2018 Summary of Benefits

BlueMedicare Select (PPO) H5434-002

Bay, Broward, Charlotte, Collier, Duval, Escambia, Highlands, Hillsborough, Lee, Manatee, Marion, Orange, Osceola, Palm Beach, Pinellas, Santa Rosa and St. Lucie

Florida Blue

Y0011_33826 0817 CMS Accepted

BlueMedicare Select (PPO)

Summary of Benefits

January 1, 2018 - December 31, 2018

This booklet provides a summary of what BlueMedicare Select (PPO) covers. It also explains what you pay for covered services and supplies. To get a complete list of services and supplies we cover, contact your local agent or call our Customer Service Department. You may also view the "Evidence of Coverage" for this plan on our website, **www.BlueMedicareFL.com.** The Evidence of Coverage includes a complete list of services we cover.

Things to Know About BlueMedicare Select (PPO)

Eligibility requirements

To join, you must:

- be entitled to Medicare Part A; and
- be enrolled in Medicare Part B; and
- live in our service area.

Our service area includes the following counties in Florida: Bay, Broward, Charlotte, Collier, Duval, Escambia, Highlands, Hillsborough, Lee, Manatee, Marion, Orange, Osceola, Palm Beach, Pinellas, Santa Rosa and St. Lucie.

Which doctors, hospitals and pharmacies can I use?

We have a network of doctors, hospitals and other providers. With a PPO plan you can use both in-network and out-of-network providers. You will usually pay less money for your covered services if you use providers in our network. And you can rest easy knowing that we've got you covered at home and when you're away. If you need emergency care, urgent care or dialysis, you will pay in-network cost sharing for services you receive from out-of-network providers.

In most situations, you must use our network pharmacies to fill your prescriptions for covered Part D drugs.

You may save money by using a **preferred** retail pharmacy instead of a **standard** one. You can also use our mail order pharmacy to have your prescription delivered to your home.

Find doctors, pharmacies and our comprehensive formulary (list of covered Part D drugs) on our website, **www.BlueMedicareFL.com.**

What do we cover?

Our plan includes *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

Our plan members also get *more than what is covered* by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Medicare Part D drugs. In addition, we cover drugs covered under Medicare Part B, such as chemotherapy drugs and certain other drugs your doctor gives you.

Hours of Operation

From October 1 to February 14 we're open 8 a.m. - 8 p.m. local time, 7 days a week.

From February 15 to September 30, we're open 8 a.m. - 8 p.m. local time, Monday through Friday.

Phone Numbers and Website

If you are a current member of this plan, call 1-800-926-6565

If you are not currently a member of this plan, call 1-855-601-9465

TTY users: Call 1-800-955-8770

Our website: **www.BlueMedicareFL.com**

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 **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.

This document is available in other formats such as Braille and large print.

This information is available for free in other languages. Please call our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 to February 14, except for Thanksgiving and Christmas. From February 15 to September 30, we are open Monday - Friday, 8:00 a.m. – 8:00 p.m., local time.

Esta información está disponible de manera gratuita en otros idiomas. Comuníquese con Atención al cliente al 1-800-926-6565. (Usuarios de equipo telescritor TTY llamen al 1-877-955-8773.) Estamos abiertos de 8:00 a.m. a 8:00 p.m. hora local los siete días de la semana, desde el 1 de octubre hasta el 14 de febrero, excepto el día de Acción de Gracias (Thanksgiving) y el día de Navidad. Desde el 15 de febrero al 30 de septiembre, estamos abiertos de lunes a viernes de 8:00 a.m. a 8:00 p.m. hora local.

Florida Blue is a PPO plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat BlueMedicare PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Premiums and Benefits	BlueMedicare Select (PPO)
Monthly Plan Premium	You pay $147.80. You must continue to pay your Medicare Part B premium.
Deductible	$295 per year *for Part D prescription drugs*.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $5,900 for services from in-network providers. • $10,000 for services from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, we will pay the full cost of covered medical services and supplies for the rest of the year. You will still need to pay your monthly plan premium. **Note:** (*Amounts you pay for Part D drugs and dental and vision services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.)*
Inpatient Hospital Coverage	***Prior Authorization is required for non-emergency Inpatient Hospital stays.*** In-Network • Days 1-7: $225 copay per day • After day 7: You pay nothing. Out-of-Network • Days 1-27: $200 copay per day • Days 28-90: You pay nothing.
Outpatient Hospital Coverage	In-Network • Up to a $120 copayment Please call us or see the plan's Evidence of Coverage for specific cost-sharing for services received in an outpatient hospital setting. Out-of-Network • 40% coinsurance
Doctor Visits	In-Network • $5 copay per primary care visit • $45 copay per specialist visit Out-of-Network 40% of the Medicare-allowed amount for primary care and specialist visits

