Florida Blue
Your local Blue Cross Blue Shield | MEDICARE

2022 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage
Medicare Advantage Plan without Part D Prescription Drug Coverage

BlueMedicare Value (PPO) H5434-033

BlueMedicare Patriot (PPO) H5434-044

1/1/2022 – 12/31/2022

The plans' service area includes:

Brevard, Orange, Osceola and Seminole Counties

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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 current 2022 *"Medicare & You"* 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 H5434-033 service area includes the following counties in Florida: Brevard, Orange, Osceola and Seminole

Our H5434-044 service area includes the following counties in Florida: Brevard and Orange

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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.

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) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
Monthly Plan Premium	▪ **$0** You must continue to pay your Medicare Part B premium.	▪ **$0** You must continue to pay your Medicare Part B premium.
Part B Premium Buy-Down	▪ This plan does not include a Part B premium buy-down.	▪ BlueMedicare Patriot will reduce your monthly Medicare Part B premium by up to **$50**.
Deductible	▪ **$0** per year for health care services ▪ **$150** per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 6 (Select Care Drugs))	▪ **$0** per year for health care services ▪ This plan does not include Part D Prescription Drug Benefits
Maximum Out-of-Pocket Responsibility	▪ **$4,500** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$10,000** 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.	▪ **$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. ▪ **$10,000** 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) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
Inpatient Hospital Care	In-Network ◊ ▪ **$300** copay per day, days 1-6 ▪ **$0** copay per day, after day 6 Out-of-Network **50%** of the Medicare-allowed amount	In-Network ◊ ▪ **$350** copay per day, days 1-4 ▪ **$0** copay per day, after day 4 Out-of-Network **50%** of the Medicare-allowed amount
Outpatient Hospital Care (Authorization applies to in-network services only)	In-Network ▪ **$90** copay per visit for Medicare-covered observation services ▪ **$250** copay for all other services ◊ Out-of-Network **50%** of the Medicare-allowed amount	In-Network ▪ **$90** copay per visit for Medicare-covered observation services ▪ **$300** copay for all other services ◊ Out-of-Network **50%** of the Medicare-allowed amount

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	**BlueMedicare Patriot (PPO)** Brevard and Orange H5434-044
Ambulatory Surgery Center	In-Network ◊ **$150** copay for surgery services provided at an Ambulatory Surgery Center Out-of-Network **50%** of the Medicare-allowed amount	In-Network ◊ **$300** copay for surgery services provided at an Ambulatory Surgery Center Out-of-Network **50%** of the Medicare-allowed amount
Doctor's Office Visits	In-Network ▪ **$0** copay per Level 1 primary care visit ▪ **$10** copay per Level 2 all other primary care visit ▪ **$35** copay per Level 1 specialist visit ▪ **$49** copay per Level 2 all other specialist visit Out-of-Network **50%** of the Medicare-allowed amount	In-Network ▪ **$10** copay per primary care visit ▪ **$45** copay per specialist visit Out-of-Network **50%** of the Medicare-allowed amount
Preventive Care	In-Network **$0** copay Out-of-Network **50%** of the Medicare-allowed amount ▪ 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) ▪ Obesity screening and therapy to	In-Network **$0** copay Out-of-Network **50%** of the Medicare-allowed amount ▪ 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) ▪ Obesity screening and therapy to

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	**BlueMedicare Patriot (PPO)** Brevard and Orange H5434-044
	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	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** ▪ **$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** ▪ **$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** ▪ **$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** ▪ **$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 medical illness, injury or condition that requires immediate medical attention. ▪ **$30** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$30** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$125** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$30** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$30** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$125** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and

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	Worldwide Urgently Needed Services Does not include emergency transportation.	Worldwide Urgently Needed Services Does not include emergency transportation.
Diagnostic Services/ Labs/Imaging	In-Network ◊ **Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$40** copay at an outpatient hospital facility **X-Rays** ▪ **$15** copay at a physician's office or at an Independent Diagnostic Testing Facility (IDTF) ▪ **$150** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a physician's office or 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	In-Network ◊ **Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$40** copay at an outpatient hospital facility **X-Rays** ▪ **$15** copay at a physician's office or at an Independent Diagnostic Testing Facility (IDTF) ▪ **$150** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$0** copay at a physician's office or at an IDTF ▪ **$75** 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** In-Network ▪ **$35** copay for Level 1 exams to diagnose and treat hearing and balance issues ▪ **$49** copay for all other exams to diagnose and treat hearing and balance issues Out-of-Network **50%** of the Medicare-allowed amount **Additional Hearing Services** In-Network ▪ **$0** copay for one routine hearing exam per year ▪ **$0** copay for evaluation and fitting of hearing aids	**Medicare-Covered Hearing Services** In-Network ▪ **$45** copay for specialist exams to diagnose and treat hearing and balance issues Out-of-Network **50%** of the Medicare-allowed amount **Additional Hearing Services** In-Network ▪ **$0** copay for one routine hearing exam per year ▪ **$0** copay for evaluation and fitting of hearing aids

