Florida Blue

2019 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

BlueMedicare Complete (HMO SNP) H1035-029

BlueMedicare Complete (HMO SNP) H1035-030

January 1, 2019 – December 31, 2019

The plan's service area includes:
Orange, Hillsborough, and Polk Counties

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not 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." You may also view the "Evidence of Coverage" for these plans on our website, www.floridablue.com/medicare. The Evidence of Coverage includes a complete list of services we cover.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as BlueMedicare Complete (HMO SNP)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what BlueMedicare Complete (HMO SNP) covers and what you pay.

- 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.

Sections in this booklet

- Things to Know About BlueMedicare Complete (HMO SNP)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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

This document 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 – March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday – Friday, 8:00 a.m. – 8:00 p.m., local time.

Things to Know About BlueMedicare Complete (HMO SNP)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. local time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. local time.

BlueMedicare Complete (HMO SNP) Phone Numbers and Website

- If you are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
- If you are not a member of this plan, call us at 1-855-601-9465, TTY: 1-800-955-8770.
- Our website: www.floridablue.com/medicare

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Who can join?

To join BlueMedicare Complete (HMO SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and receive certain levels of assistance from the Florida Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual-eligible. BlueMedicare HMO Complete (HMO SNP) may enroll dual-eligibles who are in the SMLB, SLMB Plus, QMB, QMB Plus, FBDE, QI and QDWI programs. You must also live in our service area. Our service area for BlueMedicare Complete (HMO SNP) includes the following counties in Florida: Hillsborough, Orange and Polk.

NOTE: You cannot be enrolled in both a Medicaid Managed Care plan and a DSNP plan in Florida. For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services.

Which doctors, hospitals, and pharmacies can I use?

