

2023 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

Medicare Advantage Plan without Part D Prescription Drug Coverage

BlueMedicare Value (PPO) H5434-025

BlueMedicare Patriot (PPO) H5434-040

1/1/2023 – 12/31/2023



The plans' service area includes:

Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton counties

The benefit information provided is a summary of what we cover and what you pay. 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 this plan on our website, www.floridablue.com/medicare.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You* 2023 handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

To join, you must:

- be entitled to Medicare Part A; and
- be enrolled in Medicare Part B; and
- live in **our service area**.

Our H5434-025 service area includes the following counties in Florida: Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton

Our H5434-040 service area includes the following counties in Florida: Bay, Escambia, Okaloosa, Santa Rosa and Walton

Which doctors, hospitals, and pharmacies can I use?

We have 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 can see our plan's provider and pharmacy directory on our website (www.floridablue.com/medicare). Or call us and we will send you a copy of the provider and pharmacy directories.
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Have Questions? Call Us

- 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.
 - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
 - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at www.floridablue.com/medicare.

Important Information

Through this document you will see the “♦” symbol. Services with this symbol may require prior authorization from the plan before you receive the services from network providers. If you do not get a prior authorization when required, you may have to pay out-of-network cost-sharing, even though you received services from a network provider. Please contact your doctor or refer to the Evidence of Coverage (EOC) for more information about services that require a prior authorization from the plan.

Monthly Premium, Deductible and Limits

	BlueMedicare Value (PPO) Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025	BlueMedicare Patriot (PPO) Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040
Monthly Plan Premium	<ul style="list-style-type: none">• \$0 You must continue to pay your Medicare Part B premium.	<ul style="list-style-type: none">• \$0 You must continue to pay your Medicare Part B premium.
Part B Premium Buy-Down	<ul style="list-style-type: none">• This plan does not include a Part B premium buy-down.	<ul style="list-style-type: none">• BlueMedicare Patriot will reduce your monthly Medicare Part B premium by up to \$50.
Deductible	<ul style="list-style-type: none">• \$0 per year for health care services• \$150 per year for Part D prescription drugs applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier).	<ul style="list-style-type: none">• \$0 per year for health care services• This plan does not include Part D Prescription Drug Benefit
Maximum Out-of-Pocket Responsibility	<ul style="list-style-type: none">• \$4,800 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.	<ul style="list-style-type: none">• \$5,500 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.

BlueMedicare Value (PPO) Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025	BlueMedicare Patriot (PPO) Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040
<ul style="list-style-type: none"> • \$8,950 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers combined. 	<ul style="list-style-type: none"> • \$8,950 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers combined.

Medical and Hospital Benefits

	BlueMedicare Value (PPO) Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025	BlueMedicare Patriot (PPO) Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040
Inpatient Hospital Coverage	<u>In-Network</u> ♦ <ul style="list-style-type: none"> • \$295 copay per day for days 1-6 • \$0 copay per day, after day 6 <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> ♦ <ul style="list-style-type: none"> • \$350 copay per day for days 1-4 • \$0 copay per day, after day 4 <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Outpatient Hospital Coverage (Authorization applies to in-network services only)	<u>In-Network</u> <ul style="list-style-type: none"> • \$90 copay per visit for Medicare-covered observation services • \$200 copay for all other services ♦ <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> <ul style="list-style-type: none"> • \$90 copay per visit for Medicare-covered observation services • \$300 copay for all other services ♦ <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Ambulatory Surgical Center (ASC) Services	<u>In-Network</u> ♦ \$185 copay for surgery services provided at an Ambulatory Surgical Center <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> ♦ \$300 copay for surgery services provided at an Ambulatory Surgical Center <u>Out-of-Network</u> 47% of the Medicare-allowed amount

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Doctor Visits	<u>In-Network</u> <ul style="list-style-type: none"> • \$5 copay per provider of choice visit • \$42 copay per specialist visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> <ul style="list-style-type: none"> • \$10 copay per provider of choice visit • \$45 copay per specialist visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Preventive Care	<u>In-Network</u> \$0 copay <u>Out-of-Network</u> 47% of the Medicare-allowed amount <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C Screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) 	<u>In-Network</u> \$0 copay <u>Out-of-Network</u> 47% of the Medicare-allowed amount <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C Screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP)