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	▪ **$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. **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits. ▪ Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum. Out-of-Network **Additional Hearing Services** ▪ Member must submit receipts for reimbursement at 50**%** of maximum allowed for one routine hearing exam per year. ▪ Member must submit receipts for reimbursement at 50**%** of maximum allowed for evaluation and fitting of hearing aids. ▪ Member must submit receipts for reimbursement at 50**%** 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.	▪ **$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. **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits. ▪ Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum. Out-of-Network **Additional Hearing Services** ▪ Member must submit receipts for reimbursement at 50**%** of maximum allowed for one routine hearing exam per year. ▪ Member must submit receipts for reimbursement at 50**%** of maximum allowed for evaluation and fitting of hearing aids. ▪ Member must submit receipts for reimbursement at 50**%** 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	**Medicare-Covered Dental Services** In-Network ◊ **$35** copay for Level 1 non-routine dental care **$49** copay for all other non-routine dental care Out-of-Network **50%** of the Medicare-allowed amount **Additional Dental Services** In-Network ▪ **$0** copay for covered preventive dental services ▪ **$0** copay for covered comprehensive dental services	**Medicare-Covered Dental Services** In-Network ◊ **$45** copay for non-routine dental care Out-of-Network **50%** of the Medicare-allowed amount **Additional Dental Services** In-Network ▪ **$0** copay for covered preventive dental services ▪ **$0** copay for covered comprehensive dental services

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	Out-of-Network ▪ Member pays up front and is reimbursed 50**%** of non-participating rates for covered preventive dental services. ▪ Member pays up front and is reimbursed 50**%** of non-participating rates for covered comprehensive dental services.	Out-of-Network ▪ Member pays up front and is reimbursed 50**%** of non-participating rates for covered preventive dental services. ▪ Member pays up front and is reimbursed 50**%** of non-participating rates for covered comprehensive dental services.
Vision Services	**Medicare-Covered Vision Services** In-Network ▪ **$35** copay for Level 1 physician services to diagnose and treat eye diseases and conditions ▪ **$49** copay for all other 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 Out-of-Network **50%** of the Medicare-allowed amount **Additional Vision Services** In-Network ▪ **$0** copay for an annual routine eye examination ▪ **$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. ▪ **$200** maximum allowance per year towards the purchase of lenses, frames or contacts. Out-of-Network ▪ Member must pay 100**%** of the charges and submit the itemized receipt(s) for reimbursement of 50**%** of the in-network allowed amount for an annual routine eye examination. ▪ Member must pay 100% of the charges and submit the itemized receipt(s) for	**Medicare-Covered Vision Services** In-Network ▪ **$45** copay for specialist 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 Out-of-Network **50%** of the Medicare-allowed amount **Additional Vision Services** In-Network ▪ **$0** copay for an annual routine eye examination ▪ **$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. ▪ **$250** maximum allowance per year towards the purchase of lenses, frames or contacts. Out-of-Network ▪ Member must pay 100**%** of the charges and submit the itemized receipt(s) for reimbursement of 50**%** of the in-network allowed amount for an annual routine eye examination. ▪ Member must pay 100% of the charges and submit the itemized

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	reimbursement of 50% of the in-network allowed amount for lenses, frames, or contacts. ▪ Member is responsible for all amounts in excess of the 50**%** 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.	receipt(s) for reimbursement of 50% of the in-network allowed amount for lenses, frames, or contacts. ▪ Member is responsible for all amounts in excess of the 50**%** 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** In-Network ◊ ▪ **$318** copay per day, days 1-5 ▪ **$0** copay per day, days 6-90 ▪ 190-day lifetime benefit maximum in a psychiatric hospital Out-of-Network **50%** of the Medicare-allowed amount **Outpatient Mental Health Services** In-Network ◊ **$20** copay Out-of-Network **50%** of the Medicare-allowed amount	**Inpatient Mental Health Services** In-Network ◊ ▪ **$318** copay per day, days 1-5 ▪ **$0** copay per day, days 6-90 ▪ 190-day lifetime benefit maximum in a psychiatric hospital Out-of-Network **50%** of the Medicare-allowed amount **Outpatient Mental Health Services** In-Network ◊ **$20** copay Out-of-Network **50%** of the Medicare-allowed amount
Skilled Nursing Facility (SNF)	In-Network ◊ ▪ **$0** copay per day, days 1-20 ▪ **$160** copay per day, days 21-100 Out-of-Network **50%** of the Medicare-allowed amount Our plan covers up to 100 days in a SNF per benefit period.	In-Network ◊ ▪ **$0** copay per day, days 1-20 ▪ **$160** copay per day, days 21-100 Out-of-Network **50%** of the Medicare-allowed amount Our plan covers up to 100 days in a SNF per benefit period.
Physical Therapy	In-Network ◊ **$40** copay per visit Out-of-Network **50%** of the Medicare-allowed amount	In-Network ◊ **$40** copay per visit Out-of-Network **50%** of the Medicare-allowed amount
Ambulance	In-Network ◊ **$310** copay for each Medicare-covered trip (one-way) Out-of-Network **$310** copay for each Medicare-covered trip (one-way)	In-Network ◊ **$250** copay for each Medicare-covered trip (one-way) Out-of-Network **$250** copay for each Medicare-covered trip (one-way)

