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2012 Summary of Benefits

MEDVANTAGE RX PLUS (HMO-POS)

Florida Health Care Plans, Inc.
(H1035)

Volusia and Flagler Counties, Florida

SECTION I—INTRODUCTION TO THE SUMMARY OF BENEFITS FOR FHCP MEDVANTAGE RX PLUS (HMO-POS)

**January 1, 2012 - December 31, 2012
VOLUSIA AND FLAGLER COUNTIES, FL**

Thank you for your interest in FHCP's Medvantage Rx Plus (HMO-POS) plans. These plans are offered by FLORIDA HEALTH CARE PLAN, INC., (FHCP) a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Florida Health Care Plan, Inc. and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like FHCP Medvantage Rx Plus (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call FHCP at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare FHCP Medvantage Rx Plus (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more

benefits, which may change from year to year.

WHERE IS FLORIDA HEALTH CARE PLANS AVAILABLE?

The service area for this plan includes: Flagler, Volusia Counties, FL. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN FLORIDA HEALTH CARE PLANS?

You can join FHCP Medvantage Rx Plus (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in FHCP unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

FHCP Medvantage Rx Plus (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. FHCP Medvantage Rx Plus (HMO-POS) offers an optional point-of-service benefit. If you choose this optional benefit, in some cases, you may also go to doctors out of our network. The health providers in our network can change at

any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at <http://www.fhcp.com/medicare/overview/overview.htm>. Our number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

FHCP Medvantage Rx Plus (HMO-POS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://www.fhcp.com/medicare/>

[pharmacies/overview.htm](#). Our Member Services number is listed at the end of this introduction.

FHCP Medvantage Rx Plus (HMO-POS) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

FHCP's Medvantage Rx Plus (HMO-POS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

FHCP Medvantage Rx Plus (HMO-POS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://www.fhcp.com/medicare/formulary/formulary.htm>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an

alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose

Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of FHCP Medvantage Rx Plus (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of FHCP Medvantage Rx Plus (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact FHCP Medvantage Rx Plus (HMO-POS) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Florida Health Care Plan, Inc. for more details.

- **Some Antigen:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs** provided through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS ?

The Medicare program rates how well plans perform in different categories (for example, detecting

and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our Member Service number is listed below.

Please call Florida Health Care Plan, Inc. for more information about FHCP Medvantage Rx Plus (HMO-POS).

Visit us at <http://www.fhcp.com/medicare/overview/overview.htm> or, call us:

Member Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday,
Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call

Locally (386)615-4022
toll-free (877)615-4022

for questions related to the Medicare Advantage Program or Part D Prescription Drug program.
(TTY/TDD—TRS Relay 711)

Prospective members should call

locally (386)676-7110 or
toll-free (800)232-0578

for questions related to the Medicare Advantage Program or Part D Prescription Drug program.
(TTY/TDD—TRS Relay 711)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call Member Service at the phone number listed above.

SECTION II – SUMMARY OF BENEFITS

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
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IMPORTANT INFORMATION

1 – Premium and Other Important Information

- In 2012 the monthly Part B Premium is \$99.90 and the yearly Part B deductible amount IS \$140.
- If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.
- Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

General

\$45.50 monthly plan premium in addition to your monthly Medicare Part B Premium.

Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

In-Network

\$4,500 out-of-pocket limit for Medicare-covered services.

