2018

Summary of benefits

FHCP's Premier Plan (HMO)
and
FHCP's Premier Plus Plan (HMO)

A Medicare Advantage HMO Plan

Brevard, Seminole and St. Johns Counties

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

H1035_NR829 (08/17/2017)

NOTES

Discrimination is Against the Law

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

Florida Health Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact Daria Siciliano, RN-BC, CCM.

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

Daria Siciliano, RN-BC, CCM,
Director of Member Services,
1340 Ridgewood Avenue,
Holly Hill, FL 32117.
1-844-219-6137, TTY: TRS Relay 711, 386-676-7149,
rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, Daria Siciliano, RN-BC, CCM Manager of Member Services 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.

If you or someone you're helping has questions about **Florida Health Care Plans**, you have the right to get help and information in your language at no cost. To talk to an interpreter, call **1-877-615-4022. (TTY: TRS Relay 711)**

Si usted o alguien a quien ayuda tienen preguntas sobre **Florida Health Care Plans**, tienen derecho a obtener ayuda e información en su idioma de manera gratuita. Para hablar con un intérprete, llame al **1-877-615-4022. (TTY: TRS Relay 711)**

Si ou menm, oswa yon moun w ap ede, gen kesyon sou **Florida Health Care Plans** ,ou gen dwa pou jwenn enfòmasyon nan lang ou gratis. Pou ale ak yon entèprèt, rele **1-877-615-4022. (TTY: TRS Relay 711)**

Nếu quý vị, hoặc người nào đó mà quý vị đang giúp đỡ, có các thắc mắc về **Florida Health Care Plans**, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của quý vị miễn phí. Để trao đổi với phiên dịch, hãy gọi theo số **1-877-615-4022. (TTY: TRS Relay 711)**

Se você, ou alguém que estiver a ajudar, tiver dúvidas sobre **Florida Health Care Plans**, tem o direito de obter ajuda e informações na sua língua, sem nenhumas custas. Para falar com um intérprete, ligue para **1-877-615-4022. (TTY: TRS Relay 711)**

如果您或您正協助的某人對**Florida Health Care Plans**
有疑問，您有權免費以您的語言取得本協助及資訊。如欲與口譯員交談，請致電**1-877-615-4022. (TTY: TRS Relay 711)**

Si vous ou une personne que vous aidez avez des questions au sujet de **Florida Health Care Plans**, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, veuillez appeler le **1-877-615-4022. (TTY: TRS Relay 711)**

Kung ikaw, o ang isang taong tinutulungan mo, ay may mga tanong tungkol sa **Florida Health Care Plans**, mayroon kang karapatang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang interpreter, tumawag sa **1-877-615-4022. (TTY: TRS Relay 711)**

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы о программе **Florida Health Care Plans**, Вы имеет право бесплатно получить ответы в переводе на Ваш язык. Для того чтобы воспользоваться помощью устного переводчика, позвоните по телефону **1-877-615-4022. (TTY: TRS Relay 711)**

ذا كان لديك أو الشخص الذي تساعده استفسارات حول [**Florida Health Care Plans**, يحق لك تلقي المساعدة والمعلومات بلغتك مجاناً. تحدث إلى مترجم فوري، اتصل على الرقم [**1-877-615-4022. (TTY: TRS Relay 711)**].

se voi, o una persona che state aiutando, avete domande relative al **Florida Health Care Plans**, avete diritto a ottenere assistenza e informazioni gratuitamente nella vostra lingua. Per parlare con un interprete, chiamare il numero **1-877-615-4022. (TTY: TRS Relay 711)**

Falls Sie oder jemand, dem Sie helfen, irgendwelche Fragen über **Florida Health Care Plans** haben, so haben Sie Anspruch auf kostenlose Unterstützung und Informationen in Ihrer eigenen Sprache. Bitte rufen Sie uns unter der Nummer **1-877-615-4022. (TTY: TRS Relay 711)** an, um mit einem Dolmetscher/einer Dolmetscherin zu sprechen.

귀하 또는 귀하가 도와드리고 있는 분이**Florida Health Care Plans**에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결되려면**1-877-615-4022. (TTY: TRS Relay 711)** 번으로 전화해 주십시오.

Jeśli Ty lub ktoś, komu pomagasz macie pytania dotyczące **Florida Health Care Plans**, macie prawo uzyskać pomoc i informacje w swoim języku, bez żadnych kosztów. Porozmawiaj z tłumaczem, zadzwoń pod numer **1-877-615-4022. (TTY: TRS Relay 711)**

જો તમને અથવા તમે જેને મદદ કરી રહ્યાં છો તેમને **Florida Health Care Plans** વિશે કોઈ પ્રશ્નો હોય, તો તમને તમારી ભાષામાં કોઇ પણ ખર્ચ વિના મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે **1-877-615-4022. (TTY: TRS Relay 711)** પર ફોન કરો.

