$3,400	\$6,750
FHCP Medicare Rx Plus POS		
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$119.00	\$119.00
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	<u>In-Network</u> \$3,400 <u>Out-of-Network</u> \$8,000	<u>In-Network</u> \$6,750 <u>Out-of-Network</u> \$8,000
IN-NETWORK MEDICAL BENEFITS		
Primary care office visits	<u>In-Network</u> \$0 copay per visit	<u>In-Network</u> \$0 copay per visit
Specialist office visits	<u>In-Network</u> \$20 copay per visit	<u>In-Network</u> \$8 - \$40 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day	<u>In-Network</u> \$300 copay per day for days 1-6 and \$0 after day 6.	<u>In-Network</u> \$350 copay per day for days 1-6 and \$0 after day 6.

	2025 (this year)	2026 (next year)
before you're discharged is your last inpatient day.		
Part D drug coverage deductible (Go to Section 1.7 for details)	\$0	\$615 (Applies to Tiers 4 and 5) except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Section 1.7 for details including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copay/Coinsurance during the Initial Coverage Stage: Drug Tier 1: <i>Standard cost-sharing:</i> \$17 copay <i>Preferred cost-sharing:</i> \$0 copay Drug Tier 2: <i>Standard cost-sharing:</i> \$20 copay <i>Preferred cost-sharing:</i> \$0 copay Drug Tier 3: <i>Standard cost-sharing:</i> \$47 copay You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> \$42 copay You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: <i>Standard cost-sharing:</i>	Copay/Coinsurance during the Initial Coverage Stage: Drug Tier 1: <i>Standard cost-sharing:</i> \$17 copay <i>Preferred cost-sharing:</i> \$0 copay Drug Tier 2: <i>Standard cost-sharing:</i> \$20 copay <i>Preferred cost-sharing:</i> \$0 copay Drug Tier 3: <i>Standard cost-sharing:</i> \$47 copay You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> \$42 copay You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: <i>Standard cost-sharing:</i>

Cost	2025 (this year)	2026 (next year)
	25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: <i>Standard cost-sharing:</i> 33% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> 33% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 6: <i>Standard cost-sharing:</i> \$0 copay <i>Preferred cost-sharing:</i> \$0 copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs	25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: <i>Standard cost-sharing:</i> 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 6: <i>Standard cost-sharing:</i> \$0 copay <i>Preferred cost-sharing:</i> \$0 copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1

Changes to Benefits & Costs for Next Year

Section 1.1 – Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$49	<i>There is no change for the upcoming year.</i>
Additional premium for optional supplemental benefits If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	\$70 This additional premium is for the supplemental Optional Point of Service benefit.	\$70 This additional premium is for the supplemental Optional Point of Service benefit.

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

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

	2025 (this year)	2026 (next year)
In-Network Maximum out-of-pocket amount FHCP Medicare Rx Plus Your costs for covered medical services (such as copayments) count toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$3,400	\$6,750 Once you've paid \$6,750 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.
Out-of-Network Maximum out-of-pocket amount (for FHCP Medicare Rx Plus POS only) Your costs for covered medical services (such as copayments) count toward your out-of-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$8,000	\$8,000 Once you've paid \$8,000 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* (<https://fhcpmedicare.com/providersearch>) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at <https://fhcpmedicare.com/providersearch>
- Call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) for help.

For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 – Changes to the Pharmacy Network

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

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* (<https://fhcpmedicare.com/pharmacysearch>) to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at <https://fhcpmedicare.com/pharmacysearch>
- Call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) for help.

