2018 Summary of Benefits

BlueMedicare Preferred (HMO) H2758-004

Clay and Duval

Florida Blue

HMO coverage is offered by BeHealthy Florida, Inc., DBA Florida Blue Preferred HMO, an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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BlueMedicare Preferred (HMO)

Summary of Benefits

January 1, 2018 - December 31, 2018

This booklet provides a summary of what BlueMedicare Preferred (HMO) 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 Preferred (HMO)

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: Clay and Duval

Which doctors, hospitals and pharmacies can I use?

We have a network of doctors, hospitals and other providers. In most cases, you must receive care from network providers. Your plan generally does not cover care you receive from out-of-network providers. There are three exceptions to this requirement:

- We cover emergency care and urgently needed services you receive from out-of-network providers.
- If providers in our network cannot provide a type of Medicare-covered care you need, we will cover the care if you receive it from an out-of-network provider. You must receive approval from our plan before seeking care from an out-of-network provider in this situation.
- We will cover care you receive at an out-of-network Medicare-certified dialysis facility.

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

We're open from: 8 a.m. – 8 p.m. local time, 7 days a week.

Phone Numbers and Website

If you are a current member of this plan, call 1-844-783-5189

If you are not currently a member of this plans 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 **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.

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

Florida Blue Preferred HMO is an HMO plan with a Medicare contract. Enrollment in Florida Blue Preferred HMO depends on contract renewal.

This information is available for free in other languages. Please call our Member Services number at 1-844-783-5189. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week.

Esta información está disponible de manera gratuita en otros idiomas. Comuníquese con Atención al cliente al 1-844-783-5189. (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.

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.

Premiums and Benefits	BlueMedicare Preferred (HMO)
Monthly Plan Premium	You pay $0.00 per month. You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	You yearly limit(s) in this plan: $3,400 for services from in-network providers. 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. **Note:** (*Amounts you pay for Part D drugs and dental, hearing 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.*** • Days 1-5: $100 copay per day • After day 5: You pay nothing
Outpatient Hospital Coverage	Up to a $100 copay. Please call us or see the plan's Evidence of Coverage for specific cost-sharing for services received in an outpatient hospital setting.
Doctor Visits	***Prior authorization is required for specialist visits.*** • You pay nothing per primary care visit • $10 copay per specialist visit
Preventive Care	You pay nothing. 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

Premiums and Benefits	BlueMedicare Preferred (HMO)
Preventive Care *(continued)*	• 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.
Emergency Care	**Medicare Covered Emergency Care** $80 copay per visit If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. **Additional Emergency Care Services** Worldwide Emergency Care $75 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage has a $25,000 limit and does not include emergency transportation.** This copay will not be waived if admitted to the hospital.
Urgently Needed Services	**Medicare Covered Urgently Needed Services** $25 copay at an Urgent Care Center If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for urgently needed services. **Additional Urgently Needed Services** Worldwide Urgently Needed Services $75 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage has a $25,000 limit and does not include emergency transportation.** This copay will not be waived if admitted to the hospital.

Premiums and Benefits	BlueMedicare Preferred (HMO)
Diagnostic Services/Labs/Imaging	***Prior Authorization is required for certain services. Call Member Services for additional information.*** **Laboratory Services** • You pay nothing at Alignment Care Centers. • $5 copay at all other locations **X-Rays** You pay nothing **Diagnostic Ultrasound** $5 copay **Advanced Imaging Services** (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) $75 copay **Radiation Therapy** 20% coinsurance
Hearing Services	***Prior authorization is required for the Medicare-covered exam.*** **Medicare-Covered Hearing Services** You pay nothing for exams to diagnose and treat hearing and balance issues. **Routine Hearing Services** • You pay nothing for one (1) routine hearing exam per year. • You pay nothing for the fitting/evaluation of hearing aids per year. • This plan does not cover 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) $50 copay **Additional Dental Services** (cleanings, oral exams, X-rays, extraction of erupted tooth or exposed root, adjustment of complete or partial denture) You pay nothing.