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<p>2 – Doctor and Hospital Choice (For more information, see Emergency Care - #15 & Urgently Needed Care-#16)</p>	<ul style="list-style-type: none"> ▪ You may go to any doctor, specialist or hospital that accepts Medicare. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ You must go to network doctors, specialists, and hospitals. ▪ Referral required for network hospitals and specialists (for certain benefits).
INPATIENT CARE		
<p>3 – Inpatient Hospital Care (includes substance Abuse and Rehabilitation Services)</p>	<ul style="list-style-type: none"> ▪ In 2012 the amounts for each benefit period are: <ul style="list-style-type: none"> – Days 1-60: \$1156 deductible – Days 61-90: \$289 per day – Days 91-150: \$578 per lifetime reserve day ▪ Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. ▪ Lifetime reserve days can only be used once. ▪ A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ For Medicare-covered hospital stays: <ul style="list-style-type: none"> – Days 1-8: \$200 copay per day – Days 9-90: \$0 copay per day – \$0 copay for additional hospital days. ▪ No limit to the number of days covered by the plan each hospital stay ▪ Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
<p>4 – Inpatient Mental Health Care</p>	<ul style="list-style-type: none"> ▪ In 2012 the amounts for each benefit period are: <ul style="list-style-type: none"> – Days 1-60: \$1156 deductible – Days 61-90: \$289 per day – Days 91-150: \$578 per lifetime reserve day ▪ You get up to 190 days in a Psychiatric Hospital in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ For Medicare-covered hospital stays: <ul style="list-style-type: none"> – Days 1-7: \$200 copay per day – Days 8-90: \$0 copay per day – \$0 copay for additional hospital days ▪ Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. ▪ Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
<p>5 – Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<ul style="list-style-type: none"> ▪ In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: <ul style="list-style-type: none"> –Days 1-20: \$0 per day –Days 21-100: \$144.50 per day ▪ 100 days for each benefit period. ▪ A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ For SNF stays: <ul style="list-style-type: none"> – Days 1-7: \$0 copay per day – Days 8-100: \$50 copay per day ▪ Plan covers up to 100 days each benefit period. ▪ No prior hospital stay is required.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	<ul style="list-style-type: none"> ▪ \$0 copay 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for Medicare-covered home health visits.
7 – Hospice	<ul style="list-style-type: none"> ▪ You pay part of the cost for outpatient drugs and inpatient respite care. ▪ You must get care from a Medicare-certified hospice. 	<p>General</p> <ul style="list-style-type: none"> ▪ You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE		
8 – Doctor Office Visits	<ul style="list-style-type: none"> ▪ 20% coinsurance 	<p>General</p> <ul style="list-style-type: none"> ▪ Authorization rules may apply. <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$8 copay for each primary care doctor visit for Medicare-covered benefits. ▪ \$30 copay for each in-area network urgent care Medicare-covered visit. ▪ \$30 copay for each specialist visit for Medicare-covered benefits.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
9 – Chiropractic Services	<ul style="list-style-type: none"> ▪ Supplemental routine care not covered ▪ 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint of body part) if you get it from a chiropractor or other qualified providers. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ \$20 copay for each Medicare-covered visits. ▪ Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint of body part) if you get it from a chiropractor or other qualified providers.
10 – Podiatry Services	<ul style="list-style-type: none"> ▪ Supplemental routine care not covered. ▪ 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ \$30 copay for each Medicare-covered visit. ▪ Medicare-covered podiatry benefits are for medically-necessary foot care.
11 – Outpatient Mental Health Care	<ul style="list-style-type: none"> ▪ 40% coinsurance for most outpatient mental health services. ▪ Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible ▪ “Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization. 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$30 copay for each Medicare-covered individual therapy visit. ▪ \$30 copay for each Medicare-covered group therapy visit ▪ \$30 copay for each Medicare-covered individual therapy visit with a psychiatrist. ▪ \$30 copay for each Medicare-covered group therapy visit with a psychiatrist. ▪ \$100 for Medicare-covered partial hospitalization program services.
12 – Outpatient Substance Abuse Care	<ul style="list-style-type: none"> ▪ 20% coinsurance 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$30 copay Medicare-covered individual therapy visit. ▪ \$30 copay for Medicare-covered group visits