BlueMedicare Complete (HMO SNP) has a 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 must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website. (www.floridablue.com/medicare).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- Our plan members get *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 Part D drugs. In addition, we cover Part B drugs including chemotherapy and some other 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.floridablue.com/medicare.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six tiers. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	$30.30 per month. You may pay a lower premium or no premium based on your level of assistance. In addition, you must keep paying your Medicare Part B premium.	$30.30 per month. You may pay a lower premium or no premium based on your level of assistance. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost 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.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost 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.
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital Care	*Prior Authorization is required for non-emergency Inpatient Hospital stays.* In-Network: $0 Copay per stay Medicaid: $0 Copay per admission for Medicaid-covered services.	*Prior Authorization is required for non-emergency Inpatient Hospital stays.* In-Network: $0 Copay per stay Medicaid: $0 Copay per admission for Medicaid-covered services.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Outpatient Hospital Care	*Prior Authorization is required for Medicare-covered Outpatient Hospital Services. (Does not apply to Observation Services.)* In-Network: Medicare-covered Outpatient Hospital Services (Except Observation Services): $0 Copay per visit. Medicare-covered Observation Services: $0 Copay per visit. Medicaid: $3 Copay, per visit, if not exempt from cost sharing.	*Prior Authorization is required for Medicare-covered Outpatient Hospital Services. (Does not apply to Observation Services.)* In-Network: Medicare-covered Outpatient Hospital Services (Except Observation Services): $0 Copay per visit. Medicare-covered Observation Services: $0 Copay per visit. Medicaid: $3 Copay, per visit, if not exempt from cost sharing.
Doctor's Office Visits	In-Network: Primary care physician visit: $0 Copay. Specialist[1] visit: $0 Copay. Medicaid: • $2 copayment per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for practitioner services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.	In-Network: Primary care physician visit: $0 Copay. Specialist[1] visit: $0 Copay. Medicaid: • $2 copayment per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for practitioner services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Preventive Care	In-Network: You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. Medicaid: $3 copayment for covered preventive screenings provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.	In-Network: You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. Medicaid: $3 copayment for covered preventive screenings provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.
Emergency Care	In-Network: $0 Copay. Medicaid: • $3 copayment, per visit, if not exempt from cost sharing. • 5% coinsurance up to the first $300 of Medicaid payment for each visit in the emergency room for non-emergency services, not to exceed $15.	In-Network: $0 Copay. Medicaid: • $3 copayment, per visit, if not exempt from cost sharing. • 5% coinsurance up to the first $300 of Medicaid payment for each visit in the emergency room for non-emergency services, not to exceed $15.
Urgently Needed Services	In-Network: $0 Copay. Medicaid: $2 copayment for services in a practitioner office setting, per provider or group provider, per day, if not exempt from cost sharing.	In-Network: $0 Copay. Medicaid: $2 copayment for services in a practitioner office setting, per provider or group provider, per day, if not exempt from cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Diagnostic Services/Labs/Imaging[1]	*Prior Authorization is required for certain services. Call Member Services for more information.* <u>In-Network:</u> Laboratory Services You pay nothing at an Independent Clinical Laboratory or outpatient hospital facility. X-Rays You pay nothing at an Independent Diagnostic Testing Facility (IDTF) or outpatient hospital facility Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) You pay nothing at a specialist's office, IDTF or outpatient hospital facility Radiation Therapy You pay nothing <u>Medicaid:</u> • $1 copayment for independent laboratory services per provider, per day, if not exempt from cost sharing. • $1 copayment for portable X-Ray services per provider, per day, if not exempt from cost sharing. • $2 copayment per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.	*Prior Authorization is required for certain services. Call Member Services for more information.* <u>In-Network:</u> Laboratory Services You pay nothing at an Independent Clinical Laboratory or outpatient hospital facility. X-Rays You pay nothing at an Independent Diagnostic Testing Facility (IDTF) or outpatient hospital facility Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) You pay nothing at a specialist's office, IDTF or outpatient hospital facility Radiation Therapy You pay nothing <u>Medicaid:</u> • $1 copayment for independent laboratory services per provider, per day, if not exempt from cost sharing. • $1 copayment for portable X-Ray services per provider, per day, if not exempt from cost sharing. • $2 copayment per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Hearing Services[1]	<u>Medicare-Covered Hearing Services:</u> Exam to diagnose and treat hearing and balance issues: $0 Copay. <u>Non-Medicare Covered Hearing Services:</u> Routine hearing exam (1 per year): $0 Copay. Evaluation and fitting of hearing aids: $0 Copay. $1,000 maximum benefit allowance per year toward any model hearing aid. (Limit of 2 per year.) <u>Medicaid:</u> $0 Copay. For recipients who have moderate hearing loss or greater, including the following services: • One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient. • Up to three pairs of ear molds per year, per recipient. • One fitting and dispensing service per ear, every three years, per recipient.	<u>Medicare-Covered Hearing Services:</u> Exam to diagnose and treat hearing and balance issues: $0 Copay. <u>Non-Medicare Covered Hearing Services:</u> Routine hearing exam (1 per year): $0 Copay. Evaluation and fitting of hearing aids: $0 Copay. $1,000 maximum benefit allowance per year toward any model hearing aid. (Limit of 2 per year.) <u>Medicaid:</u> $0 Copay. For recipients who have moderate hearing loss or greater, including the following services: • One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient. • Up to three pairs of ear molds per year, per recipient. • One fitting and dispensing service per ear, every three years, per recipient.
Dental Services	*Prior Authorization is required for certain services. Call Member Services for more information.* <u>Medicare-Covered Dental Services:</u> 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: $0 Copay.	*Prior Authorization is required for certain services. Call Member Services for more information.* <u>Medicare-Covered Dental Services:</u> 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: $0 Copay.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
	Non-Medicare Covered Dental Services: Cleanings, oral exams, X-rays, extraction of erupted tooth or exposed root, adjustment of complete or partial denture, dentures, crowns, and other dental benefits: $6,000 annual benefit maximum. Medicaid: • $2 copayment for oral and maxillofacial surgery services per practitioner office visit, per day. • $3 copayment for dental services provided at a Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing. Covered Adult Services (Ages 21 and Over) • One comprehensive evaluation every three years, per recipient. For recipients age 21 years and older, a comprehensive evaluation is reimbursed for the purpose of determining the need for full or partial dentures, or problem focused services. • Limited evaluations, as medically indicated. • One complete series of intraoral radiographs every three years, per recipient. • One panoramic radiograph every three years, per recipient. • Prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows: • One upper, lower, or complete set of full or removable partial dentures per recipient.	Non-Medicare Covered Dental Services: Cleanings, oral exams, X-rays, extraction of erupted tooth or exposed root, adjustment of complete or partial denture, dentures, crowns, and other dental benefits: $6,000 annual benefit maximum. Medicaid: • $2 copayment for oral and maxillofacial surgery services per practitioner office visit, per day. • $3 copayment for dental services provided at a Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing. Covered Adult Services (Ages 21 and Over) • One comprehensive evaluation every three years, per recipient. For recipients age 21 years and older, a comprehensive evaluation is reimbursed for the purpose of determining the need for full or partial dentures, or problem focused services. • Limited evaluations, as medically indicated. • One complete series of intraoral radiographs every three years, per recipient. • One panoramic radiograph every three years, per recipient. • Prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows: • One upper, lower, or complete set of full or removable partial dentures per recipient.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
