Florida Blue

2019 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

BlueMedicare Preferred (HMO) H2758-002

BlueMedicare Preferred POS (HMO-POS) H2758-008

January 1, 2019 – December 31, 2019

The plan's service area includes:
Manatee, Pinellas and Sarasota 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 Preferred (HMO) and BlueMedicare Preferred POS (HMO-POS)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what BlueMedicare Preferred (HMO) and BlueMedicare Preferred POS (HMO-POS) 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 Preferred (HMO) and BlueMedicare Preferred POS (HMO-POS)
- 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 1-844-783-5189. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week.

Things to Know About BlueMedicare Preferred (HMO) and BlueMedicare Preferred POS (HMO-POS)

Hours of Operation

- We're open from 8:00 a.m. to 8:00 p.m. local time, 7 days a week.

BlueMedicare Preferred (HMO) and BlueMedicare Preferred POS (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call us at 1-844-783-5189, 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 Preferred (HMO) and BlueMedicare Preferred POS (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area for BlueMedicare Preferred (HMO) includes the following counties in Florida: Manatee and Sarasota. Our service area for BlueMedicare Preferred POS (HMO-POS) includes the following counties in Florida: Manatee, Sarasota, and Pinellas.

Which doctors, hospitals, and pharmacies can I use?

BlueMedicare Preferred (HMO) and BlueMedicare Preferred POS have 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. However, this plan includes a point-of-service benefit which provides coverage for certain services when received from out-of-network providers.

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: Initial Coverage, Coverage Gap and Catastrophic Coverage.

SECTION II - SUMMARY OF BENEFITS	BlueMedicare Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	You do not pay a separate monthly plan premium for BlueMedicare Preferred (HMO). You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for BlueMedicare Preferred POS (HMO-POS). You must continue to pay 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: • $3,400 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 You will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	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: • $4,900 for services you receive from in-network providers. • $8,000 for services you receive from out-of-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 You will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

SECTION II - SUMMARY OF BENEFITS	BlueMedicare Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital Care	*Prior Authorization is required for non-emergency Inpatient Hospital stays.* In-Network: • Days 1-5: $120 Copay per day. • After the 5th day the plan pays 100% of covered expenses.	*Prior Authorization is required for non-emergency Inpatient Hospital stays.* In-Network: • Days 1-5: $120 Copay per day. • After the 5th day the plan pays 100% of covered expenses. Out-of-Network: After you have met the Medicare deductible of $1,340 per benefit period, you pay: • Days 1-60: $0 Copay per day. • Days 61-90: $335 Copay per day. Lifetime Reserve Days: Days 1-60: $670 Copay per day.
Outpatient Hospital Care[1]	*Prior Authorization is required for Medicare-covered Outpatient Hospital Services.* In-Network: Medicare-covered Outpatient Hospital Services (Except Observation Services): $150 Copay per visit. Medicare-covered Observation Services: $85 Copay per visit.	*Prior Authorization is required for Medicare-covered Outpatient Hospital Services.* In-Network: Medicare-covered Outpatient Hospital Services (Except Observation Services): $100 Copay per visit. Medicare-covered Observation Services: $85 Copay per visit.
Doctor's Office Visits	*Prior Authorization is required for Specialist visits.* In-Network: Primary care physician visit: $0 Copay. Specialist[1] visit: $30 Copay.	*Prior Authorization is required for Specialist visits.* In-Network: Primary care physician visit: $0 Copay. Specialist[1] visit: $25 Copay. Out-of-Network: Primary care physician visit: $30 Copay. Specialist visit: $45 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 Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
COVERED MEDICAL AND HOSPITAL BENEFITS		
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.	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.
Emergency Care	If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. In- and Out-of-Network: $85 Copay. Worldwide Emergency Coverage Emergency coverage is provided worldwide. Worldwide emergency coverage does not include emergency transportation. There is a $25,000 limit on Worldwide emergency/urgent coverage. Out-of-Network: $75 Copay.	If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. In- and Out-of-Network: $85 Copay. Worldwide Emergency Coverage Emergency coverage is provided worldwide. Worldwide emergency coverage does not include emergency transportation. There is a $25,000 limit on Worldwide emergency/urgent coverage. Out-of-Network: $75 Copay.
Urgently Needed Services	Medicare Covered Urgently Needed Services: If you are admitted within 48 hours, the copay is waived. In-Network: $0 Copay (Preferred locations). $30 Copay (Non-Preferred locations). Out-of-Network: $0 Copay (Preferred locations). $30 Copay (Non-Preferred locations).	Medicare Covered Urgently Needed Services: If you are admitted within 48 hours, the copay is waived. In-Network: $25 Copay. Out-of-Network: $25 Copay.