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	<ul style="list-style-type: none"> • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • “Welcome to Medicare” preventive visit 	<ul style="list-style-type: none"> • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • “Welcome to Medicare” preventive visit
Emergency Care	Medicare-Covered Emergency Care <ul style="list-style-type: none"> • \$90 copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. Worldwide Emergency Care Services <ul style="list-style-type: none"> • \$125 copay for Worldwide Emergency Care • \$25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	Medicare-Covered Emergency Care <ul style="list-style-type: none"> • \$90 copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. Worldwide Emergency Care Services <ul style="list-style-type: none"> • \$125 copay for Worldwide Emergency Care • \$25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.
Urgently Needed Services	Medicare-Covered Urgently Needed Services Urgently needed services are provided to treat a non-emergency, unforeseen	Medicare-Covered Urgently Needed Services Urgently needed services are provided to treat a non-emergency, unforeseen

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	<p>medical illness, injury or condition that requires immediate medical attention.</p> <ul style="list-style-type: none"> • \$30 copay at an Urgent Care Center, in- or out-of-network <p>Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed.</p> <ul style="list-style-type: none"> • \$30 copay at a Convenient Care Center, in- or out-of-network <p>Worldwide Urgently Needed Services</p> <ul style="list-style-type: none"> • \$125 copay for Worldwide Urgently Needed Services • \$25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services <p>Does not include emergency transportation.</p>	<p>medical illness, injury or condition that requires immediate medical attention.</p> <ul style="list-style-type: none"> • \$30 copay at an Urgent Care Center, in- or out-of-network <p>Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed.</p> <ul style="list-style-type: none"> • \$30 copay at a Convenient Care Center, in- or out-of-network <p>Worldwide Urgently Needed Services</p> <ul style="list-style-type: none"> • \$125 copay for Worldwide Urgently Needed Services • \$25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services <p>Does not include emergency transportation.</p>
Diagnostic Services/ Labs/Imaging	<p><u>In-Network</u> ♦</p> <p>Diagnostic Procedures and Tests</p> <ul style="list-style-type: none"> • \$75 copay at an Independent Diagnostic Testing Facility (IDTF) • \$75 copay at an outpatient hospital facility • \$0 copay for allergy testing <p>Laboratory Services</p> <ul style="list-style-type: none"> • \$0 copay at an Independent Clinical Laboratory • \$40 copay at an outpatient hospital facility <p>X-Rays</p> <ul style="list-style-type: none"> • \$15 copay at a physician's office or at an IDTF • \$150 copay at an outpatient hospital facility 	<p><u>In-Network</u> ♦</p> <p>Diagnostic Procedures and Tests</p> <ul style="list-style-type: none"> • \$75 copay at an Independent Diagnostic Testing Facility (IDTF) • \$75 copay at an outpatient hospital facility • \$0 copay for allergy testing <p>Laboratory Services</p> <ul style="list-style-type: none"> • \$0 copay at an Independent Clinical Laboratory • \$40 copay at an outpatient hospital facility <p>X-Rays</p> <ul style="list-style-type: none"> • \$15 copay at a physician's office or at an IDTF • \$150 copay at an outpatient hospital facility