หากคุณ หรือคนที่คุณกำลังช่วยเหลืออยู่มีคำถามเกี่ยวกับ **Florida Health Care Plans** คุณจะได้รับการช่วยเหลือและได้รับข้อมูลในภาษาของคุณโดยที่ไม่มีค่าใช้จ่ายใดๆ หากต้องการพูดคุยกับล่ามแปลภาษา โทร.

1-877-615-4022. (TTY: TRS Relay 711)

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Summary of Benefits

January 1, 2018 - December 31, 2018

FHCP's Premier Plan (HMO)
H1035, Plan 010
FHCP's Premier Plus Plan (HMO)
H1035**,** Plan 011

This booklet gives you a summary of health and drug plan services that we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage".

Who can join?
To join **FHCP's Premier Plan (HMO) and FHCP's Premier Plus Plan (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: Brevard, Seminole and St. Johns.

Which doctors, hospitals, and pharmacies can I use?
FHCP's Premier Plan (HMO) and FHCP's Premier Plus Plan (HMO) has an extensive network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider/pharmacy directory at our website, ***www.fhcp.com/medicare_2018_MAPDdirectory*.** Or, call us and we will send you a copy of the provider/pharmacy directory.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, ***www.fhcp.com/medicare_2018_formulary*.** Or, call us and we will send you a copy of the formulary.

Things to Know About FHCP
Hours of Operation
You can call us 7 days a week from 8 a.m. to 8 p.m. Eastern Standard time.

FHCP's Phone Numbers and Website
- If you are a member of this plan, call toll-free *1-877-615-4022*. Hearing Impaired call TRS Relay 711.
- If you are not a member of this plan, call toll-free *1-855-Go2FHCP (1-855-462-3427)*. Hearing Impaired call TRS Relay 711.
- Our website: *www.fhcp.com/fhcp-medicare*

NOTES

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

Florida Health Care Plans (FHCP) is an HMO with a Medicare contract. Enrollment in Florida Health Care Plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitation, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. This document is available in other formats such as Braille and large print.

SUMMARY OF BENEFITS

January 1, 2018 – December 31, 2018

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010	FHCP's Premier Plus Plan (HMO) PBP 011
MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS		
Monthly Plan Premium	$0 per month. You must keep paying your Medicare Part B premium.	$24 per month. You must keep paying your Medicare Part B premium.
Deductible Medical Pharmacy (Part D)	This plan does not have a deductible. $0 per year	This plan does not have a deductible. $0 per year
Maximum Out-of-pocket Responsibility (does not include prescription drugs)	$6,700 annually The most you pay for copays, coinsurance and other costs for medical services for the year.	$4,000 annually The most you pay for copays, coinsurance and other costs for medical services for the year.
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital Coverage	➢ $245 copay per day for days 1 through 7 ➢ $0 copay per day for days 8 through 90 ➢ $0 copay per day for days 91 and beyond You pay the Inpatient Hospital copayments each time you're admitted to a hospital, no matter how many days have passed since your last admission. Authorization rules may apply.	➢ $200 copay per day for days 1 through 7 ➢ $0 copay per day for days 8 through 90 ➢ $0 copay per day for days 91 and beyond You pay the Inpatient Hospital copayments each time you're admitted to a hospital, no matter how many days have passed since your last admission. Authorization rules may apply.
Outpatient Hospital Coverage Outpatient Hospital Ambulatory Surgical Center	 $300 copay $250 copay Authorization rules may apply.	 $200 copay $150 copay Authorization rules may apply.
Doctor Visits Primary Specialists	 $0 copay per visit $40 copay per visit A copay will apply for No-show Specialist visits. Authorization rules may apply.	 $0 copay per visit $20 copay per visit A copay will apply for No-show Specialist visits. Authorization rules may apply.