Section 1.5 – Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
IN-NETWORK MEDICAL BENEFITS		
Ambulance services	<u>In- and Out-of-Network</u> You pay a \$175 copay per one-way trip for air ambulance	<u>In- and Out-of-Network</u> You pay a 20% coinsurance per one-way trip for air ambulance
Cardiac rehabilitation services	<u>In-Network</u> You pay a \$20 copay per session for Medicare-covered cardiac rehabilitation at all outpatient places of service	<u>In-Network</u> You pay a \$25 copay per session for Medicare-covered cardiac rehabilitation at all outpatient places of service

	2025 (this year)	2026 (next year)
	You pay a \$20 copay per session for Medicare-covered intensive cardiac rehabilitation visits at all outpatient places of service	You pay a \$25 copay per session for Medicare-covered intensive cardiac rehabilitation visits at all outpatient places of service
Chiropractic services	<u>In-Network</u> You pay a \$20 copay per visit for Medicare-covered chiropractic service	<u>In-Network</u> You pay a \$15 copay per visit for Medicare-covered chiropractic service
Dental services	<u>In-Network</u> You pay a \$20 copay per visit for Medicare-covered non-routine dental care	<u>In-Network</u> You pay a \$40 copay per visit for Medicare-covered non-routine dental care
Dental Services (additional benefits)	<u>In-Network</u> <u>Clinical Oral Evaluations</u> You pay a \$0 copay 2 evaluations per calendar year <u>Diagnostic Imaging (X-rays)</u> <u>Bitewing X-rays</u> You pay a \$0 copay Maximum 1 set per calendar year <u>Intraoral and Panoramic</u> You pay a \$0 copay 1 set every 3 years <u>Dental Prophylaxis (Cleanings)</u> You pay a \$0 copay 2 per calendar year <u>Prosthodontics, Removable</u> You pay a \$0 copay Maximum 1 per calendar year	Non-Medicare preventive and comprehensive Dental Services are <u>not</u> covered

	2025 (this year)	2026 (next year)
	<u>Oral and Maxillofacial Surgery</u> You pay a \$0 copay Maximum of 1 per calendar year for an erupted tooth or an exposed root	
Durable medical equipment (DME) and related supplies	<u>In-Network</u> You pay 0% of the cost for Medicare-covered Nebulizers at a Preferred Retail Pharmacy	<u>In-Network</u> You pay 20% of the cost for Medicare-covered Nebulizers at a Preferred Retail Pharmacy
Emergency services	<u>In- and Out-of-Network</u> You pay a \$100 copay for each Medicare-covered Emergency Room visit	<u>In- and Out-of-Network</u> You pay a \$130 copay for each Medicare-covered Emergency Room visit
Inpatient hospital care - Acute	<u>In-Network</u> For each Medicare-covered stay, you pay: - Days 1-6: \$300 copay per day - After the 6th day, the plan pays 100% of covered expenses	<u>In-Network</u> For each Medicare-covered stay, you pay: Days 1-6: \$350 copay per day After the 6th day, the plan pays 100% of covered expenses
Inpatient services in a psychiatric hospital	<u>In-Network</u> For each Medicare-covered stay, you pay: - Days 1-5: \$300 copay per day - After the 5th day, the plan pays 100% of the covered expenses	<u>In-Network</u> For each Medicare-covered stay, you pay: Days 1-6: \$350 copay per day Days 7-90: \$0 copay per day
Medicare Part B prescription drugs	<u>In-Network</u> You pay a 0% coinsurance for the following Part B drugs. Albuterol, ipratropium, albuterol-ipratropium	<u>In-Network</u> You pay a 20% coinsurance for the following Part B drugs. Albuterol, ipratropium, albuterol-ipratropium