		BlueMedicare Value (PPO)	BlueMedicare Patriot (PPO)
		Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025	Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040
Hearing Services	Advanced Imaging Services	Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan <ul style="list-style-type: none"> • \$0 copay at a physician's office or at an IDTF • \$110 copay at an outpatient hospital facility Radiation Therapy <ul style="list-style-type: none"> • 20% of the Medicare-allowed amount <u>Out-of-Network</u> 47% of the Medicare-allowed amount	Advanced Imaging Services Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan <ul style="list-style-type: none"> • \$0 copay at a physician's office or at an IDTF • \$75 copay at an outpatient hospital facility Radiation Therapy <ul style="list-style-type: none"> • 20% of the Medicare-allowed amount <u>Out-of-Network</u> 47% of the Medicare-allowed amount
	Medicare-Covered Hearing Services	<u>In-Network</u> <ul style="list-style-type: none"> • \$42 copay for exams to diagnose and treat hearing and balance issues <u>Out-of-Network</u> <ul style="list-style-type: none"> • 47% of the Medicare-allowed amount Additional Hearing Services <u>In-Network</u> <ul style="list-style-type: none"> • \$0 copay for one routine hearing exam per year • \$0 copay for evaluation and fitting of hearing aids • \$750 per ear. You pay a \$0 copay for up to 2 hearing aids every year with a maximum benefit allowance of \$750 per ear. 	Medicare-Covered Hearing Services <u>In-Network</u> <ul style="list-style-type: none"> • \$45 copay for exams to diagnose and treat hearing and balance issues <u>Out-of-Network</u> <ul style="list-style-type: none"> • 47% of the Medicare-allowed amount Additional Hearing Services <u>In-Network</u> <ul style="list-style-type: none"> • \$0 copay for one routine hearing exam per year • \$0 copay for evaluation and fitting of hearing aids • \$500 per ear. You pay a \$0 copay for up to 2 hearing aids every year with a maximum benefit allowance of \$500 per ear.

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	<p>NOTE: Hearing aids must be purchased through our participating provider to receive in-network benefits.</p> <ul style="list-style-type: none"> Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum. <p><u>Out-of-Network</u></p> <ul style="list-style-type: none"> Member must submit receipts for reimbursement at 53% of maximum allowed for one routine hearing exam per year. Member must submit receipts for reimbursement at 53% of maximum allowed for evaluation and fitting of hearing aids. Member must submit receipts for reimbursement at 53% of maximum allowed for up to 2 hearing aids every year. Subject to benefit maximum. Member is responsible for any amount after the benefit allowance has been applied. 	<p>NOTE: Hearing aids must be purchased through our participating provider to receive in-network benefits.</p> <ul style="list-style-type: none"> Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum. <p><u>Out-of-Network</u></p> <ul style="list-style-type: none"> Member must submit receipts for reimbursement at 53% of maximum allowed for one routine hearing exam per year. Member must submit receipts for reimbursement at 53% of maximum allowed for evaluation and fitting of hearing aids. Member must submit receipts for reimbursement at 53% of maximum allowed for up to 2 hearing aids every year. Subject to benefit maximum. Member is responsible for any amount after the benefit allowance has been applied.
Dental Services	<p>Medicare-Covered Dental Services</p> <p><u>In-Network</u> ♦</p> <ul style="list-style-type: none"> \$42 copay for non-routine dental care <p><u>Out-of-Network</u></p> <p>47% of the Medicare-allowed amount</p> <p>Additional Dental Services</p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> \$0 copay for covered preventive dental services \$0 copay for covered comprehensive dental services 	<p>Medicare-Covered Dental Services</p> <p><u>In-Network</u> ♦</p> <ul style="list-style-type: none"> \$45 copay for non-routine dental care <p><u>Out-of-Network</u></p> <p>47% of the Medicare-allowed amount</p> <p>Additional Dental Services</p> <p><u>In-Network</u></p> <ul style="list-style-type: none"> \$0 copay for covered preventive dental services \$0 copay for covered comprehensive dental services