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SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
COVERED MEDICAL AND HOSPITAL BENEFITS		
	<u>Worldwide Emergency Coverage</u> Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.** There is a $25,000 limit on Worldwide emergency/urgent coverage. $75 Copay.	<u>Worldwide Emergency Coverage</u> Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.** There is a $25,000 limit on Worldwide emergency/urgent coverage. $75 Copay.
Diagnostic Services/Labs/Imaging[1]	*Prior Authorization is required for certain services. Call Member Services for additional information.* <u>In-Network:</u> Laboratory Services $0 Copay. X-Rays $0 Copay. Diagnostic Ultrasound $0 Copay. Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) $150 Copay. Radiation Therapy 20% Coinsurance.	*Prior Authorization is required for certain services. Call Member Services for additional information.* <u>In-Network:</u> Laboratory Services $0 Copay. X-Rays $5 Copay. Diagnostic Ultrasound $5 Copay. Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) $120 Copay. Radiation Therapy 20% Coinsurance.
Hearing Services	Medicare-Covered Hearing Services[1] *Prior Authorization is required for Medicare-Covered Hearing Services.* <u>In-Network:</u> Exam to diagnose and treat hearing and balance issues: $30 Copay.	Medicare-Covered Hearing Services[1] *Prior Authorization is required for Medicare-Covered Hearing Services.* <u>In-Network:</u> Exam to diagnose and treat hearing and balance issues: • Primary care physician's office: $0 Copay. • Specialist's office: $25 Copay.

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SECTION II - SUMMARY OF BENEFITS	BlueMedicare Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
COVERED MEDICAL AND HOSPITAL BENEFITS		
	Routine Hearing Services In-Network: • Routine hearing exam (one per year): $0 Copay. • $0 Copay for evaluation and fitting of hearing aids. • $1,000 allowance every two years for any model.	Routine Hearing Services In-Network: • Routine hearing exam (one per year): $0 Copay. • $0 Copay for evaluation and fitting of hearing aids. • This plan does not cover hearing aids.
Dental Services	*Prior authorization is required for Medicare-covered comprehensive dental services.* In-Network: Medicare-Covered Dental Services (non-routine dental care such as setting factures 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) In-Network: $0 copay.	*Prior authorization is required for Medicare-covered comprehensive dental services.* In-Network: Medicare-Covered Dental Services (non-routine dental care such as setting factures 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.
Vision Services	*Prior authorization is required for Medicare-covered vision services. Prior Authorization is not required for glaucoma screenings and diabetic retinal exams.* In-Network: Medicare-Covered Vision Services[1] • $30 Copay for physician services to diagnose and treat eye diseases and conditions.	*Prior authorization is required for Medicare-covered vision services. Prior Authorization is not required for glaucoma screenings and diabetic retinal exams.* In-Network: Medicare-Covered Vision Services[1] • $25 Copay for physician services to diagnose and treat eye diseases and conditions.

