

2018 Summary of Benefits

BlueMedicare Choice (Regional PPO) R3332-001

State of Florida



Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.

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BlueMedicare Choice (Regional PPO)

Summary of Benefits

January 1, 2018 - December 31, 2018

This booklet provides a summary of what BlueMedicare Choice (Regional PPO) covers. It also explains what you pay for covered services and supplies. To get a complete list of services 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 Choice (Regional 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 is the entire State of Florida.

Which doctors, hospitals and pharmacies can I use?

We have a network of doctors, hospitals and other providers. With a Regional 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 an RPP0 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 Regional 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 | Blue Medicare Choice (Regional PPO) |
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| Monthly Plan Premium | You pay \$41.00. You must continue to pay your Medicare Part B premium. |
| Deductible | \$950 per year for out-of-network medical services. \$260 per year <i>for Part D prescription drugs.</i> |
| Maximum Out-of-Pocket Responsibility | Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$6,700 for services from in-network providers. • \$10,000 for services from in and out-of-network providers combined. <p>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.</p> <p>Note: (<i>Amounts you pay for Part D drugs and hearing and vision services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.</i>)</p> |
| Inpatient Hospital Coverage | <i>Prior Authorization is required for non-emergency Inpatient Hospital stays.</i> <u>In-Network</u> <ul style="list-style-type: none"> • Days 1-5: \$295 copay per day • After day 5: You pay nothing. <u>Out-of-Network</u> <ul style="list-style-type: none"> • Days 1-27: \$495 copay per day after the \$950 yearly out-of-network deductible • Days 28-90: You pay nothing. |
| Outpatient Hospital Coverage | <u>In-Network</u> <ul style="list-style-type: none"> • 20% coinsurance for surgeries • Up to a \$150 copayment for all other. Please call us or see the plan's Evidence of Coverage for specific cost-sharing for services received in an outpatient hospital setting <u>Out-of-Network</u> <ul style="list-style-type: none"> • OON Deductible then 50% coinsurance. |
| Doctor Visits | <u>In-Network</u> <ul style="list-style-type: none"> • \$10 copay per primary care visit • \$45 copay per specialist visit <u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible |

| Premiums and Benefits | Blue Medicare Choice (Regional PPO) |
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| <p>Preventive Care</p> | <p><u>In-Network</u> You pay nothing.</p> <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount</p> <p>Covered preventive services include:</p> <ul style="list-style-type: none"> • 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 <p>Any additional preventive services approved by Medicare during the contract year will be covered by our plan or Original Medicare.</p> |

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| Premiums and Benefits | Blue Medicare Choice (Regional PPO) |
| Emergency Care | <p>Medicare Covered Emergency Care <u>In- and Out-of-Network</u> \$80 copay per visit</p> <p>If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.</p> <p>Additional Emergency Care Services <u>Worldwide Emergency Care</u> \$125 copay</p> <p>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.</p> |
| Urgently Needed Services | <p>Medicare Covered Urgently Needed Services <u>In- and Out-of-Network</u></p> <ul style="list-style-type: none"> • \$10 copay at a Convenient Care Center • \$50 copay at an Urgent Care Center <p>Additional Urgently Needed Services <u>Worldwide Urgently Needed Services</u> \$125 copay</p> <p>Emergency coverage is provided worldwide. Worldwide emergency coverage does not include emergency transportation.</p> |
| Diagnostic Services/Labs/Imaging | <p><i>Prior Authorization is required for certain services. Call Member Services for additional information.</i></p> <p>Laboratory Services <u>In-Network</u></p> <ul style="list-style-type: none"> • You pay nothing at an Independent Clinical Laboratory. • \$40 copay at an outpatient hospital facility <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>X-Rays <u>In-Network</u></p> <ul style="list-style-type: none"> • \$50 copay at an Independent Diagnostic Testing Facility (IDTF) • \$150 copay at an outpatient hospital facility <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> |

| Premiums and Benefits | Blue Medicare Choice (Regional PPO) |
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| Diagnostic Services/Labs/Imaging (continued) | <p>Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan)</p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> • \$40 copay at a specialist’s office • \$40 copay at an IDTF • \$150 copay at an outpatient hospital facility <p><u>Out-of-Network</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>Radiation Therapy</p> <p><u>In-Network</u></p> <p>20% coinsurance</p> <p><u>Out-of-Network</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> |
| Hearing Services | <p>Medicare-Covered Hearing Services (a referral will be required from your Primary Care Provider (PCP) for a Medicare-Covered hearing exam)</p> <p>Exams to diagnose and treat hearing and balance issues:</p> <p><u>In-Network</u></p> <p>\$45 copay</p> <p><u>Out-of-Network</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>Routine Hearing Services In- and out-of-network.</p> <ul style="list-style-type: none"> • 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 | <p><i>Prior authorization is required for Medicare-covered comprehensive dental services.</i></p> <p>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)</p> <p><u>In-Network:</u></p> <p>\$45 copay</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> |