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	<u>Out-of-Network</u> <ul style="list-style-type: none"> Member pays up front and is reimbursed 53% of non-participating rates for covered preventive dental services. Member pays up front and is reimbursed 53% of non-participating rates for covered comprehensive dental services. 	<u>Out-of-Network</u> <ul style="list-style-type: none"> Member pays up front and is reimbursed 53% of non-participating rates for covered preventive dental services. Member pays up front and is reimbursed 53% of non-participating rates for covered comprehensive dental services.
Vision Services	Medicare-Covered Vision Services <u>In-Network</u> <ul style="list-style-type: none"> \$42 copay for physician services to diagnose and treat eye diseases and conditions \$0 copay for glaucoma screening (once per year for members at high risk of glaucoma) \$0 copay for one diabetic retinal exam per year \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery <u>Out-of-Network</u> <ul style="list-style-type: none"> 47% of the Medicare-allowed amount Additional Vision Services <u>In-Network</u> <ul style="list-style-type: none"> \$0 copay for one routine eye exam per year \$0 copay for lenses, frames or contacts. Subject to the annual maximum plan benefit allowance. Member responsible for any amounts in excess of the annual maximum plan benefit allowance. 	Medicare-Covered Vision Services <u>In-Network</u> <ul style="list-style-type: none"> \$45 copay for physician services to diagnose and treat eye diseases and conditions \$0 copay for glaucoma screening (once per year for members at high risk of glaucoma) \$0 copay for one diabetic retinal exam per year \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery <u>Out-of-Network</u> <ul style="list-style-type: none"> 47% of the Medicare-allowed amount Additional Vision Services <u>In-Network</u> <ul style="list-style-type: none"> \$0 copay for one routine eye exam per year \$0 copay for lenses, frames or contacts. Subject to the annual maximum plan benefit allowance. Member responsible for any amounts in excess of the annual maximum plan benefit allowance.

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		<ul style="list-style-type: none"> • \$200 maximum allowance per year towards the purchase of lenses, frames or contacts. <p><u>Out-of-Network</u></p> <ul style="list-style-type: none"> • Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 53% of the in-network allowed amount for one routine eye exam per year. • Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 53% of the in-network allowed amount for lenses, frames, or contacts. • Member is responsible for all amounts in excess of the 53% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance for lenses, frames or contacts. • Total reimbursement is subject to the annual maximum plan benefit allowance. 	<ul style="list-style-type: none"> • \$250 maximum allowance per year towards the purchase of lenses, frames or contacts. <p><u>Out-of-Network</u></p> <ul style="list-style-type: none"> • Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 53% of the in-network allowed amount for one routine eye exam per year. • Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 53% of the in-network allowed amount for lenses, frames, or contacts. • Member is responsible for all amounts in excess of the 53% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance for lenses, frames or contacts. • Total reimbursement is subject to the annual maximum plan benefit allowance.
Mental Health Services	Inpatient Mental Health Services <u>In-Network</u> ♦ <ul style="list-style-type: none"> • \$318 copay per day for days 1-5 • \$0 copay per day for days 6-90 • 190-day lifetime benefit maximum in a psychiatric hospital 	Inpatient Mental Health Services <u>In-Network</u> ♦ <ul style="list-style-type: none"> • \$318 copay per day for days 1-5 • \$0 copay per day for days 6-90 • 190-day lifetime benefit maximum in a psychiatric hospital 	

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	<u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>Out-of-Network</u> 47% of the Medicare-allowed amount
	Outpatient Mental Health Services <u>In-Network</u> ♦ \$20 copay	Outpatient Mental Health Services <u>In-Network</u> ♦ \$20 copay
	<u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>Out-of-Network</u> 47% of the Medicare-allowed amount
Skilled Nursing Facility (SNF)	<u>In-Network</u> ♦ • \$0 copay per day for days 1-20 • \$160 copay per day for days 21-100 <u>Out-of-Network</u> 47% of the Medicare-allowed amount Our plan covers up to 100 days in a SNF per benefit period.	<u>In-Network</u> ♦ • \$0 copay per day for days 1-20 • \$160 copay per day for days 21-100 <u>Out-of-Network</u> 47% of the Medicare-allowed amount Our plan covers up to 100 days in a SNF per benefit period.
Physical Therapy	<u>In-Network</u> ♦ \$40 copay per visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> ♦ \$40 copay per visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Ambulance	<u>In-Network</u> ♦ \$250 copay for each Medicare-covered trip (one-way) <u>Out-of-Network</u> \$325 copay for each Medicare-covered trip (one-way)	<u>In-Network</u> ♦ \$250 copay for each Medicare-covered trip (one-way) <u>Out-of-Network</u> \$250 copay for each Medicare-covered trip (one-way)
Transportation	Not Covered	Not Covered
Medicare Part B Drugs	<u>In-Network</u> • \$5 copay for allergy injections	<u>In-Network</u> • \$5 copay for allergy injections