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SECTION II - SUMMARY OF BENEFITS		
	BlueMedicare Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
COVERED MEDICAL AND HOSPITAL BENEFITS		
	• $0 Copay for glaucoma screening (once per year, for members at high risk of glaucoma). • $0 Copay for diabetic retinal exams. • $0 Copay for one pair of eyeglasses or contact lenses after each cataract surgery. Additional Vision Services • $0 Copay for an annual routine eye examination. • $100 allowance every two years towards the purchase of lenses, frames or contact lenses.	• $0 Copay for glaucoma screening (once per year, for members at high risk of glaucoma). • $0 Copay for diabetic retinal exams. • $0 Copay for one pair of eyeglasses or contact lenses after each cataract surgery. Additional Vision Services • $0 Copay for an annual routine eye examination. • $100 allowance every two years towards the purchase of lenses, frames or contact lenses.
Mental Health Care	Inpatient Mental Health Care *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. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. <u>In-Network:</u> • Days 1-15: $100 Copay per day. • Days 16-90: $0 Copay.	Inpatient Mental Health Care *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. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. <u>In-Network:</u> • Days 1-5: $120 Copay per day. • Days 6-190: $0 Copay. <u>Out-of-Network:</u> After you have met the Medicare deductible of $1,340 per benefit period, you pay: Days 1-60: $0 Copay per day. Days 61-90: $335 Copay per day. <u>Lifetime Reserve Days</u> Days 1-60: $670 Copay per day.

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COVERED MEDICAL AND HOSPITAL BENEFITS		
	Outpatient Mental Health Care *Prior authorization is required for non-emergency services.* In-Network: $35 Copay.	Outpatient Mental Health Care *Prior authorization is required for non-emergency services.* In-Network: $25 Copay.
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: $100 Copay per day.	*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: $150 Copay per day.
Physical Therapy[1]	*Prior authorization is required for physical therapy services.* In-Network: $30 Copay.	*Prior authorization is required for physical therapy services.* In-Network: $25 Copay.
Ambulance	*Prior authorization is required for non-emergency ambulance services.* In- and Out-of-Network: $150 Copay for each Medicare-covered trip (one way). Copay is waived if admitted within 48 hours.	*Prior authorization is required for non-emergency ambulance services.* In- and Out-of-Network: $125 Copay for each Medicare-covered trip (one-way). Copay is waived if admitted within 48 hours.
Transportation	In- and Out-of-Network: • $0 Copay for 25 one-way trips annually to clinical locations (20 mile limit). • Unlimited trips to Alignment Care Centers	In- and Out-of-Network: Not covered.

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Manatee, Sarasota, and Pinellas</th></tr>
<tr><td colspan="3">COVERED MEDICAL AND HOSPITAL BENEFITS</td></tr>
<tr><td>Medicare Part B Drugs</td><td>Prior authorization is required for Medicare Part B-covered prescription drugs.
<u>In-Network:</u>
20% Coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs.</td><td>Prior authorization is required for Medicare Part B-covered prescription drugs.
<u>In-Network:</u>
20% Coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs.</td></tr>
<tr><td colspan="3">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 $3,820.
You may get your drugs at network retail pharmacies and mail order pharmacies.</td><td>Preferred Retail Cost-Sharing<table><tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$1 Copay</td><td>$3 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$35 Copay</td><td>$105 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>$100 Copay</td><td>$300 Copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$7 Copay</td><td>$0 Copay</td></tr></table></td><td>Preferred Retail Cost-Sharing<table><tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$7 Copay</td><td>$21 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$35 Copay</td><td>$105 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>$85 Copay</td><td>$255 Copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$7 Copay</td><td>$0 Copay</td></tr></table></td></tr>
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Standard Retail</td><td>Standard Retail Cost-Sharing
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<table><tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$7 Copay</td><td>$7 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$14 Copay</td><td>$28 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$42 Copay</td><td>$112 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>$92 Copay</td><td>$262 Copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$7 Copay</td><td>$0 Copay</td></tr></table></td></tr>
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<tr><td>Initial Coverage
Mail Order</td><td>Mail Order
<table><tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$1 Copay</td><td>$3 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$35 Copay</td><td>$105 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>$100 Copay</td><td>$300 Copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$7 Copay</td><td>$0 Copay</td></tr></table>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 Brand cost sharing.</td><td>Mail Order
<table><tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$7 Copay</td><td>$21 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$35 Copay</td><td>$105 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Brand)</td><td>$85 Copay</td><td>$255 Copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$7 Copay</td><td>$0 Copay</td></tr></table>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 Brand cost sharing.</td></tr>
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	BlueMedicare Preferred (HMO) Manatee and Sarasota	BlueMedicare Preferred POS (HMO-POS) Manatee, Sarasota, and Pinellas
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) 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) 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.

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

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.