Florida Complete Care- In The Community-(HMO I-SNP) **offered by Florida Complete Care**

Annual Notice of Changes for 2023

You are currently enrolled as a member of Florida Complete Care- In The Community. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at https://fc2healthplan.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Florida Complete Care- In The Community.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Florida Complete Care- In The Community.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-833-FC2-PLAN (1-833-322-7526 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. seven days a week (except Thanksgiving and Christmas) from Oct. 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday (except federal holidays) from April 1 - Sept. 30.
- This information is available in different formats, including braille, large print, and audio. Please call Member Services at the number listed above if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Florida Complete Care- In The Community - (HMO I-SNP)

- Florida Complete Care is an HMO I-SNP plan with a Medicare contract. Enrollment in Florida Complete Care depends on contract renewal.
- When this document says "we," "us," or "our," it means Florida Complete Care. When it says "plan" or "our plan," it means Florida Complete Care- In The Community (HMO I-SNP).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Florida Complete Care-In The Community in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$34.30	$35.90
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered : Part A and Part B services. (See Section 1.2 for details.)	$3400	$3400
Doctor office visits	Primary care visits: 20 % coinsurance per visit Specialist visits: 20% coinsurance per visit	Primary care visits: $0 per visit Specialist visits: 20% coinsurance per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	• $1556 deductible • Days 1–60: $0 copay • Days 61–90: $389 copay per day • Days 91 and beyond: $778 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: all costs.	• $1600 deductible • Days 1–60: $0 copay • Days 61–90: $400 copay per day • Days 91 and beyond: $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: all costs.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $480 25% Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4430.00	Deductible: $505 25% Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4660.00

SECTION 1 Changes to Benefit and Cost for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$34.30	$35.90

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

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

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

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3400	$3400 Once you have paid $3400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.FC2healthplan.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Podiatry (Supplemental Benefit)	Podiatry (Supplemental Benefit) is not covered.	Podiatry (Supplemental Benefit): **$0 copayment** Six (6) visits per year to a network specialist. Covered supplemental services include: • Paring or cutting of benign hyperkeratotic lesions (e.g., corn, wart, callus) • Trimming or debridement of nails ***Authorization is only required for standard Medicare benefit, not for routine foot care.***

Cost	2022 (this year)	2023 (next year)
Over the Counter (OTC)	$250 per quarter	$275 per quarter
Chiropractic Services	*Authorization not required*	*Authorization is required*
Psychiatric Services	*Authorization not required*	*Authorization is required*
Additional Telehealth Services	You pay 20% of the total cost for all types of telehealth visits (including Primary Care physician (PCP) visits)	You pay 0% for Primary Care Physician (PCP) telehealth visits. You pay 20% for all other types of telehealth visits
Outpatient Diagnostic Procedures, Tests and Lab Services	*Authorization not required*	*Authorization is required for some procedures/test in certain settings*
Outpatient Hospital Services	*Authorization not required*	*Authorization is required*
Outpatient Blood Services	*Authorization not required*	*Authorization is required*
Diabetic Supplies	*Authorization not required*	*Authorization is required for non-preferred diabetic supplies*
Diabetic Services and Diabetic Therapeutic Shoes or Inserts	*Authorization not required*	*Authorization is required*

Cost	2022 (this year)	2023 (next year)
Skilled Nursing Facility (SNF)	20% Coinsurance For each stay per benefit period: • Days 1-20: $0 copay • Days 21-100: $194.50 copay per day • Days 101 and beyond: All costs.	No Coinsurance
Meals	*Authorization not required* • Meals offered for a medical condition that requires the enrollee to remain at home for a period of time are provided in a 5-day pack of shelf stable meals available up to two times per year. The 5-day pack includes 10 total meals. • Meals offered following discharge from a SNF or hospital setting are provided up 2 meals per day for 14 days once per year.	*Authorization is required* Immediately following surgery, inpatient hospitalization, or for members determined to be frail, the following meal benefits are provided: • Meals offered for emergency situations. 5-day pack of shelf stable meals available up to two times per year (2 meals per day, total of 20 meals per year). • Frozen meals offered for up to 14 days following discharge from a SNF or hospital setting (2 meals per day, total of 28 meals per year).