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
13 – Outpatient Services/ Surgery	<ul style="list-style-type: none"> ▪ 20% coinsurance for the doctor’s services ▪ Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. ▪ 20% coinsurance for ambulatory surgical center facility charges 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$100 copay for each Medicare-covered ambulatory surgical center visit. ▪ \$0 to \$200 copay for each Medicare-covered outpatient hospital facility visit.
14 – Ambulance Services (medically necessary ambulance services)	<ul style="list-style-type: none"> ▪ 20% coinsurance 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ \$175 copay for Medicare-covered ambulance benefits.
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<ul style="list-style-type: none"> ▪ 20% coinsurance for the doctor’s services ▪ Specified copayment for outpatient hospital facility emergency services. ▪ Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital ▪ You don’t have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. ▪ NOT covered outside the U.S. except under limited circumstances. 	<p>General</p> <ul style="list-style-type: none"> ▪ \$65 copay for Medicare-covered emergency room visits. ▪ Worldwide coverage. ▪ If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	<ul style="list-style-type: none"> ▪ 20% coinsurance, or a set copay ▪ NOT covered outside the U.S. except under limited circumstances 	<p>General</p> <ul style="list-style-type: none"> ▪ \$30 copay for Medicare-covered urgently needed care visits.
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	<ul style="list-style-type: none"> ▪ 20% coinsurance 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$20 copay for Medicare-covered Occupational Therapy visits ▪ \$20 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	<ul style="list-style-type: none"> ▪ 20% coinsurance 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ 20% of the cost for Medicare-covered items.
19 – Prosthetic Devices (includes braces, artificial limbs & eyes, etc.)	<ul style="list-style-type: none"> ▪ 20% coinsurance 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ 20% of the cost for Medicare-covered items.
20 – Diabetes Programs and Supplies	<ul style="list-style-type: none"> ▪ 20% coinsurance for diabetes self-management training ▪ 20% coinsurance for diabetes supplies ▪ 20% coinsurance for diabetic therapeutic shoes or inserts 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for Diabetes self-monitoring training. ▪ \$0 to \$10 copay for Diabetes monitoring supplies. ▪ 20% coinsurance for Therapeutic shoes or inserts
21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	<ul style="list-style-type: none"> ▪ 20% coinsurance for diagnostic tests and x-rays ▪ \$0 copay for Medicare-covered lab services. ▪ Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol. ▪ 20% coinsurance for a digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50. 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for Medicare-covered lab services. ▪ \$0 to \$175 copay for Medicare-covered diagnostic procedures and tests. ▪ \$10 to \$25 copay for Medicare-covered X-rays. ▪ \$10 to \$200 copay for Medicare-covered diagnostic radiology services (not including x-rays). ▪ \$10 to \$25 copay for Medicare-covered therapeutic radiology services. <ul style="list-style-type: none"> ▪ If a doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$8 to \$30 may apply. ▪ If a doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$8 to \$30 may apply.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
PREVENTIVE SERVICES		
22 – Cardiac and Pulmonary Rehabilitation Services	<ul style="list-style-type: none"> ▪ 20% coinsurance for Cardiac Rehabilitation services ▪ 20% coinsurance for Pulmonary Rehabilitation services ▪ 20% coinsurance for Intensive Cardiac Rehabilitation services ▪ This applies to program services provided in a doctor’s office. Specified cost sharing for program services provided by hospital outpatient departments. 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$20 copay for Medicare-covered Cardiac Rehabilitation Services ▪ \$20 copay for Medicare-covered Intensive Cardiac Rehabilitation Services ▪ \$20 copay for Medicare-covered Pulmonary Rehabilitation Services
23—Preventive Services and Wellness/Education Programs	<p>No coinsurance, copayment of deductible for the following:</p> <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm Screening ▪ Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions ▪ Cardiovascular Screening ▪ Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine ▪ Hepatitis B Vaccine for people with Medicare who are at risk. ▪ HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. ▪ Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. 	<p>General</p> <ul style="list-style-type: none"> ▪ \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
<p>23—Preventive Services and Wellness/Education Programs, continued</p>	<ul style="list-style-type: none"> ▪ Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine. You may only need the Pneumonia Vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. ▪ Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. ▪ Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	<ul style="list-style-type: none"> ▪ HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. <p>In-Network The Plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Nutritional benefit ▪ Additional Smoking Cessation ▪ Health Club Membership. Fitness Classes ▪ Nursing Hotline
<p>24—Kidney Disease and Conditions</p>	<ul style="list-style-type: none"> ▪ 20% coinsurance for renal dialysis ▪ 20% coinsurance for kidney disease education services 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for renal dialysis ▪ \$0 copay for kidney disease education services

