Florida Blue

2019 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

BlueMedicare Value (PPO) H5434-025

January 1, 2019 – December 31, 2019

The plan's service area includes:
Escambia and Santa Rosa 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 Value (PPO)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what BlueMedicare Value (PPO) 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 Value (PPO)
- 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 Value (PPO)

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.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

BlueMedicare Value (PPO) 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 1-800-601-9465 (TTY: 1-800-955-8770).
- Our website:www.floridablue.com/medicare

Who can join?

To join BlueMedicare Value (PPO), 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 includes the following counties in Florida: Escambia and Santa Rosa.

Which doctors, hospitals, and pharmacies can I use?

BlueMedicare Value (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, you may pay more 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 Value (PPO) Escambia and Santa Rosa	
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 Value (PPO). You must continue to pay your Medicare Part B premium.
How much is the deductible?	$1,000 per year out-of-network deductible for medical services. $250 per year for Part D prescription drugs (not applicable to Tiers 1 and 6).
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. • $10,000 for services you receive from in and out-of-network providers combined. 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 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: • Days 1-5: $350 Copay per day. • After the 5th day the plan pays 100% of covered expenses. Out-of-Network: 50% of the Medicare-allowed amount.
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): $250 Copay per visit. Medicare-covered Observation Services: $90 Copay per visit. Out-of-Network: 50% of the Medicare-allowed amount.

SECTION II - SUMMARY OF BENEFITS BlueMedicare Value (PPO) Escambia and Santa Rosa	
Doctor's Office Visits	In-Network: Primary care physician visit: $10 Copay. Specialist visit: $50 Copay. Out-of-network: Primary care physician visit: 50% of the Medicare-allowed amount. Specialist visit: 50% of the Medicare-allowed amount.
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. Out-of-network: 50% of the Medicare-allowed amount. Deductible does not apply.
Emergency Care	If you are admitted to the hospital, 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-Network and Out-of-Network: $90 Copay. Worldwide Emergency Coverage 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. There is a $25,000 limit per year on Worldwide emergency and urgent care coverage combined. Out-of-Network: $125 Copay.
Urgently Needed Services	In-Network and Out-of-Network: • $10 Copay at Convenient Care Center. • $50 Copay at an Urgent Care Center. Worldwide Emergency/Urgent Care Coverage $125 Copay. Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.** There is a $25,000 limit per year on Worldwide emergency and urgent care coverage.

SECTION II - SUMMARY OF BENEFITS BlueMedicare Value (PPO) Escambia and Santa Rosa	
Diagnostic Services, Labs and Imaging	*Prior Authorization is required for certain services. Call Member Services for additional information.* In-Network: Laboratory Services • $0 at an Independent Clinical Laboratory. • $40 Copay at an outpatient hospital facility. X-Rays • $15 at an Independent Diagnostic Testing Facility (IDTF). • $150 Copay at an outpatient hospital facility. Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) • $75 Copay at a specialist's office. • $75 Copay at an IDTF. • $150 Copay at an outpatient hospital facility. Radiation Therapy 20% of the Medicare-allowed amount Out-of-Network: 50% of the Medicare-allowed amount.
Hearing Services	Medicare-Covered Hearing Services (a referral will be required from your Primary Care Provider (PCP) for a Medicare-Covered hearing exam) Exams to diagnose and treat hearing and balancing issues: In-Network: $50 Copay. Out-of-Network: 50% of the Medicare-allowed amount.

SECTION II - SUMMARY OF BENEFITS BlueMedicare Value (PPO) Escambia and Santa Rosa	
	Routine Hearing Services In-Network and Out-of-Network: • A $45 copay applies to in-network routine hearing exams. Member cost-sharing for out-of-network routine hearing exams is 50%. The deductible does not apply. • $0 Copay for evaluation and fitting of hearing aids (one per year). • Up to two hearing aids per year (one per ear) for either a $699 or $999 Copay per aid.
Dental Services	*Prior authorization is required for Medicare-covered comprehensive dental services.* 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): In-Network: $50 Copay. Out-of-Network: 50% of the Medicare-allowed amount.
Vision Services	Medicare-Covered Vision Services In-Network: • $50 Copay for physician services to diagnose and treat eye diseases and conditions. • $0 for glaucoma screening (once per year for members at high risk of glaucoma). • $0 for diabetic retinal exams. • $0 for one pair of eyeglasses or contact lenses after each cataract surgery. Out-of-network: 50% of the Medicare-allowed amount. **Additional Vision Services** In-Network • $0 Copay for one routine eye exam every year Out-of-Network • Reimbursed 50% of covered costs. Deductible does not apply.

SECTION II - SUMMARY OF BENEFITS BlueMedicare Value (PPO) Escambia and Santa Rosa	
Mental Health Care	*Prior authorization is required for non-emergency services for both inpatient and outpatient services.* Inpatient Mental Health Care 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. In-Network: • Days 1-5: $318 Copay per day. • Days 6-90: $0 Copay per day. Out-of-Network 50% of the Medicare-allowed amount. Outpatient Mental Health Care In-Network: $40 Copay. Out-of-Network: 50% of the Medicare-allowed amount.
Skilled Nursing Facility (SNF)	*Prior authorization is required for SNF stays.* Our plan covers up to 100 days in a SNF per benefit period. In-Network: • Days 1-20: $0 Copay per day. • Days 21-100: $160 Copay per day. Out-of-Network: 50% of the Medicare-allowed amount.
Physical Therapy	*Prior authorization is required for all therapy services.* In-Network: $40 Copay. Out-of-Network: 50% of the Medicare-allowed amount.
Ambulance	*Prior authorization is required for non-emergency services.* In-Network and Out-of-Network: $275 Copay.
Transportation	In-Network and Out-of-Network: Not Covered.

SECTION II - SUMMARY OF BENEFITS

BlueMedicare Value (PPO)
Escambia and Santa Rosa

Medicare Part B Drugs

Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.

In-Network:

- $5 Copay for allergy injections.
- 20% Coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs.

Out-of-Network:

50% of the Medicare-allowed amount.

PRESCRIPTION DRUG BENEFITS

Deductible Stage

This plan has a $250 deductible. The deductible does not apply to Tiers 1 and 6.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach $3,820

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)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	28% Coinsurance	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay

Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	28% Coinsurance	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay

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.

SECTION II - SUMMARY OF BENEFITS BlueMedicare Value (PPO) Escambia and Santa Rosa	
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.
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.

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

This information is not a complete description of benefits. Call 1-855-601-9465 for more information. TTY users should call 1-800-955-8770.

Out-of-network/noncontracted providers are under no obligation to treat BlueMedicare Value (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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).

Health coverage is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue, an Independent Licensee of the Blue Cross and Blue Shield Association.