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010	FHCP's Premier Plus Plan (HMO) PBP 011
Preventive Care	$0 copay Please contact FHCP's Marketing Department and ask for a copy of Chapter 4 from the 2018 Evidence of Coverage. Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Preventive Services are covered in full when received by an FHCP participating provider.	$0 copay Please contact FHCP's Marketing Department and ask for a copy of Chapter 4 from the 2018 Evidence of Coverage. Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Preventive Services are covered in full when received by an FHCP participating provider.
Emergency Care	$80 copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Emergency care is available worldwide.	$80 copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Emergency care is available worldwide.
Urgently Needed Services Urgent Care Center	$40 copay per visit Urgently needed services are available worldwide.	$20 copay per visit Urgently needed services are available worldwide.
Diagnostic Services/Labs/Imaging Diagnostic Radiology Services (such as MRIs, CT scans) Diagnostic Tests and Procedures Lab Services Outpatient X-rays Therapeutic Radiology Services (such as radiation treatment for cancer)	$10-275 copay, depending on the service $0-300 copay, depending on the service $0 copay $10 copay $10-50 copay, depending on the service	$10-175 copay, depending on the service $0-200 copay, depending on the service $0 copay $10 copay $10-50 copay, depending on the service

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010	FHCP's Premier Plus Plan (HMO) PBP 011
Diagnostic Services/Labs/Imaging, continued	Please contact FHCP's Marketing Department and ask for a copy of Chapter 4 from the 2018 Evidence of Coverage. Authorization rules may apply.	Please contact FHCP's Marketing Department and ask for a copy of Chapter 4 from the 2018 Evidence of Coverage. Authorization rules may apply.
Hearing Services Exam to diagnose and treat hearing and balance issues	$0 copay per visit	$0 copay per visit
Routine hearing exam (up to 1 every year)	$0 copay per visit	$0 copay per visit
Hearing aid fitting/evaluation (up to 1 every year)	$0 copay per visit	$0 copay per visit
Dental Services Preventive Dental	Not covered	Not covered
Limited Dental Services	$40 copay per visit Limited dental services do not include services in connection with care, treatment, filling, removal, or replacement of teeth. Authorization rules may apply.	$20 copay per visit Limited dental services do not include services in connection with care, treatment, filling, removal, or replacement of teeth. Authorization rules may apply.
Vision Services Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$15-40 copay, depending on the service	$15-20 copay, depending on the service
Eyeglasses or contact lenses after cataract surgery	$0 copay	$0 copay
Routine eye exam (up to 1 every year when performed by an Optometrist)	$15 copay per visit	$15 copay per visit
Eyeglasses (frames and lenses) up to 1 every two years.	Plan pays up to $90 every two years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist.	Plan pays up to $90 every two years toward the purchase of eyeglasses (lenses and frames) from a participating Optometrist.

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010	FHCP's Premier Plus Plan (HMO) PBP 011
Mental Health Services Outpatient therapy visits Group Individual Inpatient visit	 $40 copay per visit $40 copay per visit ➢ $245 copay per day for days 1 through 6 ➢ $0 copay per day for days 7 through 90 ➢ $0 copay per day for days 91 and beyond You pay the Inpatient Hospital Psychiatric copayments each time you're admitted to a hospital, no matter how many days have passed since your last admission. Authorization rules may apply.	 $20 copay per visit $20 copay per visit ➢ $200 copay per day for days 1 through 7 ➢ $0 copay per day for days 8 through 90 ➢ $0 copay per day for days 91 and beyond You pay the Inpatient Hospital Psychiatric copayments each time you're admitted to a hospital, no matter how many days have passed since your last admission. Authorization rules may apply.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. ➢ $0 copay per day for days 1 through 20 ➢ $160 copay per day for days 21 through 100 No prior hospital stay required. When admitted to a Skilled Nursing Facility (SNF), you're covered as defined by Original Medicare guidelines. FHCP does not cover custodial care. FHCP follows Original Medicare guidelines in determining authorization and benefit period for SNF services. Authorization rules may apply.	Our plan covers up to 100 days in a SNF. ➢ $0 copay per day for days 1 through 20 ➢ $160 copay per day for days 21 through 100 No prior hospital stay required. When admitted to a Skilled Nursing Facility (SNF), you're covered as defined by Original Medicare guidelines. FHCP does not cover custodial care. FHCP follows Original Medicare guidelines in determining authorization and benefit period for SNF services. Authorization rules may apply.
Physical Therapy	$30 copay per visit Authorization rules may apply.	$20 copay per visit Authorization rules may apply.
Ambulance	$275 copay Emergency transportation services are available worldwide. Non-emergency transportation must be pre-authorized by FHCP.	$175 copay Emergency transportation services are available worldwide. Non-emergency transportation must be pre-authorized by FHCP.