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
<p>25 – Prescription Drugs</p>	<ul style="list-style-type: none"> ▪ Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. 	<p>DRUGS COVERED UNDER MEDICARE PART B</p> <p>General</p> <ul style="list-style-type: none"> ▪ 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. <p>DRUGS COVERED UNDER MEDICARE PART D</p> <p>General</p> <ul style="list-style-type: none"> ▪ This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://fhcp.com/medicare/formulary/formulary.htm on the web. ▪ Different out-of-pocket costs may apply for people who: <ul style="list-style-type: none"> ➢ have limited incomes, ➢ Live in long term care facilities, or ➢ Have access to Indian/Tribal/Urban (Indian Health Service). ▪ Your in-network prescription coverage may be limited to the plan’s service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details. ▪ Total yearly drug costs are the total drug costs paid by both you and the plan. ▪ The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. ▪ Some drugs have quantity limits. ▪ Your provider must get prior authorization from FHCP Medvantage Rx Plus (HMO-POS) for certain drugs.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
<p>25 – Prescription Drugs, continued</p>		<ul style="list-style-type: none"> ▪ You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. ▪ If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. ▪ If you request a formulary exception for a drug and FHCP Medvantage Rx Plus (HMO-POS) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug. <p><u>In-Network</u> \$0 deductible.</p> <p><u>Initial Coverage</u> You pay the following until total yearly drug costs reach \$2,930:</p> <p><i>RETAIL PHARMACY</i></p> <p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$2 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy. ▪ \$6 copay for a three-month (93-day) supply of drugs in this tier from a preferred pharmacy. ▪ \$11 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ \$33 copay for a three-month (93-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$7 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy. ▪ \$21 copay for a three-month (93-day) supply of drugs in this tier from a preferred pharmacy. ▪ \$17 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ \$51 copay for a three-month (93-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 3: Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ 25% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy. ▪ 25% coinsurance for a three-month (93-day) supply of drugs in this tier from a preferred pharmacy. ▪ 50% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ 50% coinsurance for a three-month (93-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 4: Non-Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ 50% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy. ▪ 50% coinsurance for a three-month (93-day) supply of drugs in this tier from a preferred pharmacy. ▪ 60% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ 60% coinsurance for a three-month (93-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><u>Tier 5: Specialty Tier Drugs</u></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy. ▪ 33% coinsurance for a three-month (93-day) supply of drugs in this tier from a preferred pharmacy. ▪ 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ 33% coinsurance for a three-month (93-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 6: Injectable Drugs</u></p> <ul style="list-style-type: none"> ▪ 25% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy. ▪ 25% coinsurance for a three-month (93-day) supply of drugs in this tier from a preferred pharmacy. ▪ 25% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ 25% coinsurance for a three-month (93-day) supply of drugs in this tier from a non-preferred pharmacy. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><i>LONG TERM CARE PHARMACY</i></p> <p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$11 copay for a one-month (31-day) supply of drugs in this tier. <p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$17 copay for a one-month (31-day) supply of drugs in this tier. <p><u>Tier 3: Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ 50% coinsurance for a one-month (31-day) supply of drugs in this tier. <p><u>Tier 4: Non-Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ 60% coinsurance for a one-month (31-day) supply of drugs in this tier. <p><u>Tier 5 : Specialty Tier Drugs</u></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <p><u>Tier 6: Injectable Drugs</u></p> <ul style="list-style-type: none"> ▪ 25% coinsurance for a one-month (31-day) supply of drugs in this tier. <p><i>MAIL ORDER</i></p> <p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$3 copay for a three-month (93-day) supply of drugs in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$18 copay for a three-month (93-day) supply of drugs in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><u>Tier 3: Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ 25% coinsurance for a three-month (93-day) supply of drugs in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 4: Non-Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ 50% coinsurance for a three-month (93-day) supply of drugs in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 5: Specialty Tier Drugs</u></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a three-month (93-day) supply of drugs in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 6: Injectable Drugs</u></p> <ul style="list-style-type: none"> ▪ 25% coinsurance for a three-month (93-day) supply of drugs in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Additional Coverage Gap</u> You pay the following:</p>