	• One reline, per denture, per 366 days, per recipient. Traditional Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures. Covered Children Services (Ages under 21) The Medicaid children's dental services program may provide reimbursement for adjunctive general services, diagnostic services, diagnostic imaging, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, prosthodontic and orthodontic treatment, including complete and partial dentures.	• One reline, per denture, per 366 days, per recipient. Traditional Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures. Covered Children Services (Ages under 21) The Medicaid children's dental services program may provide reimbursement for adjunctive general services, diagnostic services, diagnostic imaging, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, prosthodontic and orthodontic treatment, including complete and partial dentures.
Vision Services	*Prior Authorization is required for certain services. (Diabetic Retinal Exam and Glaucoma Screening are exempt.) Call Member Services for more information.* <u>Medicare-Covered Vision Services:</u> $0 Copay for the following services: • physician services to diagnose and treat eye diseases and conditions. • glaucoma screening (once per year for members at high risk of glaucoma). • diabetic retinal exams. • one pair of eyeglasses or contact lenses after each cataract surgery. <u>Non-Medicare Covered Vision Services</u> • Routine Eye Exam: $0 Copay. (1 every year) • $200 allowance per year toward the purchase of lenses, frames or contacts.	*Prior Authorization is required for certain services. (Diabetic Retinal Exam and Glaucoma Screening are exempt.) Call Member Services for more information.* <u>Medicare-Covered Vision Services:</u> $0 Copay for the following services: • physician services to diagnose and treat eye diseases and conditions. • glaucoma screening (once per year for members at high risk of glaucoma). • diabetic retinal exams. • one pair of eyeglasses or contact lenses after each cataract surgery. <u>Non-Medicare Covered Vision Services</u> • Routine Eye Exam: $0 Copay. (1 every year) • $200 allowance per year toward the purchase of lenses, frames or contacts.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
	Medicaid: • $0 copayment for visual aid services. • $2 copayment for optometrist services, per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for optometrist services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing. Florida Medicaid covers one frame every two years and two lenses every 365 days.	Medicaid: • $0 copayment for visual aid services. • $2 copayment for optometrist services, per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for optometrist services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing. Florida Medicaid covers one frame every two years and two lenses every 365 days.
Mental Health Care	Inpatient Mental Health Services *Prior authorization is required for non-emergency services.* Inpatient Mental Health Services: Limited 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. $0 Copay per stay. Outpatient Mental Health Services $0 Copay. Medicaid: • $2 copayment per provider, per day, if not exempt from cost sharing. • $3 copayment for outpatient mental health services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.	Inpatient Mental Health Services *Prior authorization is required for non-emergency services.* Inpatient Mental Health Services: Limited 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. $0 Copay per stay. Outpatient Mental Health Services $0 Copay. Medicaid: • $2 copayment per provider, per day, if not exempt from cost sharing. • $3 copayment for outpatient mental health services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Skilled Nursing Facility (SNF)	*Prior authorization is required for SNF stays.* Our plan covers up to 100 days in an SNF per benefit period. In-Network: Days 1-20: $0 Copay per day. Days 21-100: $0 Copay per day. Medicaid: $0 copay for Medicaid-covered services.	*Prior authorization is required for SNF stays.* Our plan covers up to 100 days in an SNF per benefit period. In-Network: Days 1-20: $0 Copay per day. Days 21-100: $0 Copay per day. Medicaid: $0 copay for Medicaid-covered services.
Physical Therapy[1]	Medicare-Covered Services: In-Network: $0 Copay. Medicaid: Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services. • $0 copayment for respiratory system services. • $0 copayment for physical therapy services. • $2 copayment per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost sharing. • $3 copayment for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing. • $3 copayment, per visit to an outpatient hospital, if not exempt from cost sharing.	Medicare-Covered Services: In-Network: $0 Copay. Medicaid: Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services. • $0 copayment for respiratory system services. • $0 copayment for physical therapy services. • $2 copayment per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost sharing. • $3 copayment for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing. • $3 copayment, per visit to an outpatient hospital, if not exempt from cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Ambulance	*Prior authorization is required for non-emergency ambulance services.* In- and Out-of-Network: $0 Copay. Medicaid: $0 Copay for Medicaid-covered services.	*Prior authorization is required for non-emergency ambulance services.* In- and Out-of-Network: $0 Copay. Medicaid: $0 Copay for Medicaid-covered services.
Transportation	In-Network: $0 Copay. Unlimited one-way trips per calendar year to plan-approved locations for scheduled medical-related services and prescriptions transportation within your service area. Medicaid: $1 Copay per one way trip. Non-Emergency Medical Transportation (NEMT) services are available only to eligible beneficiaries who cannot obtain transportation through any other means (such as family, friends or community resources).	In-Network: $0 Copay. Unlimited one-way trips per calendar year to plan-approved locations for scheduled medical-related services and prescriptions transportation within your service area. Medicaid: $1 Copay per one way trip. Non-Emergency Medical Transportation (NEMT) services are available only to eligible beneficiaries who cannot obtain transportation through any other means (such as family, friends or community resources).
Medicare Part B Drugs	*Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.* In-Network: Chemotherapy and other Medicare Part-B covered drugs: $0 Copay. Allergy injections: $0 Copay. Medicaid: • $0 copayment for prescription drugs obtained through the Prescription Drug Services program.	*Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.* In-Network: Chemotherapy and other Medicare Part-B covered drugs: $0 Copay. Allergy injections: $0 Copay. Medicaid: • $0 copayment for prescription drugs obtained through the Prescription Drug Services program.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
	• $2 copayment for practitioner services, per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for Part B prescription drug administration provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.	• $2 copayment for practitioner services, per provider or group provider, per day, if not exempt from cost sharing. • $3 copayment for Part B prescription drug administration provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
PRESCRIPTION DRUG BENEFITS		