	2025 (this year)	2026 (next year)
Opioid treatment program services	<u>In-Network</u> You pay a \$20 copay for Opioid treatment program services	<u>In-Network</u> You pay a \$40 copay for Opioid treatment program services
Outpatient diagnostic tests and therapeutic services and supplies	<u>In-Network</u> For Medicare-covered therapeutic radiology (radiation therapy) services, you pay: \$10 copay per visit at an in-network Independent Diagnostic Testing facility or physician's office, additional office visit copay may apply \$50 copay per visit at an in-network hospital outpatient department or provider-based department of a hospital/clinic, additional office visit copay may apply For Medicare-covered Diagnostic Procedures/Tests, you pay: Sleep Study \$175 copay per visit at an in-network hospital outpatient department or provider-based department of a hospital/clinic For Medicare-covered diagnostic radiology services, you pay: Interventional Services, Advanced Imaging and Nuclear Medicine	<u>In-Network</u> For Medicare-covered therapeutic radiology (radiation therapy) services, you pay: 20% coinsurance per visit at all in-network locations of service For Medicare-covered Diagnostic Procedures/Tests, you pay: Sleep Study \$350 copay per visit at an in-network hospital outpatient department or provider-based department of a hospital/clinic For Medicare-covered diagnostic radiology services, you pay: Interventional Services, Advanced Imaging and Nuclear Medicine

	2025 (this year)	2026 (next year)
	\$200 copay per visit at an in-network hospital outpatient department or provider-based department of a hospital/clinic, additional office visit copay may apply	\$275 copay per visit at an in-network hospital outpatient department or provider-based department of a hospital/clinic, additional office visit copay may apply
Outpatient hospital observation	<u>In-Network</u> You pay a \$200 copay per stay for Outpatient Hospital Observation	<u>In-Network</u> You pay a \$350 copay per stay for Outpatient Hospital Observation
Outpatient hospital services	<u>In-Network</u> You pay a \$200 copay for all other outpatient hospital services	<u>In-Network</u> You pay a \$350 copay for outpatient hospital services
Outpatient mental health care	<u>In-Network</u> You pay a \$20 copay for Medicare-covered mental health specialty services and psychiatric services for individual or group therapy visit	<u>In-Network</u> You pay a \$40 copay for Medicare-covered mental health specialty services and psychiatric services for individual or group therapy visit
Outpatient rehabilitation services (physical/occupational/speech language therapy)	<u>In-Network</u> - You pay a \$20 copay per Medicare-covered physical therapy visit - You pay a \$20 copay per Medicare-covered occupational therapy visit - You pay a \$20 copay per Medicare-covered speech-language therapy visit - You pay a \$0 copay for Medicare-covered home-based Lymphedema Services	<u>In-Network</u> You pay a \$25 copay per Medicare-covered physical therapy visit You pay a \$25 copay per Medicare-covered occupational therapy visit You pay a \$25 copay per Medicare-covered speech-language therapy visit You pay a \$25 copay for Medicare-covered home-based Lymphedema Services

	2025 (this year)	2026 (next year)
Outpatient substance abuse services	<u>In-Network</u> You pay a \$20 copay per visit for Medicare-covered individual or group therapy	<u>In-Network</u> You pay a \$40 copay per visit for Medicare-covered individual or group therapy
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	<u>In-Network</u> - You pay a \$200 copay for all other Medicare-covered services provided in an outpatient hospital - You pay a \$150 copay for all other Medicare-covered services provided in an ambulatory surgical center	<u>In-Network</u> You pay a \$350 copay for Medicare-covered services provided in an outpatient hospital You pay a \$275 copay for Medicare-covered services provided in an ambulatory surgical center
Partial hospitalization services and Intensive outpatient services	<u>In-Network</u> You pay a \$55 copay per day for Medicare-covered partial hospitalization services	<u>In-Network</u> You pay a \$100 copay per day for Medicare-covered partial hospitalization services and intensive outpatient services
Physician/Practitioner services, including doctor's office visits	<u>In-Network</u> You pay a \$20 copay for each Medicare-covered specialist visit	<u>In-Network</u> You pay an \$8 copay for the following Medicare-covered specialist visit: Psychiatrist You pay a \$40 copay for each Medicare-covered specialist visit
Podiatry services	<u>In-Network</u> You pay a \$20 copay for each Medicare-covered visit when services are provided by a podiatrist	<u>In-Network</u> You pay a \$30 copay for each Medicare-covered visit when services are provided by a podiatrist
Pulmonary rehabilitation services	<u>In-Network</u> You pay a \$20 copay per Medicare-covered pulmonary rehabilitation sessions	<u>In-Network</u> You pay a \$25 copay per Medicare-covered pulmonary rehabilitation sessions