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><i>RETAIL PHARMACY</i> Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$2 copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred pharmacy. ▪ \$6 copay for a three-month (93-day) supply of all drugs covered in this tier from a preferred pharmacy. ▪ \$11 copay for a one-month (31-day) supply of all drugs covered in this tier from a non-preferred pharmacy. ▪ \$33 copay for a three-month (93-day) supply of all drugs covered in this tier from a non-preferred pharmacy. <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$7 copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred pharmacy. ▪ \$21 copay for a three-month (93-day) supply of all drugs covered in this tier from a preferred pharmacy. ▪ \$17 copay or a one-month (31-day) supply of all drugs covered in this tier from a non-preferred pharmacy. ▪ \$51 copay for a three-month (93-day) supply of all drugs covered in this tier from a non-preferred pharmacy. <p><i>LONG-TERM CARE PHARMACY</i></p> <p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$11 copay for a one-month (31-day) supply of all drugs covered in this tier. <p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$17 copay for a one-month (31-day) supply of all drugs covered in this tier.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p>MAIL ORDER</p> <p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$3 copay for a three-month (93-day) supply of all drugs covered in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$18 copay for a three-month (93-day) supply of all drugs covered in this tier. ▪ Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <p>After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan’s costs for generic drugs, until your yearly out-of-pocket drug costs reach \$4,700.</p> <p><u>Catastrophic Coverage</u></p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> ➢ 5% coinsurance, or ➢ A \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p><u>OUT-OF-NETWORK</u></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from FHCP Medvantage Rx Plus (HMO-POS).</p>

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><u>Out-of-Network Initial Coverage</u> You will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p><u>Tier 1: Preferred Generic Drugs</u> ▪ \$11 copay for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Tier 2: Non-Preferred Generic Drugs</u> ▪ \$17 copay for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Tier 3: Preferred Brand Drugs</u> ▪ 50% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Tier 4: Non-Preferred Brand Drugs</u> ▪ 60% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Tier 5: Specialty Tier Drugs</u> ▪ 33% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Tier 6: Injectable Drugs</u> ▪ 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p> <p><u>Additional Out-of-Network Coverage Gap</u> You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p>

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
25 – Prescription Drugs, continued		<p><u>Tier 1: Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$11 copay for a one-month (31-day) supply of all drugs covered in this tier. <p><u>Tier 2: Non-Preferred Generic Drugs</u></p> <ul style="list-style-type: none"> ▪ \$17 copay for a one-month (31-day) supply of all drugs covered in this tier. <p><u>Tier 3: Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total year drug costs reach \$4,700. ▪ You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach \$4,700. <p><u>Tier 4: Non-Preferred Brand Drugs</u></p> <ul style="list-style-type: none"> ▪ You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total year drug costs reach \$4,700. ▪ You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach \$4,700.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
<p>25 – Prescription Drugs, continued</p>		<p><u>Tier 5: Specialty Tier Drugs</u></p> <ul style="list-style-type: none"> ▪ You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total year drug costs reach \$4,700. ▪ You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach \$4,700. <p><u>Tier 6: Injectable Drugs</u></p> <ul style="list-style-type: none"> ▪ You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total year drug costs reach \$4,700. ▪ You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach \$4,700. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p> <p><u>Out-of-Network Catastrophic Coverage</u></p> <ul style="list-style-type: none"> ➤ After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan’s cost of the drug minus your cost share, which is the greater of: <ul style="list-style-type: none"> ➤ 5% coinsurance ➤ A \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs, or <p>You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan’s In-Network allowable amount.</p>