Deductible Stage

These plans have a $415 deductible for drugs in Tiers 3, 4 and 5.

Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year for drugs in Tiers 1, 2 and 6. For drugs in Tiers 3, 4 and 5, you must first meet your Part D deductible.

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 $3,820.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Brand)	$99 Copay	$297 Copay
Tier 5 (Specialty Tier)	25% Coinsurance	Not Applicable
Tier 6 (Supplemental Drugs)	$0 Copay	Not Applicable

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Brand)	$99 Copay	$297 Copay
Tier 5 (Specialty Tier)	25% Coinsurance	Not Applicable
Tier 6 (Supplemental Drugs)	$0 Copay	Not Applicable

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Initial Coverage Mail Order	Mail Order	Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Brand)	$99 Copay	$297 Copay
Tier 5 (Specialty Tier)	25% Coinsurance	Not Applicable
Tier 6 (Supplemental Drugs)	$0 Copay	Not Applicable

Your cost-sharing may be different if you use a Long Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy. Please call us or see the plan's "Evidence of Coverage" on our website (www.floridablue.com/medicare) for complete information about your costs for covered drugs.

If you request and the plan approves a formulary exception, you will pay Tier 4: Non-Preferred Drug cost sharing.

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Brand)	$99 Copay	$297 Copay
Tier 5 (Specialty Tier)	25% Coinsurance	Not Applicable
Tier 6 (Supplemental Drugs)	$0 Copay	Not Applicable

Your cost-sharing may be different if you use a Long Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy. Please call us or see the plan's "Evidence of Coverage" on our website (www.floridablue.com/medicare) for complete information about your costs for covered drugs.

If you request and the plan approves a formulary exception, you will pay Tier 4: Non-Preferred Drug cost sharing.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Complete (HMO SNP) Orange	BlueMedicare Complete (HMO SNP) Hillsborough and Polk
Coverage Gap Stage	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820. 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), Tier 2 (Generic) and Tier 6 (Select Care Drugs) – or 37% of the cost, whichever is lower. • For generic drugs in all other tiers, you pay 37% of the cost. • For brand-name drugs, you pay 25% of the cost (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of $5,100.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820. 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), Tier 2 (Generic) and Tier 6 (Select Care Drugs) – or 37% of the cost, whichever is lower. • For generic drugs in all other tiers, you pay 37% of the cost. • For brand-name drugs, you pay 25% of the cost (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of $5,100.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • $3.40 Copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs, or • 5% of the cost.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • $3.40 Copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs, or • 5% of the cost.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

Florida Blue HMO is an HMO plan with a Medicare contract Enrollment in Florida Blue HMO depends on contract renewal. HMO coverage is offered by Health Options, Inc., DBA Florida Blue 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. This information is not a complete description of benefits. Call 1-855-601-9465 for more information. TTY users should call 1-800-955-8770.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-926-6565 (TTY: 1-800-955-8770). ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-926-6565 (TTY: 1-877-955-8773).

You must continue to pay your Medicare Part B premium. If you meet certain eligibility requirements for both Medicare and Medicaid, your Part B premiums may be covered in full. Premiums, copays, coinsurance and deductibles may vary based on the level of Extra Help you receive. Please contact Florida Blue HMO for details. This plan is available to anyone who has both Medical Assistance from the State and Medicare. Sponsored by Health Options, Inc., d/b/a Florida Blue HMO, and the State of Florida, Agency for Health Care Administration.

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.