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<ul style="list-style-type: none"> • 20% of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ♦ <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<ul style="list-style-type: none"> • 20% of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ♦ <u>Out-of-Network</u> 47% of the Medicare-allowed amount

Additional Benefits

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At Home Care	<u>In-Network</u> We offer this benefit through our partnership with our participating provider who connects youthful, energetic adults to enrollees who require assistance with transportation, companionship, household chores, use of electronic devices, exercise and activity. Benefits include the following: At Home Care, 60 hours per year. Services include support with Instrumental Activities of Daily Living (IADL). <u>Out-of-Network</u> Not Available	<u>In-Network</u> We offer this benefit through our partnership with our participating provider who connects youthful, energetic adults to enrollees who require assistance with transportation, companionship, household chores, use of electronic devices, exercise and activity. Benefits include the following: At Home Care, 60 hours per year. Services include support with Instrumental Activities of Daily Living (IADL). <u>Out-of-Network</u> Not Available
Caregiver Support for Member	<u>In-Network</u> Provides coverage for coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits	<u>In-Network</u> Provides coverage for coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits

<div> <div> BlueMedicare Value (PPO) Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025 </div> <div> BlueMedicare Patriot (PPO) Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040 </div> </div>	
include:	include:
<ul style="list-style-type: none"> • A web-based tool that contains educational content covering topics on health, wealth, senior living, in-home care and lifestyle • Access for caregivers and family members to post updates and videos; tools to manage documents, stay organized and on top of upcoming tasks and appointments. Search tools (i.e., senior housing search and in-home care search). <p>See the “Evidence of Coverage” for benefit details. <u>Out-of-Network</u> Not Available</p>	<ul style="list-style-type: none"> • A web-based tool that contains educational content covering topics on health, wealth, senior living, in-home care and lifestyle • Access for caregivers and family members to post updates and videos; tools to manage documents, stay organized and on top of upcoming tasks and appointments. Search tools (i.e., senior housing search and in-home care search). <p>See the “Evidence of Coverage” for benefit details. <u>Out-of-Network</u> Not Available</p>
Diabetic Supplies	
<u>In-Network</u> <ul style="list-style-type: none"> • \$0 copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: <ul style="list-style-type: none"> ◦ Lifescan (One Touch®) Glucose Meters ◦ Lancets ◦ Test Strips <p><u>Out-of-Network</u> 47% of the Medicare-allowed amount</p> <p>Important Note: Insulin, insulin syringes and needles for self-administration in the home are obtained from an in-network retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit. Applicable Part D co-pays and deductibles apply.</p>	<u>In-Network</u> <ul style="list-style-type: none"> • \$0 copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: <ul style="list-style-type: none"> ◦ Lifescan (One Touch®) Glucose Meters ◦ Lancets ◦ Test Strips <p><u>Out-of-Network</u> 47% of the Medicare-allowed amount</p> <p>Important Note: Lifescan (OneTouch®) as well as other brands of glucose meters and test strips can also be obtained through our participating DME network.</p>

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	Lifescan (OneTouch®) as well as other brands of glucose meters and test strips can also be obtained through our participating DME network.	
Medicare Diabetes Prevention Program	<u>In-Network</u> \$0 copay for Medicare-covered services <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> \$0 copay for Medicare-covered services <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Podiatry	<u>In-Network</u> \$35 copay for each Medicare-covered podiatry visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> \$35 copay for each Medicare-covered podiatry visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Chiropractic	<u>In-Network</u> \$20 copay for each Medicare-covered chiropractic service <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> \$20 copay for each Medicare-covered chiropractic service <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Medical Equipment and Supplies	<u>In-Network</u> ♦ <ul style="list-style-type: none"> • 20% of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters • 0% of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> ♦ <ul style="list-style-type: none"> • 20% of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters • 0% of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment <u>Out-of-Network</u> 47% of the Medicare-allowed amount