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
26 – Dental Services	<ul style="list-style-type: none"> ▪ Preventive dental services (such as cleaning) not covered. 	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ In general, preventive dental benefits (such as cleaning) not covered. ▪ \$30 copay for Medicare-covered dental benefits.
27 – Hearing Services	<ul style="list-style-type: none"> ▪ Supplemental routine hearing exams and hearing aids not covered. ▪ 20% coinsurance for diagnostic hearing exams. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ Hearing aids not covered. ▪ \$0 copay for Medicare-covered diagnostic hearing exams. ▪ \$0 copay for <ul style="list-style-type: none"> - up to 1 supplemental routine hearing exams(s) every year - up to 1 fitting-evaluation(s) for a hearing aid every year
28 – Vision Services	<ul style="list-style-type: none"> ▪ 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. ▪ Supplemental routine eye exams and glasses not covered. ▪ Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. ▪ Annual glaucoma screenings covered for people at risk. 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for <ul style="list-style-type: none"> – one pair of eyeglasses or contact lenses after cataract surgery – up to 1 pair(s) of glasses every two years ▪ \$15 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye. ▪ \$15 copay for up to 1 supplemental routine eye exam (s) every year.
Over-the Counter Items	<ul style="list-style-type: none"> ▪ Not Covered 	<p>General</p> <ul style="list-style-type: none"> ▪ The plan does not cover Over-the-Counter items.
Transportation (Routine)	<ul style="list-style-type: none"> ▪ Not Covered 	<p>In-Network</p> <ul style="list-style-type: none"> ▪ This plan does not cover supplemental routine transportation.

BENEFIT	ORIGINAL MEDICARE	FHCP MEDVANTAGE RX PLUS (HMO-POS) - (002)
Acupuncture	▪ Not Covered	In-Network This plan does not cover Acupuncture.
<i>OPTIONAL SUPPLEMENTAL PACKAGE #1</i>		
Premium and Other Important Information		General Package: 1—Optional Point of Service Benefit: \$20 monthly premium, in addition to your \$45.50 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - POS option
Point of Service		Out-of-Network Optional POS benefits are available. Contact the plan for details.

SECTION III

This section further explains some of the benefits of your plan. To get a complete list of benefits, limitations, and exclusions call Florida Health Care Plans and ask for the “Evidence of Coverage.”

INPATIENT CARE

3 – Inpatient Hospital Care; and

4 – Inpatient Mental Health Care

You pay the copayments shown in Section II each time you’re admitted to a hospital, no matter how many days have passed since your last admission.

5—Skilled Nursing Facility (SNF)

When admitted to a Skilled Nursing Facility, you’re covered for skilled care as defined by Original Medicare guidelines. Your plan does not cover custodial care. FHCP follows Original Medicare guidelines in determining authorization for skilled nursing facility services.

OUTPATIENT CARE

8 - Doctor Office Visits

You pay:

- \$8 copay per visit at an in-network Primary Care Provider
- \$30 copay per visit at an in-network Walk-in or Urgent Care Center
- \$30 copay per visit at an in-network Specialist
- A copay will apply for No-show PCP or Specialist visits.
- Drugs covered under Medicare Part B, generic or brand-name, will require a 20% coinsurance.

11—Outpatient Mental Health Care

You pay:

- \$30 copay for each Medicare-covered individual or group therapy visit.
- \$30 copay for each Medicare-covered individual or group therapy visit with a psychiatrist.
- \$100 per day for Medicare-covered partial hospitalization program services.

13—Outpatient Services/Surgery

For Medicare-covered outpatient services received, you pay:

- \$200 copay per stay for Surgical and Outpatient Monitoring Services. The member will not pay more than the \$200 copay.
- \$175 copay per visit for Surgical Services
- \$200 per visit for Other Interventional and Outpatient Monitoring Services (examples: Cardiac Cath., Angioplasties, Vascular and Arterial Studies, and Other Cardiac procedures/studies). The member will not pay more than the \$200 copay.
- \$200 copay per visit for Other Interventional Services (examples: Cardiac Cath., Angioplasties, Vascular and Arterial Studies, and Other Cardiac procedures/studies)
- \$30 copay per visit at an in-network Specialist’s office for a Sleep Study
- \$175 copay per visit at an in-network Hospital, as an outpatient for a Sleep Study

OUTPATIENT CARE, continued

13—Outpatient Surgery/Services

- \$200 per stay for Outpatient Monitoring Services. The member will not pay more than the \$200 copay.