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010	FHCP's Premier Plus Plan (HMO) PBP 011
Transportation	Not covered	Not covered
Medicare Part B Drugs Chemotherapy drugs Other Part B drugs When administered in a Dialysis Center	20% of the cost 20% of the cost 20% of the cost Part B drugs are available at FHCP In-network Preferred Retail Pharmacies only, up to a 31-day supply, OR when administered by an in-network physician or an out-of-network physician.	20% of the cost 20% of the cost 20% of the cost Part B drugs are available at FHCP In-network Preferred Retail Pharmacies only, up to a 31-day supply, OR when administered by an in-network physician or an out-of-network physician.
ADDITIONAL MEDICAL BENEFITS		
Foot Care (podiatry services) Medicare-covered foot exams and treatment Routine foot care	$40 copay per visit $10 copay per visit Routine foot care is covered for individuals with diabetes or other conditions that result in damage to the nerve and blood supply of their feet, or poor circulation in the feet (i.e. cutting or removal of corns, warts, calluses or nails). Limited to 6 visits per year.	$20 copay per visit $10 copay per visit Routine foot care is covered for individuals with diabetes or other conditions that result in damage to the nerve and blood supply of their feet, or poor circulation in the feet (i.e. cutting or removal of corns, warts, calluses or nails). Limited to 6 visits per year.
Medical Equipment/Supplies Durable Medical Equipment (e.g., wheelchairs, oxygen, etc.) Prosthetic Devices (braces, artificial limbs, etc.) and related medical supplies Diabetic supplies: 50 Test Strips/sensors Lancets Glucometer Therapeutic shoes or inserts	20% of the cost 20% of the cost $10 copay $10 copay $0 copay 20% of the cost	20% of the cost 20% of the cost $10 copay $10 copay $0 copay 20% of the cost

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010	FHCP's Premier Plus Plan (HMO) PBP 011
Medical Equipment/Supplies, continued	Diabetic Supplies/Services are limited to specific manufacturers, products and/or brands issued by participating pharmacies and DME suppliers. Contact FHCP for additional information. Authorization rules may apply.	Diabetic Supplies/Services are limited to specific manufacturers, products and/or brands issued by participating pharmacies and DME suppliers. Contact FHCP for additional information. Authorization rules may apply.
Outpatient Rehabilitation Services Occupational therapy visit Speech and language therapy visit Pulmonary rehab services Cardiac (heart) rehab services - For a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks.	 $30 copay per visit $30 copay per visit $30 copay per session $30 copay per session Authorization rules may apply.	 $20 copay per visit $20 copay per visit $20 copay per session $20 copay per session Authorization rules may apply.
Wellness Programs (e.g. fitness) Preferred Fitness Program Telemedicine Primary Care Psychologist Acute Low Back and Neck Pain Program	 $0 copay per visit $10 copay per visit $30 copay per visit $30 copay per visit For additional Wellness programs, please contact FHCP's Marketing Department and ask for a copy of Chapter 4 from the 2018 Evidence of Coverage.	 $0 copay per visit $10 copay per visit $30 copay per visit $20 copay per visit For additional Wellness programs, please contact FHCP's Marketing Department and ask for a copy of Chapter 4 from the 2018 Evidence of Coverage.

Premiums and Benefits	FHCP's Premier Plan (HMO) PBP 010		FHCP's Premier Plus Plan (HMO) PBP 011	
OUTPATIENT PRESCRIPTION DRUGS				
Part D Deductible	$0 per year		$0 per year	
Initial Coverage				
	You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.		You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.	
	STANDARD Retail Cost-Sharing		**STANDARD Retail Cost-Sharing**	
	One-month supply	**Three-month supply**	**One-month supply**	**Three-month supply**
Tier 1 – Preferred Generic	$10 copay	$30 copay	$10 copay	$30 copay
Tier 2 – Generic	$20 copay	$60 copay	$20 copay	$60 copay
Tier 3 – Preferred Brand	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4 – Non-Preferred Brand	$100 copay	$300 copay	$100 copay	$300 copay
Tier 5 – Injectable Drugs	33% coinsurance	Not Offered	33% coinsurance	Not Offered
Tier 6 – Specialty	33% coinsurance	Not Offered	33% coinsurance	Not Offered
	PREFERRED Retail Cost-Sharing		**PREFERRED Retail Cost-Sharing**	
	One-month supply	**Three-month supply**	**One-month supply**	**Three-month supply**
Tier 1 – Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 – Generic	$7 copay	$21 copay	$7 copay	$21 copay
Tier 3 – Preferred Brand	$42 copay	$126 copay	$42 copay	$126 copay
Tier 4 – Non-Preferred Brand	$90 copay	$270 copay	$90 copay	$270 copay
Tier 5 – Injectable Drugs	25% coinsurance	Not Offered	25% coinsurance	Not Offered
Tier 6 – Specialty	33% coinsurance	Not Offered	33% coinsurance	Not Offered
	STANDARD MAIL ORDER Cost-Sharing		**STANDARD MAIL ORDER Cost-Sharing**	
	Three-month supply		**Three-month supply**	
Tier 1 – Preferred Generic	$0 copay		$0 copay	
Tier 2 – Generic	$18 copay		$18 copay	
Tier 3 – Preferred Brand	$123 copay		$123 copay	
Tier 4 – Non-Preferred Brand	$267 copay		$267 copay	
	You may get drugs at FHCP's network Preferred and Standard Retail pharmacies, as well as, FHCP's Standard Mail Order pharmacy.		You may get drugs at FHCP's network Preferred and Standard Retail pharmacies, as well as, FHCP's Standard Mail Order pharmacy.	