Premiums and Benefits	BlueMedicare Preferred (HMO)
Vision Services	***Prior authorization is required for Medicare-covered eye exams.*** **Medicare-Covered Vision Services** • $10 copay for physician services to diagnose and treat eye diseases and conditions • You pay nothing for glaucoma screening • You pay nothing for one pair of eyeglasses or contact lenses after each cataract surgery. **Additional Vision Services** You pay nothing for one routine eye exam every 12 months **The maximum plan benefit amount for all eyewear is $100 every 2 years.**
Mental Health Services	**Inpatient Mental Health Services** ***Prior authorization is required for non-emergency 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 health services provided in a general hospital. • Days 1-3: $395 copay per day • Days 4-90: You pay nothing. **Outpatient Mental Health Services** ***Prior authorization is required for non-emergency services.*** $20 copay
Skilled Nursing Facility (SNF)	***Prior authorization is required for SNF stays.*** Our plan covers up to 100 days in a SNF per benefit period. • Days 1-20: You pay nothing. • Days 21-100: $125 copay per day
Physical Therapy	***Prior authorization is required for all therapy services.*** Occupational, physical therapy and speech and language therapy visits • $20 copay for services received at any location. 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.*** $100 copay for each Medicare-covered trip (one-way) ***This copayment is waived if you are admitted to the hospital within 48 hours.***

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Transportation (Routine)	***Prior authorization is required for Transportation services.*** 25 one-way trips per calendar year to plan-approved locations for health-related services within a 20 mile radius of your permanent residence. Locations include provider offices, hospitals and pharmacies. Transportation to Alignment's Care Centers does not have a mile limitation and does not count against the 20 one-way trip limit. You pay nothing
Medicare Part B Drugs	***Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.*** 20% coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs
Foot Care *(podiatry services)*	***Prior Authorization is required for all podiatry services.*** Diagnosis and treatment of injuries and diseases of the feet. Routine care for members with certain conditions affecting the lower limbs. You pay nothing
Medical Equipment/Supplies	***Prior authorization is required for certain equipment/supplies. Call Member Services for additional information.*** **Durable Medical Equipment** 20% coinsurance **Prosthetics** 20% coinsurance **Diabetic Supplies** • You pay nothing for diabetic supplies except for therapeutic shoes and inserts. • $10 copay for Diabetic Therapeutic shoes or inserts
Wellness Programs	• SilverSneakers® fitness program by Tivity Health. • Health Education • Enhanced Disease Management • Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline) You pay nothing to participate in these programs.
Outpatient Surgery	***Prior Authorization is required for certain services. Please call Member Services for additional information.*** • $100 copayment in an ambulatory surgical center • $100 copayment for in an outpatient hospital facility

<table>
<tr><th>Premiums and Benefits</th><th>BlueMedicare Preferred (HMO)</th></tr>
<tr><td colspan="2">Part D Prescription Drug Benefits</td></tr>
<tr><td>Deductible Stage
This plan does not have a deductible.

Initial Coverage Stage
You begin in this stage when you fill your first prescription of the year.

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>
Cost-Sharing for a one-month supply (up to 30 days) of a covered Part D prescription drug
<table>
<tr><th>Tier</th><th>Standard Retail/Preferred Retail</th><th>Mail Order</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$7 copay Standard
$0 copay Preferred</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$14 copay Standard
$7 copay Preferred</td><td>$7 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$42 copay Standard
$35 copay Preferred</td><td>$35 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$92 copay Standard
$85 copay Preferred</td><td>$85 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>33% of the cost</td></tr>
<tr><td>Tier 6 (Select Care Drugs)</td><td>$7 copay Standard
$7 copay Preferred</td><td>$7 copay</td></tr>
</table>
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 100) 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</td><td>
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:

For generic drugs in Tier 1 (Preferred Generics) and Tier 6 (Select Care Drugs), you pay the same copayments that you paid in the Initial Coverage Stage – or 44% of the cost, whichever is lower.
For generic drugs in all other tiers, you pay 44% of the cost.
For brand-name drugs, you pay 35% of the cost (plus a portion of the dispensing fee).

You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $5,000.
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Premiums and Benefits	BlueMedicare Preferred (HMO)
Catastrophic Coverage	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