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Outpatient Occupational and Speech Therapy	<u>In-Network</u> ♦ \$40 copay per visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> ♦ \$40 copay per visit <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Telehealth	<u>In-Network</u> ♦ <ul style="list-style-type: none"> • \$30 copay for Urgently Needed Services • \$5 copay for Primary Care Services • \$40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location • \$40 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital • \$42 copay for Dermatology Services • \$20 copay for individual sessions for outpatient Mental Health Specialty Services • \$20 copay for individual sessions for outpatient Psychiatry Specialty Services • \$20 copay for Opioid Treatment Program Services • \$20 copay for individual sessions for outpatient Substance Abuse Specialty Services • \$0 copay for Diabetes Self-Management Training • \$0 copay for Dietician Services <u>Out-of-Network</u> 47% of the Medicare-allowed amount	<u>In-Network</u> ♦ <ul style="list-style-type: none"> • \$30 copay for Urgently Needed Services • \$10 copay for Primary Care Services • \$40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location • \$40 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital • \$45 copay for Dermatology Services • \$20 copay for individual sessions for outpatient Mental Health Specialty Services • \$20 copay for individual sessions for outpatient Psychiatry Specialty Services • \$20 copay for Opioid Treatment Program Services • \$20 copay for individual sessions for outpatient Substance Abuse Specialty Services • \$0 copay for Diabetes Self-Management Training • \$0 copay for Dietician Services <u>Out-of-Network</u> 47% of the Medicare-allowed amount
Health Education	<u>In-Network</u> meQuilibrium's digital coaching platform delivers clinically validated and highly personalized resilience	<u>In-Network</u> meQuilibrium's digital coaching platform delivers clinically validated and highly personalized resilience

<p>BlueMedicare Value (PPO) Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025</p>		<p>BlueMedicare Patriot (PPO) Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040</p>	
	<p>solutions to help people improve their ability to manage stress and successfully cope with life's challenges. To get started visit www.floridablue.com/medicare to log in to My Health Link™, your member portal. Select "My Health Center" then "meQuilibrium".</p> <p><u>Out-of-Network</u> Not Available</p>		<p>solutions to help people improve their ability to manage stress and successfully cope with life's challenges. To get started visit www.floridablue.com/medicare to log in to My Health Link™, your member portal. Select "My Health Center" then "meQuilibrium".</p> <p><u>Out-of-Network</u> Not Available</p>
Over-the-Counter Items	<ul style="list-style-type: none"> • <u>In-Network</u> • \$75 quarterly allowance for the purchase of non-prescription items such as vitamins and aspirin. • Any balance not used for a quarter will not carry over to the next quarter. <p><u>Out-of-Network</u> Not Available</p>		<p><u>In-Network</u></p> <ul style="list-style-type: none"> • \$50 quarterly allowance for the purchase of non-prescription items such as vitamins and aspirin. • Any balance not used for a quarter will not carry over to the next quarter. <p><u>Out-of-Network</u> Not Available</p>
SilverSneakers® Fitness Program	<p><u>In-Network</u></p> <ul style="list-style-type: none"> • Gym membership and classes available at fitness locations across the country, including national chains and local gyms. • Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more. <p><u>Out-of-Network</u> Not Available</p>		<p><u>In-Network</u></p> <ul style="list-style-type: none"> • Gym membership and classes available at fitness locations across the country, including national chains and local gyms. • Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more. <p><u>Out-of-Network</u> Not Available</p>

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HealthyBlue Rewards	<u>In-Network</u> <ul style="list-style-type: none"> Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings. <u>Out-of-Network</u> Not Available	<u>In-Network</u> <ul style="list-style-type: none"> Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings. <u>Out-of-Network</u> Not Available

Part D Prescription Drug Benefits

	BlueMedicare Value (PPO) Bay, Calhoun, Escambia, Franklin, Gadsden, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla and Walton H5434-025	BlueMedicare Patriot (PPO) Bay, Escambia, Okaloosa, Santa Rosa and Walton H5434-040
Deductible Stage:	<ul style="list-style-type: none"> \$150 per year for Part D prescription drugs (applies to Tier 3 (Preferred Brand), 4 (Non-Preferred Drug) and 5 (Specialty Tier)) You begin in this stage when you fill your first prescription of the year. You pay the full cost of prescription drugs up to the deductible amount before moving to the initial coverage stage. In the deductible stage, if your prescription drug cost exceeds the deductible amount and moves you into the initial stage, you may have to pay the deductible and applicable tier cost share. 	<ul style="list-style-type: none"> This plan does not include Part D Prescription Drug Benefits

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- There is no deductible for BlueMedicare Value for Select Insulins. You pay \$35 for Select Insulins for a one-month supply.