<table>
<tr><th>Premiums and Benefits</th><th>FHCP's Premier Plan
(HMO)
PBP 010</th><th>FHCP's Premier Plus Plan
(HMO)
PBP 011</th></tr>
<tr><td></td><td>➢ Preferred Retail is defined as FHCP's In-house Pharmacies
➢ Standard Retail is defined as select contracted Walgreens Pharmacies
➢ Standard Mail Order is defined as FHCP's Mail Order Pharmacy

If you reside in a long-term care facility, you pay the same cost-sharing as at a Standard Retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</td><td>➢ Preferred Retail is defined as FHCP's In-house Pharmacies
➢ Standard Retail is defined as select contracted Walgreens Pharmacies
➢ Standard Mail Order is defined as FHCP's Mail Order Pharmacy

If you reside in a long-term care facility, you pay the same cost-sharing as at a Standard Retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</td></tr>
<tr><td>Coverage Gap</td><td colspan="2"></td></tr>
<tr><td></td><td>During this stage, you pay 35% of the negotiated price (plus a portion of the dispensing fee) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 44% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare.</td><td>During this stage, you pay 35% of the negotiated price (plus a portion of the dispensing fee) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. For generic drugs, you pay whichever is lower:

<table>
<tr><th colspan="2">STANDARD Retail
Cost-Sharing</th></tr>
<tr><td colspan="2">Tier 1 – Preferred Generic</td></tr>
<tr><td>One month supply</td><td>$10 copay</td></tr>
<tr><td>Three month supply</td><td>$30 copay</td></tr>
<tr><td colspan="2">Tier 2 – Generic</td></tr>
<tr><td>One month supply</td><td>$20 copay</td></tr>
<tr><td>Three month supply</td><td>$60 copay</td></tr>
<tr><th colspan="2">PREFERRED Retail
Cost-Sharing</th></tr>
<tr><td colspan="2">Tier 1 – Preferred Generic</td></tr>
<tr><td>One month supply</td><td>$0 copay</td></tr>
<tr><td>Three month supply</td><td>$0 copay</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Premiums and Benefits</th><th>FHCP's Premier Plan
(HMO)
PBP 010</th><th colspan="2">FHCP's Premier Plus Plan
(HMO)
PBP 011</th></tr>
<tr><td rowspan="11"></td><td rowspan="11"></td><td colspan="2">Tier 2 – Generic</td></tr>
<tr><td>One month supply</td><td>$7 copay</td></tr>
<tr><td>Three month supply</td><td>$21 copay</td></tr>
<tr><td colspan="2">STANDARD MAIL ORDER
Cost-Sharing</td></tr>
<tr><td colspan="2">Tier 1 – Preferred Generic</td></tr>
<tr><td>Three month supply</td><td>$0 copay</td></tr>
<tr><td colspan="2">Tier 2 – Generic</td></tr>
<tr><td>Three month supply</td><td>$18 copay</td></tr>
<tr><td colspan="2">OR

You pay no more than 44% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Catastrophic Coverage</td><td colspan="3"></td></tr>
<tr><td></td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:
➢ 5% of the cost, or
➢ $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copayment for all other drugs.</td><td colspan="2">After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:
➢ 5% of the cost, or
➢ $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copayment for all other drugs.</td></tr>
</table>

FOR MORE INFORMATION ABOUT FLORIDA HEALTH CARE PLANS, PLEASE CALL:

1-855-Go2FHCP (1-855-462-3427)
(TTY# TRS Relay 711)

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

Service Area:
Brevard, Seminole and St. Johns Counties, Florida

Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

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

Florida Health Care Plans is an HMO plan with a Medicare contract.
Enrollment in Florida Health Care Plans depends on contract renewal.