	2025 (this year)	2026 (next year)
Skilled nursing facility (SNF) care	<u>In-Network</u> For each Medicare-covered stay, you pay: • Days 1-20: \$0 copay per day (per benefit period) • Days 21-100: \$172 copay per day (per benefit period)	<u>In-Network</u> For each Medicare-covered stay, you pay: • Days 1-20: \$0 copay per day (per benefit period) • Days 21-100: \$218 copay per day (per benefit period)
Urgently needed services	<u>In- and Out-of-Network</u> • You pay a \$20 copay for Medicare-covered urgently needed visits when services are provided at an Urgent Care Center	<u>In- and Out-of-Network</u> • You pay a \$40 copay for Medicare-covered urgently needed visits when services are provided at an Urgent Care Center
Vision care	<u>In-Network</u> For Medicare-covered exams to diagnose and treat diseases and condition of the eye, you pay: • \$20 copay per visit when performed by an Ophthalmologist, referral required	<u>In-Network</u> For Medicare-covered exams to diagnose and treat diseases and condition of the eye, you pay: • \$40 copay per visit when performed by an Ophthalmologist, referral required
Worldwide Emergency/Urgent Coverage	• You pay a \$100 copay for plan-covered emergency services received outside the US or its territories • You pay a \$20 copay for plan-covered urgently needed services received outside the US or its territories	• You pay a \$130 copay for plan-covered emergency services received outside the US or its territories • You pay a \$40 copay for plan-covered urgently needed services received outside the US or its territories

	2025 (this year)	2026 (next year)
OPTIONAL POINT OF SERVICE (OUT-OF-NETWORK MEDICAL BENEFITS)		
Inpatient hospital care	For each Medicare-covered stay, you pay: - Days 1-6: \$300 copay per day - After the 6th day, the plan pays 100% of covered expenses	For each Medicare-covered stay, you pay: Days 1-6: \$350 copay per day After the 6th day, the plan pays 100% of covered expenses
Inpatient services in a psychiatric hospital	For each Medicare-covered stay, you pay: - Days 1-5: \$300 copay per day - After the 5th day, the plan pays 100% of covered expenses	For each Medicare-covered stay, you pay: Days 1-6: \$350 copay per day Days 7-90: \$0 copay per day
Skilled nursing facility	For each Medicare-covered stay, you pay: - Days 1-58: \$175 copay per day (per benefit period) - Days 59-100: \$0 copay per day (per benefit period)	For each Medicare-covered stay, you pay: Days 1-20: \$0 copay per day (per benefit period) Days 21-100: \$218 copay per day (per benefit period)
Group 2	You pay a \$40 copay	You pay a \$50 copay
Medicare-covered service categories include: - Primary Care or Specialty physicians - Outpatient Rehab (Cardiac, Intensive Cardiac, Pulmonary, Occupational, Physical & Speech-Language Pathology Therapy and Supervised Exercise Therapy) - Podiatry		

	2025 (this year)	2026 (next year)
	• Chiropractic • Outpatient Mental Health & Psychiatric Services • Outpatient Substance Use Disorder & Opioid Treatment Services • Comprehensive Dental	

Section 1.6 – Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) for more information.

Section 1.7 – Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you

get Extra Help and you don't get this material by September 30, 2025, call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 4 and 5 drugs until you've reached the yearly deductible.

- Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,100.

- Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	The deductible is \$615 (Applies to Tiers 4 and 5) During this stage, you pay:

2025 (this year)	2026 (next year)
	<i>Standard cost-sharing:</i> \$17 per one-month supply <i>Preferred cost-sharing:</i> \$0 per one-month supply for drugs on Tier 1 (Preferred Generic) <i>Standard cost-sharing:</i> \$20 per one-month supply <i>Preferred cost-sharing:</i> \$0 per one-month supply for drugs on Tier 2 (Generic) <i>Standard cost-sharing:</i> \$47 per one-month supply <i>Preferred cost-sharing:</i> \$42 per one-month supply for drugs on Tier 3 (Preferred Brand) <i>Standard cost-sharing:</i> \$0 per one-month supply <i>Preferred cost-sharing:</i> \$0 per one-month supply for drugs on Tier 6 (Vaccines) And the full cost of drugs on Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (31-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a

network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your Evidence of Coverage.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1 (Preferred Generic) We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<i>Standard cost-sharing:</i> You pay \$17 copay per prescription <i>Preferred cost-sharing:</i> You pay \$0 copay per prescription	<i>Standard cost-sharing:</i> You pay \$17 copay per prescription <i>Preferred cost-sharing:</i> You pay \$0 copay per prescription
Tier 2 (Generic): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<i>Standard cost-sharing:</i> You pay \$20 copay per prescription <i>Preferred cost-sharing:</i> You pay \$0 copay per prescription	<i>Standard cost-sharing:</i> You pay \$20 copay per prescription <i>Preferred cost-sharing:</i> You pay \$0 copay per prescription
Tier 3 (Preferred Brand): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<i>Standard cost-sharing:</i> You pay \$47 copay per prescription You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> You pay \$42 copay per prescription You pay \$35 per month supply of each covered insulin product on this tier.	<i>Standard cost-sharing:</i> You pay \$47 copay per prescription You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> You pay \$42 copay per prescription You pay \$35 per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
Tier 4 (Non-Preferred Drug): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<i>Standard cost-sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier.	<i>Standard cost-sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier.
Tier 5 (Specialty Tier): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<i>Standard cost-sharing:</i> You pay 33% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> You pay 33% of the total cost You pay \$35 per month supply of each covered insulin product on this tier.	<i>Standard cost-sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. <i>Preferred cost-sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier.
Tier 6 (Vaccines): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<i>Standard cost-sharing:</i> You pay \$0 copay per prescription <i>Preferred cost-sharing:</i> You pay \$0 copay per prescription	<i>Standard cost-sharing:</i> You pay \$0 copay per prescription <i>Preferred cost-sharing:</i> You pay \$0 copay per prescription

Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-833-866-6559 (TTY users call 1-800-955-8770) or visit www.Medicare.gov.
Medicare Prescription Payment Plan	Capital Rx, an FHCP Medicare contracted vendor, administers the Medicare Prescription Payment Plan, Below is the contact information for Capital Rx. Call: 1-877-282-2779 Calls to this number are free. 24 hours a day, 7 days a week. TTY: 1-800-955-8770 Calls to this number are free. 24 hours a day, 7 days a week. Write: Capital Rx Attn: M3P Elections 9450 SW Gemini Dr., Suite 87234 Beaverton, Oregon 97008-7105	Optum Rx, an FHCP Medicare contracted vendor, will administer the Medicare Prescription Payment Plan for 2026, Below is the contact information for Optum Rx. Call: 1-844-368-8729 Calls to this number are free, Hours are 5:00 a.m. – 10:00 p.m. CST, 7 days a week. TTY: 1-800-955-8770 Calls to this number are free. Hours are 5:00 a.m. – 10:00 p.m. CST, 7 days a week. Write: Optum Rx Attn: M3P Election Processes PO Box 650287 Dallas, TX 75265-0287

Description	2025 (this year)	2026 (next year)
	Election requests can also be emailed to M3P-Election@cap-rx.com	
How to ask FHCP Medicare to reimburse you or pay a bill you have received	Mail your request for payment together with any bills or paid receipts to us at this address: FHCP Medicare Attn: Claims Department P.O. Box 10348 Daytona Beach, FL 32120-0348	Mail your request for payment together with any bills or paid receipts to us at these addresses: <u>Part C Requests for Payment (medical services):</u> FHCP Medicare Attn: Claims Department P.O. Box 10348 Daytona Beach, FL 32120-0348 You must submit your claim to us within 12 months of the date you received the service, item, or drug. <u>Part D Requests for Payment (prescription drugs):</u> Optum Rx Claims Department PO Box 650287 Dallas, TX 75265-0287 You must submit your claim to us within 36 months of the date you received the service, item, or drug.