Cost	2022 (this year)	2023 (next year)
Medically Tailored Meals - Special Supplemental Benefit for the Chronically Ill (SSBCI)	*Authorization is not required* Benefit includes frozen meals tailored specifically to the member's dietary needs or restrictions for up to 30 days (3 meals per day, total of 90 meals per year). Benefit provided to members who are determined to be frail.	*Authorization is required* Benefit includes frozen meals tailored specifically to the member's dietary needs or restrictions for up to 30 days (3 meals per day, total of 90 meals per year). Benefit applies to the following conditions: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke

Cost	2022 (this year)	2023 (next year)
Fresh Produce Box – Special Supplemental Benefit for the Chronically Ill (SSBCI)	$0.00 copay for qualifying members. Members are eligible for a fresh produce box delivered once per month for three months following the completion of the 30 days of frozen meals. Benefit provided to members who are determined to be frail.	$0.00 copay for qualifying members. Members are eligible for a fresh produce box delivered once per month for three months following the completion of the 30 days of frozen meals. Benefit applies to the following conditions: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke

Cost	2022 (this year)	2023 (next year)
Legal Aid – Special Supplemental Benefit for Chronically Ill (SSBCI)	$0.00 copay for assistance with legal services to obtain a power of attorney for healthcare decisions. Covers legal fees up to $250.00 once per lifetime. Benefit provided to members who are determined to be frail.	$0.00 copay for assistance with legal services to obtain a power of attorney for healthcare decisions. Covers legal fees up to $250.00 once per lifetime. Benefit applies to the following conditions: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke
Dental	*Authorization not required*	*Authorization is required*

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can

immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included OR sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help", please call Member Services and ask for the "LIS Rider."

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, even if you haven't paid your deductible.

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your: Part D drugs until you have reached the yearly deductible.	The deductible is $480	The deductible is $505

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1:** You pay 25 % of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1:** You pay 25% of the total cost.
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs your *Evidence of Coverage*.	Once $4430, you will move to the next stage (the Coverage Gap Stage).	Once $4660, you will move to the next stage (the Coverage Gap Stage).

	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply at a network pharmacy: **Tier 1:** Standard cost sharing: You pay 25% of the total cost. Once your total drug costs have reached $4430, you will move to the next stage (the Coverage Gap Stage). OR you have paid $7050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply at a network pharmacy: **Tier 1:** Standard cost sharing: You pay 25% of the total cost. Once your total drug costs have reached $4660, you will move to the next stage (the Coverage Gap Stage). OR you have paid $7400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Florida Complete Care-In The Community

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Florida Complete Care-In The Community.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Florida Complete Care-In The Community.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Florida Complete Care-In The Community.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so (phone numbers are in Section 7.1 of this booklet)
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

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

SECTION 4 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *Serving Health Insurance Needs of Elders (SHINE)* counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can

call *Serving Health Insurance Needs of Elders (SHINE)* at the number listed in "Exhibit A“ in the back of this booklet. You can learn more about Serving Health Insurance Needs of Elders (SHINE) by visiting their website listed in "Exhibit A“ in the back of this booklet.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida ADAP Program and HIV/AIDS Section. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP program (the name and phone numbers for this organization are in "Exhibit A “in the back of this booklet).

SECTION 6 Questions?

Section 6.1 – Getting Help from Florida Complete Care-In The Community

Questions? We’re here to help. Please call Member Services at 1-833-FC2-PLAN (1-833-322-7526). (TTY only, call 711). We are available for phone calls 8 a.m. to 8 p.m. seven days a week (except Thanksgiving and Christmas) from Oct. 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday (except federal holidays) from April 1 - Sept. 30. Calls to these numbers are free.

Read your *2023 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage for Florida Complete Care-In The*

Community. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at https://fc2healthplan.com/. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at https://fc2healthplan.com/. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in this Annual Notice of Changes. If you have trouble locating the information you seek, please contact Member Services at the phone number on the back cover of this booklet.

Florida	
SHIP Name and Contact Information	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way Suite 270 Tallahassee, FL 32399-7000 1-800-963-5337 (toll free) 1-800-955-8770 (TTY) 1-850-414-2150 (fax) http://www.floridaSHINE.org
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Florida Medicaid 2727 Mahan Drive Tallahassee, FL 32308 1-877-711-3662 (toll free) 1-850-412-3600 (local) 1-866-886-4342 (fax) http://www.ahca.myflorida.com
AIDS Drug Assistance Program	Florida ADAP Program HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (Spanish) 1-800-2437-101 (1-800-AIDS-101) (Creole) 1-888-503-7118 (TTY) http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html