Premiums and Benefits	BlueMedicare Select (PPO)
Preventive Care	In-Network You pay nothing. Out-of-Network 40% of the Medicare-allowed amount Covered preventive services include: • Alcohol misuse screening and counseling • Annual "Wellness" visit • Bone mass measurements • Cardiovascular disease screening tests • Colorectal cancer screening • Counseling to prevent Tobacco use • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening • Hepatitis B Virus screening • Hepatitis B Virus vaccine and administration • Hepatitis C Virus screening • Human Immunodeficiency Virus screening • Influenza virus vaccine and administration • Initial preventive physical examination • Intensive behavioral therapy for cardiovascular disease • Intensive behavioral therapy for obesity • Lung cancer screening • Medical nutrition therapy • Pneumococcal vaccine and administration • Prostate cancer screening • Screening for Cervical Cancer with human Papillomavirus tests • Screening for sexually transmitted infections (STIs) and HIBC to prevent STIs • Screening mammography • Screening pap tests • Screening pelvic examinations • Ultrasound screening abdominal aortic aneurysm Any additional preventive services approved by Medicare during the contract year will be covered by our plan or Original Medicare.

Premiums and Benefits	BlueMedicare Select (PPO)
Emergency Care	**Medicare Covered Emergency Care** In- and Out-of-Network $80 copay per visit If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. **Additional Emergency Care Services** Worldwide Emergency Care $125 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.** If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	**Medicare Covered Urgently Needed Services** In- and Out-of-Network • $10 copay at a Convenient Care Center • $25 copay at an Urgent Care Center **Additional Urgently Needed Services** Worldwide Urgently Needed Services $125 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.**
Diagnostic Services/Labs/Imaging	***Prior Authorization is required for certain services. Call Member Services for additional information.*** **Laboratory Services** In-Network • You pay nothing at an Independent Clinical Laboratory. • $10 copay at an outpatient hospital facility Out-of-Network 40% of the Medicare-allowed amount **X-Rays** In-Network • $50 copay at an Independent Diagnostic Testing Facility (IDTF) • $150 copay at an outpatient hospital facility Out-of-Network 40% of the Medicare-allowed amount **Advanced Imaging Services** (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) In-Network • $50 copay at a specialist's office • $100 copay at an IDTF • $150 copay at an outpatient hospital facility

Premiums and Benefits	BlueMedicare Select (PPO)
Diagnostic Services/Labs/Imaging (continued)	Out-of-Network 40% of the Medicare-allowed amount **Radiation Therapy** In-Network 20% coinsurance Out-of-Network 40% of the Medicare-allowed amount
Hearing Services	**Medicare-Covered Hearing Services** Exams to diagnose and treat hearing and balance issues: In-Network $45 copay Out-of-Network 40% of the Medicare-allowed amount **Routine Hearing Services In- and out-of-network.** • Routine hearing exam: $45 copay. • Up to 2 hearing aids per year for either a $699 or $999 copay per aid. • $0 copay for evaluation/fitting of hearing aids.
Dental Services	***Prior authorization is required for Medicare-covered comprehensive dental services.*** **Medicare-Covered Dental Services** (non-routine dental care such as setting fractures of the jaw or facial bones, jaw surgery, extraction of teeth to prepare for radiation therapy, services covered when provided by a physician) In-Network: $45 copay Out-of-Network: 40% of the Medicare-allowed amount **Additional Dental Services** (cleanings, oral exams, X-rays, extraction of erupted tooth or exposed root, adjustment of complete or partial denture) In-Network You pay nothing. Out-of-Network 50% of the cost

Premiums and Benefits	BlueMedicare Select (PPO)
Vision Services	**Medicare-Covered Vision Services** In-Network • $45 copay for physician services to diagnose and treat eye diseases and conditions • You pay nothing for glaucoma screening (once per year for members at high risk of glaucoma). • You pay nothing for diabetic retinal exams. • You pay nothing for one pair of eyeglasses or contact lenses after each cataract surgery. Out-of-Network 40% of the Medicare-allowed amount **Additional Vision Services** In-Network • $0 copay for one routine eye exam every 12 months. • $0 Copayment then a $100 Allowance per year towards the purchase of lenses, frames or contacts Out-of-Network • You receive up to $20 reimbursement for one routine eye exam every 12 months. • You receive up to $45 reimbursement per year towards the purchase of lenses, frames or contacts
Mental Health Services	***Prior authorization is required for non-emergency services.*** **Inpatient Mental Health Services** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental services provided in a general hospital. In-Network • Days 1-5: $318 copay per day • Days 6-90: You pay nothing. Out-of-network • Days 1-27: $200 copay per day • Days 28-90: You pay nothing. ***Prior authorization is required for non-emergency services.*** **Outpatient Mental Health Services** In-Network $40 copay Out-of-Network 40% of the Medicare-covered amount