SECTION 3 How to Change Plans

To stay in FHCP Medicare Rx Plus (HMO-POS), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our FHCP Medicare Rx Plus (HMO-POS).

If you want to change plans for 2026 follow these steps:

- To **change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from FHCP Medicare Rx Plus (HMO-POS).
- To **change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from FHCP Medicare Rx Plus (HMO-POS).
- To **change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) for more information on how to do this. Or call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- To learn more about Original Medicare and the different types of Medicare plans, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Florida Blue Medicare, Inc. dba FHCP Medicare offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 – Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 - December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 - March 31, 2026.

Section 3.2 – Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you

have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
 - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call Florida's ADAP directly at 1-800-352-2437 (TTY: 1-888-503-7118), or mail them at: HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-844-368-8729 (TTY users call 1-800-955-8770) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from FHCP Medicare Rx Plus (HMO-POS)

- **Call Member Services at 1-833-866-6559. (TTY users call 1-800-955-8770).**

We're available for phone calls 8:00 a.m. to 8:00 p.m., local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m., local time, Monday through Friday, except for major holidays. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for FHCP Medicare Rx Plus (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.fhcpmedicare.com or call Member Services at 1-833-866-6559 (TTY users call 1-800-955-8770) to ask us to mail you a copy.

- **Visit www.fhcpmedicare.com**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs (formulary/Drug List)*.

Get Free Counseling about Medicare

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

Call SHINE to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call SHINE at 1-800-963-5337. Learn more about SHINE by visiting www.FLORIDASHINE.org.

Get Help from Medicare

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

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

- **Chat live with www.Medicare.gov**

You can chat live at www.Medicare.gov/talk-to-someone

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide:

- People with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language is not English, which may include:
 - Qualified Interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact:

- Florida Health Care Plans (Group & Individual): 1-877-615-4022
- FHCP Medicare: 1-833-866-6559

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

Florida Health Care Plans (Group & Individual members):

Florida Health Care Plans
Civil Rights Coordinator
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

FHCP Medicare members:

FHCP Medicare
Civil Rights Coordinator
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

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

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

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
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Form Approved
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Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-877-615-4022, a Medicare al 1-833-866-6559, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòm ki disponib gratis. Rele nan 1-877-615-4022, oswa rele Medicare nan 1-833-866-6559 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-877-615-4022 医疗保险 □Medicare)1-833-866-6559 听障专线□TTY)711。

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-877-615-4022, le Medicare au 1-833-866-6559 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-877-615-4022, Medicare 1-833-866-6559 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على:
1-877-615-4022 Medicare: 1-833-866-6559 (لذوي الإعاقة السمعية) TTY: 711

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-877-615-4022, Medicare: 1-833-866-6559, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-877-615-4022, 메디케어 1-833-866-6559, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Form Approved
OMB# 0938-1421

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મોટ સેવાઓ ઉપલબ્ધ છે.
1-877-615-4022, Medicare 1-833-866-6559, (TTY 711) પર કોલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-877-615-4022, Medicare
1-833-866-6559 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。
1-877-615-4022、メディケア 1-833-866-6559 (TTY 711) までお電話ください。

T'áá free yíníłta'go saad bee áká anilyeedígíí, ałk'ida'ánígíí, dóó t'áá ajilii hane' bee áká anilyeedígíí t'éiyá éí
hołne'. 1-877-615-4022 bich'í' náhodoonih, Medicare bich'í' 1-833-866-6559 bich'í' náhodoonih, (TTY 711).