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.

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During the Initial Coverage Stage:

- You begin in this stage after you meet your deductible (if applicable). 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 (your payments plus any Part D plan's payments) reach **\$4,660**. You may get your drugs at network retail pharmacies and mail order pharmacies.
- This plan does not include Part D Prescription Drug Benefits

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Up to a 90-day supply Tier 3, 4, 5 & up to a 100-day supply Tiers 1, 2, 6.

**Standard
Retail/LTC/Mail
Order (31-day
supply)**

**Standard
Retail/Mail Order
(90 to 100-day
supply)**

**Standard
Retail/LTC/Mail
Order
(31-day supply)**

**Standard
Retail/Mail Order
(90 to 100-day
supply)**

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*See Evidence of
Coverage for
details.*

Tier 1 - Preferred Generic	\$0 copay	\$0 copay	N/A	N/A
Tier 2 - Generic	\$5 copay	\$15 copay	N/A	N/A
Tier 3 - Preferred Brand	\$47 copay \$35 copay for Select Insulins	\$141 copay \$105 copay for Select Insulins	N/A	N/A
Tier 4 - Non-Preferred Drug	\$100 copay	\$300 copay	N/A	N/A
Tier 5 - Specialty Tier	30% of the cost \$35 copay for Select Insulins	N/A \$105 copay for Select Insulins	N/A	N/A
Tier 6 - Select Care Drugs	\$0 copay	\$0 copay	N/A	N/A

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.

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During the Coverage Gap Stage:	<ul style="list-style-type: none"> The Coverage Gap Stage begins after your total year-to-date drug cost (your payments plus any Part D plan's payments) reaches \$4,660. 	<ul style="list-style-type: none"> This plan does not include Part D Prescription Drug Benefits

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	<p>You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of \$7,400.</p> <ul style="list-style-type: none"> You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 6 (Select Care Drugs) – or 25% of the cost, whichever is lower For generic drugs, you pay 25% of the cost For brand-name drugs, you pay 25% of the cost (plus a portion of the dispensing fee) BlueMedicare Value offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be \$35 for a one-month supply. 	
Catastrophic Coverage Stage	<p>After your yearly out-of-pocket drug costs reach \$7,400, you pay the <i>greater</i> of:</p> <ul style="list-style-type: none"> \$4.15 copay for generic drugs in all tiers (including brand drugs treated as generic) and a \$10.35 copay for all other drugs in all tiers, or 5% of the cost. 	<ul style="list-style-type: none"> This plan does not include Part D Prescription Drug Benefits
Additional Drug Coverage	<ul style="list-style-type: none"> Please call us or see the plan’s “<i>Evidence of Coverage</i>” on our website (www.floridablue.com/medicare) for complete information about 	<ul style="list-style-type: none"> This plan does not include Part D Prescription Drug Benefits

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and Walton
H5434-040

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.

- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Disclaimers

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

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue 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.

If you have any questions, please contact our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Our hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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Nosotros cumplimos con las leyes federales de derechos civiles aplicables y no discriminamos por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Para información sobre nuestros servicios gratuitos de asistencia lingüística, visite floridablue.com/es/ndnotice.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-926-6565. (TTY users should call 1-800-955-8770). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-962-6565 (TTY: 1-877-955-8773). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-926-6565。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-926-6565。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-926-6565. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-926-6565. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-926-6565. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelman. Unsere Dolmetscher erreichen Sie unter 1-800-926-6565. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-926-6565. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-926-6565. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه خدمة مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-926-6565. سيقوم شخص ما يتحدث العربية مجاناً.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-926-6565 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-926-6565. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-926-6565. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal ouwa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-926-6565. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-926-6565. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがあります。通訳をご用命になるには、1-800-926-6565。