For Medicare-covered Ambulatory Surgical Center services (free-standing facility), you pay:

- \$100 copay per visit

16 – Urgently Needed Care

- Urgently needed services are available world-wide.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

20 - Diabetes Programs and Supplies

For Medicare-covered Diabetes Monitoring supplies, you pay:

- \$10 for 50 test strips/sensors.
- \$10 for lancets.
- \$0 for Glucometer.

21 - Diagnostic Test, X-rays, Lab Services and Radiology Services

For Medicare-covered Lab services, you pay:

- \$0 copay per visit.

For a Medicare-covered Echocardiogram, you pay:

- \$10 copay per visit at an in-network contract facility or physician's office
- \$25 copay per visit at an in-network hospital facility as an outpatient

For a Medicare-covered diagnostic colonoscopy, you pay:

- •\$50 copay per visit at an in-network GI lab or other non-hospital location.
- •\$100 copay per visit at an in-network ambulatory surgical center.
- •\$175 copay per visit at an in-network hospital facility, as an outpatient.

For a Bone Density Scan, you pay:

- •\$0 copay per visit at an in-network free-standing radiology facility.
- •\$30 copay per visit at an in-network hospital facility as an outpatient.

For a Medicare-covered diagnostic mammogram, you pay:

- •\$25 copay per visit at an in-network free-standing radiology facility
- •\$45 copay per visit at an in-network hospital facility as an outpatient.

For Medicare-covered X-rays, you pay:

- \$10 per visit at an in-network FHCP contract facility or physician's office, additional office visit copay may apply.
- \$25 per visit at an in-network hospital facility as an outpatient.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES, continued

21 - Diagnostic Test, X-rays, Lab Services and Radiology Services, continued

An Abdominal Aortic Aneurysm Screening ultrasound is covered once in men age 65-75 who ever smoked, you pay

- \$0 copay

For Medicare-covered diagnostic ultrasound, including Abdominal Aortic Aneurysm, you pay:

- \$10 per visit for a diagnostic ultrasound at an in-network contract facility or physician's office.
- \$25 per visit for a diagnostic ultrasound at an in-network hospital facility as an outpatient

For Medicare-covered diagnostic radiology services, you pay:

- \$10 per visit at an in-network FHCP contract facility or physician's office, additional office visit copay may apply.
- \$25 per visit at an in-network hospital facility, as an outpatient.
- \$100 per visit for Interventional Services (MRCP, Ablation), Advanced Imaging (MRI, MRA, Pet Scan, CT Scan, CTA) and Nuclear Medicine, at an in-network Independent Diagnostic Testing facility or physician's office.
- \$200 per visit for Interventional Services (MRCP, Ablation) and Advanced Imaging (MRI, MRA, Pet Scan, CT Scan, CTA) and Nuclear Medicine, at an in-network hospital facility, as an outpatient

For Medicare-covered therapeutic radiology (radiation therapy) services, you pay:

- \$10 per visit at an in-network Independent Diagnostic Testing facility or physician's office, additional office visit copay will apply.
- \$25 per visit at an in-network hospital facility, additional office visit copay will apply.

PREVENTIVE SERVICES

24 - Kidney Disease and Conditions

For Medicare-covered Renal Dialysis, you pay:

- Medicare Part B drugs when administered in a Dialysis Center require a 20% coinsurance.
- Out-of-area Renal Dialysis is covered only when you are traveling outside of FHCP's service area.

25 - Outpatient Prescription Drugs

- Medicare Part B drugs are available at FHCP In-Network Preferred pharmacies only, up to a 31-day supply, or when administered by an in-network physician or an out-of-network physician.

28 - Vision Services

You pay:

- \$15 for a Medicare-covered eye exam by an optometrist.
- \$30 for a Medicare-covered eye exam by an ophthalmologist, referral required.
- You are covered up to a \$90 credit toward the purchase of eyeglasses from a participating Optometrist every two years.

Optional Point of Service (POS) Benefit

Medvantage Rx Plus Plan (HMO-POS) - You pay \$20 each month, in addition to your monthly plan premium of \$45.50 and the Medicare Part B premium.

If you elect to add the Optional Point of Service benefit to your plan then you may choose to see any provider or utilize any facility that accepts Medicare assignment or contracted HMO provider without a referral.