| Premiums and Benefits | Blue Medicare Choice (Regional PPO) |
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| <p>Vision Services</p> | <p>Medicare-Covered Vision Services</p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> • \$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. <p><u>Out-of-Network</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>Routine Vision Services</p> <p><u>In-Network</u></p> <p>Annual routine eye examination: \$0 copay</p> <p><u>Out-of-Network</u></p> <p>Annual routine eye examination: Up to \$25 reimbursement per year</p> |
| <p>Mental Health Services</p> | <p><i>Prior authorization is required for non-emergency services.</i></p> <p>Inpatient Mental Health Services</p> <p>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.</p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> • Days 1-5: \$318 copay per day • Days 6-90: You pay nothing. <p><u>Out-of-network</u></p> <ul style="list-style-type: none"> • Days 1-27: \$495 copay per day after the \$950 yearly out-of-network deductible • Days 28-90: You pay nothing. <p><i>Prior authorization is required for non-emergency services.</i></p> <p>Outpatient Mental Health Services</p> <p><u>In-Network</u></p> <p>\$40 copay</p> <p><u>Out-of-Network</u></p> <p>\$40 copay after the \$950 yearly out-of-network deductible</p> |

| Premiums and Benefits | Blue Medicare Choice (Regional PPO) |
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| Skilled Nursing Facility (SNF) | <p><i>Prior authorization is required for SNF stays.</i></p> <p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> • Days 1-20: You pay nothing. • Days 21-100: \$160 copay per day <p><u>Out-of-Network</u></p> <ul style="list-style-type: none"> • Days 1-58: \$250 copay per day after the \$950 yearly out-of-network deductible • Days 59-100: You pay nothing. |
| Physical Therapy | <p><i>Prior authorization is required for all therapy services.</i></p> <p>Occupational, physical therapy and speech and language therapy visits</p> <p><u>In-Network</u></p> <p>\$40 copay</p> <p><u>Out-of-Network</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>A \$1,980 yearly Medicare limit applies to outpatient physical and speech therapy services. This limit is for 2017 and may change in 2018.</p> <p>A separate \$1,980 yearly Medicare limit applies to outpatient occupational therapy services. This limit is for 2017 and may change in 2018.</p> |
| Ambulance | <p><i>Prior authorization is required for non-emergency ambulance services.</i></p> <p><u>In-Network</u></p> <p>\$225 copay for each Medicare-covered trip (one-way)</p> <p><u>Out-of-Network</u></p> <p>\$250 copay for each Medicare-covered trip (one-way)</p> |
| Transportation (Routine) | <p>Not covered</p> |
| Medicare Part B Drugs | <p><i>Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.</i></p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> • \$5 copay for allergy injections • 20% coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs <p><u>Out-of-Network</u></p> <p>50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> |

| Premiums and Benefits | Blue Medicare Choice (Regional PPO) |
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| Foot Care (<i>podiatry services</i>) | Diagnosis and treatment of injuries and diseases of the feet. Routine care for members with certain conditions affecting the lower limbs. <u>In-Network</u> \$40 copay <u>Out-of-Network</u> 50% of the cost after the \$950 yearly out-of-network deductible |
| Medical Equipment/Supplies | <p><i>Prior authorization is required for certain equipment/supplies. Call Member Services for additional information.</i></p> <p>Durable Medical Equipment <u>In-Network</u></p> <ul style="list-style-type: none"> You pay nothing for equipment except motorized wheelchairs and electric scooters. 20% coinsurance for motorized wheelchairs and electric scooters <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>Prosthetics <u>In-Network</u> 20% coinsurance</p> <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> <p>Diabetic Supplies <u>In-Network</u> You pay nothing.</p> <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> |
| Wellness Programs | <ul style="list-style-type: none"> SilverSneakers[®] fitness program by Tivity Health. Diabetes Prevention Program - An evidence-based program designed to delay or prevent participants' progression to type 2 diabetes. <p><u>In- and Out-of-Network</u> You pay nothing to participate in a fitness program or a Diabetes Prevention Program.</p> |
| Outpatient Surgery | <p><i>Prior authorization is required for non-emergency services.</i></p> <p><u>In-Network</u> \$120 copay at an Ambulatory Surgical Center 20% coinsurance at an outpatient hospital facility</p> <p><u>Out-of-Network</u> 50% of the Medicare-allowed amount after the \$950 yearly out-of-network deductible</p> |

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| Premiums and Benefits | BlueMedicare Choice (Regional PPO) | | | |
| Part D Prescription Drug Benefits | | | | |
| <p>Deductible Stage You begin in this payment stage when you fill your first prescription of the year.</p> <p>During this stage, you pay the full cost of your drugs.</p> <p>You stay in this stage until you have paid \$260 for your drugs (\$260 is the amount of your deductible).</p> <p>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.</p> <p>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.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> | Cost-Sharing for a one-month supply (up to 31 days) of a covered Part D prescription drug | | | |
| | Tier | Standard Retail | Preferred Retail | Mail Order |
| | Tier 1 (Preferred Generic) | \$13 copay | \$3 copay | \$3 copay |
| | Tier 2 (Generic) | \$20 copay | \$10 copay | \$10 copay |
| | Tier 3 (Preferred Brand) | \$47 copay | \$47 copay | \$47 copay |
| | Tier 4 (Non-Preferred Brand) | \$100 copay | \$100 copay | \$100 copay |
| | Tier 5 (Specialty Tier) | 28% of the cost | 28% of the cost | 28% of the cost |
| | Tier 6 (Select Care Drugs) | \$0 copay | \$0 copay | \$0 copay |
| <p>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.</p> | | | | |
| <p>Coverage Gap Stage</p> | <p>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.</p> <p>During the Coverage Gap Stage:</p> <ul style="list-style-type: none"> 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. <p>You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$5,000.</p> | | | |
| <p>Catastrophic Coverage Stage</p> | <p>After your yearly out-of-pocket drug costs reach \$5,000, you pay the greater of:</p> <ul style="list-style-type: none"> 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 | | | |