Premiums and Benefits	BlueMedicare Select (PPO)
Skilled Nursing Facility (SNF)	***Prior authorization is required for SNF stays.*** Our plan covers up to 100 days in a SNF per benefit period. In-Network • Days 1-20: You pay nothing. • Days 21-100: $160 copay per day Out-of-Network 40% of the Medicare-allowed amount
Physical Therapy	***Prior authorization is required for all therapy services.*** Occupational, physical therapy and speech and language therapy visits In-Network $40 copay for services provided in any location Out-of-Network 40% of the Medicare-allowed amount A $1,980 yearly Medicare limit applies to outpatient physical and speech therapy services. This limit is for 2017 and may change in 2018. A separate $1,980 yearly Medicare limit applies to outpatient occupational therapy services. This limit is for 2017 and may change in 2018.
Ambulance	***Prior authorization is required for non-emergency ambulance services.*** In- and Out-of-Network $150 copay for each Medicare-covered trip (one-way)
Transportation (Routine)	Not covered
Medicare Part B Drugs	***Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.*** In-Network • $5 copay for allergy injections • 20% coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs Out-of-Network 50% of the Medicare-allowed amount
Foot Care *(podiatry services)*	Diagnosis and treatment of injuries and diseases of the feet. Routine care for members with certain conditions affecting the lower limbs. In-Network $35 copay Out-of-Network 40% of the Medicare-allowed amount

Premiums and Benefits	BlueMedicare Select (PPO)
Medical Equipment/Supplies	***Prior authorization is required for certain equipment/supplies. Call Member Services for additional information.*** **Durable Medical Equipment** In-Network • You pay nothing for equipment except motorized wheelchairs and electric scooters. • 20% coinsurance for motorized wheelchairs and electric scooters Out-of-Network 50% of the Medicare-allowed amount **Prosthetics** In-Network 20% coinsurance Out-of-Network 40% of the Medicare-allowed amount **Diabetic Supplies** In-Network You pay nothing. Out-of-Network 20% of the Medicare-allowed amount
Wellness Programs	• SilverSneakers® fitness program by Tivity Health. • Diabetes Prevention Program - An evidence-based program designed to delay or prevent participants' progression to type 2 diabetes. In- and Out-of-Network You pay nothing to participate in these programs.
Outpatient Surgery	***Prior authorization is required for non-emergency services.*** In-Network $150 copay Out-of-Network 40% of the Medicare-covered amount

<table>
<tr><th>Premium and Benefits</th><th colspan="4">BlueMedicare Select (PPO)</th></tr>
<tr><td colspan="5">Part D Prescription Drug Benefits</td></tr>
<tr><td rowspan="9">Deductible Stage
You begin in this payment stage when you fill your first prescription of the year.
During this stage, you pay the full cost of your drugs.
You stay in this stage until you have paid $295 for your drugs ($295 is the amount of your deductible).
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.
You remain in this stage until your total yearly drug costs (total drug costs paid by you and any Part D plan) reach $3,750.
You may get your drugs at network retail pharmacies and mail order pharmacies.</td><td colspan="4">Cost-Sharing for a one-month supply (up to 31 days) of a covered Part D prescription drug</td></tr>
<tr><td>Tier</td><td>Standard Retail</td><td>Preferred Retail</td><td>Mail Order</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$13 copay</td><td>$3 copay</td><td>$3 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$20 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$47 copay</td><td>$47 copay</td></tr>
<tr><td>Tier 4 (Non- Preferred Brand)</td><td>$100 copay</td><td>$100 copay</td><td>$100 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>27% of the cost</td><td>27% of the cost</td><td>27% of the cost</td></tr>
<tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td colspan="4">The cost-sharing information shown above is for a one-month supply of a covered Part D prescription drug purchased at a retail pharmacy (standard and preferred) and through our mail order pharmacy. Your cost-sharing may be different if you use a Long Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90) days) of a drug. Please call us or see the plan's "Evidence of Coverage" on our website (www.BlueMedicareFL.com) for complete information about your costs for covered drugs.</td></tr>
<tr><td>Coverage Gap Stage</td><td colspan="4">The Coverage Gap Stage begins after total yearly drug costs (what any Part D plan has paid and what you have paid) reach $3,750.
During the Coverage Gap Stage:
You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 6 (Select Care Drugs) or 44% of the cost, whichever is lower; and
For all other drugs, you pay 35% of the cost for covered brand name drugs (plus a portion of the dispensing fee) and 44% of the plan's cost for covered generic drugs.
You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $5,000.</td></tr>
<tr><td>Catastrophic Coverage Stage</td><td colspan="4">After your yearly out-of-pocket drug costs 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 copay for all other drugs</td></tr>
</table>