The Optional Point of Service benefit is “Open Access” meaning you do not need a referral to see a specialist; therefore, if you need specialized treatment you may see the specialist of your choice without a referral. **Please keep in mind that the Optional Point of Service benefit is limited to providers and facilities that accept Medicare assignment outside of FHCP’s network and contracted HMO participating providers or facilities, without a referral.** When you receive services under the Optional Point of Service benefit you are responsible for the following copayments/coinsurance. Coinsurance is based on the Medicare Fee Schedule in effect at the time of service.

OUT-OF-NETWORK BENEFIT	WHAT YOU MUST PAY
Out-of-Pocket Limit	\$8,000 – Out-of-Network
3 - Inpatient Hospital - Acute	You pay: <ul style="list-style-type: none"> · \$200 each day for day(s) 1-10 · \$0 each day beginning on day 11
4 - Inpatient Psychiatric Hospital	You pay: <ul style="list-style-type: none"> · \$200 each day for day(s) 1-10 · \$0 each day beginning on day 11
5 - Skilled Nursing Facility	You pay: <ul style="list-style-type: none"> · \$175 each day for day(s) 1-58 · \$0 each day for days(s) 59-100
GROUP 1 <ul style="list-style-type: none"> ➤ 6 - Home Health Services ➤ 21 - Outpatient Diagnostic Procedures/Tests/Lab Services ➤ 21 - Diagnostic Radiological Services ➤ 21 - Therapeutic Radiological Services ➤ 21 - Outpatient X-rays ➤ 13 - Outpatient Hospital Services ➤ 13 - Ambulatory Surgical Center (ASC) Services ➤ 18 - Durable medical Equipment (DME) ➤ 19 - Prosthetics/Medical Supplies ➤ 20 - Diabetes Programs & Supplies ➤ Medicare Part B drugs 	You pay: 20% coinsurance

Optional Point of Service (POS) Benefit, continued

OUT-OF-NETWORK BENEFIT	WHAT YOU MUST PAY
<p>GROUP 2</p> <ul style="list-style-type: none"> ➤ 22 - Cardiac Rehabilitation Services ➤ 22 - Intensive Cardiac Rehabilitation Services ➤ 22 - Pulmonary Rehabilitation Services ➤ 8 - Primary Care Physician Services ➤ 9 – Chiropractic Services ➤ 17 - Occupational Therapy Services ➤ 8 - Physician Specialist Services ➤ 11 - Mental Health Specialty Services ➤ 10 – Podiatry Services ➤ 11 - Psychiatric Services ➤ 17 - Physical Therapy and Speech-Language Pathology Services ➤ 12 - Outpatient Substance Abuse ➤ 26 – Comprehensive Dental 	<p>You pay: \$40 copay</p>

OTHER PLAN INFORMATION

WHAT IS EMERGENCY/URGENTLY NEEDED CARE?

Emergency Services

- means covered inpatient or outpatient services that are: (a) furnished by a provider qualified to furnish emergency services; and (b) needed to evaluate or stabilize an emergency medical condition.

Urgently Needed Services

- means covered services provided when an enrollee is temporarily absent from the plan's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the plan's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable given the circumstances to obtain the services through the health plan.

LOCK-IN

You must use plan providers except in emergent or urgent care situations, or for out-of-area renal dialysis. If you obtain routine care from out-of-network plan providers, neither Medicare nor Florida Health Care Plans will be responsible for the costs, unless you choose the Optional Point of Service benefit.

ONLINE ENROLLMENT CENTER

Medicare beneficiaries may enroll in Florida Health Care Plans through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.medicare.gov.

LOW INCOME SUBSIDY PREMIUM DISCLAIMER

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week), or
- Your State Medicaid Office
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to seventy-five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

FOR MORE INFORMATION

For more information about Florida Health Care Plans please call:

386-676-7110 or 1-800-232-0578
(TTY/TDD #TRS Relay 711)

Hours of Operation:
7 days a week, 8 a.m. to 8 p.m.



This brochure is for information only and does not constitute an agreement

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