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Transportation	Not covered	Not covered
Medicare Part B Drugs	In-Network ▪ **$5** copay for allergy injections ▪ **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ Out-of-Network **50%** of the Medicare-allowed amount	In-Network ▪ **$5** copay for allergy injections ▪ **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ Out-of-Network **50%** of the Medicare-allowed amount

Part D Prescription Drug Benefits

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
Deductible Stage:	▪ **$150** per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 6 (Select Care Drugs)) ▪ There is no deductible for BlueMedicare Value for Select Insulins. You pay $35 for Select Insulins.	▪ This plan does not include Part D Prescription Drug Benefits

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.

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
During the Initial Coverage Stage:	▪ You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,430**. You may get your drugs at network retail pharmacies and mail order pharmacies.	▪ This plan does not include Part D Prescription Drug Benefits

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033		BlueMedicare Patriot (PPO) Brevard and Orange H5434-044	
	Standard Retail/LTC (31-day supply)	**Mail Order (90-day supply)**	**Standard Retail/LTC (31-day supply)**	**Mail Order (90-day supply)**
Tier 1 - Preferred Generic	**$0** copay	**$0** copay	**N/A**	**N/A**
Tier 2 - Generic	**$8** copay	**$24** 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	**N/A**	**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:	▪ The Coverage Gap Stage begins after the total yearly drug cost (total drug costs paid by you *and* any Part D plan) reaches **$4,430**. You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of **$7,050**. ▪ You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 6 (Select Care Drugs) ▪ For generic drugs in all other tiers, 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 cost for Select Insulins will be $35	▪ This plan does not include Part D Prescription Drug Benefits

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Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach **$7,050**, you pay the *greater* of: ▪ **$3.95** copay for generic drugs in all tiers (including brand drugs treated as generic) and an **$9.85** copay for all other drugs in all tiers, or **5%** of the cost.	▪ This plan does not include Part D Prescription Drug Benefits
Additional Drug Coverage	▪ 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. ▪ 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.	▪ This plan does not include Part D Prescription Drug Benefits

Additional Benefits

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
At Home Care	In-Network We offer this benefit through our partnership with our participating provider who connects college students to older adults who require assistance with transportation, companionship, household chores, use of electronic devices, and exercise and activity. Benefits include the following: **At Home Care, 60 hours per year.** Services include support with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Out-of-Network Not Available	In-Network We offer this benefit through our partnership with our participating provider who connects college students to older adults who require assistance with transportation, companionship, household chores, use of electronic devices, and exercise and activity. Benefits include the following: **At Home Care, 60 hours per year.** Services include support with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Out-of-Network Not Available

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Caregiver Support for Member	In-Network Provides coverage for coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits include: ▪ 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) See the *Evidence of Coverage* for benefit details. Out-of-Network Not Available	In-Network Provides coverage for coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits include: ▪ 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) See the *Evidence of Coverage* for benefit details. Out-of-Network Not Available
Diabetic Supplies	In-Network ▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips Out-of-Network **50%** of the Medicare-allowed amount **Important Note: Insulin, insulin syringes and needles for self-administration in the home are obtained from a retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply.	In-Network ▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips Out-of-Network **50%** of the Medicare-allowed amount
Medicare Diabetes Prevention Program	In-Network **$0** copay for Medicare-covered services Out-of-Network **50%** of the Medicare-allowed amount	In-Network **$0** copay for Medicare-covered services Out-of-Network **50%** of the Medicare-allowed amount

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Podiatry	In-Network **$35** copay for each Medicare-covered podiatry visit Out-of-Network **50%** of the Medicare-allowed amount	In-Network **$35** copay for each Medicare-covered podiatry visit Out-of-Network **50%** of the Medicare-allowed amount
Chiropractic	In-Network **$20** copay for each Medicare-covered chiropractic service Out-of-Network **50%** of the Medicare-allowed amount	In-Network **$20** copay for each Medicare-covered chiropractic service Out-of-Network **50%** of the Medicare-allowed amount
Medical Equipment and Supplies	In-Network ◊ ▪ **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 Out-of-Network **50%** of the Medicare-allowed amount	In-Network ◊ ▪ **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 Out-of-Network **50%** of the Medicare-allowed amount
Outpatient Occupational and Speech Therapy	In-Network ◊ **$40** copay per visit Out-of-Network **50%** of the Medicare-allowed amount	In-Network ◊ **$40** copay per visit Out-of-Network **50%** of the Medicare-allowed amount
Telehealth ◊ (Authorization applies to in-network services only)	In-Network ▪ **$30** copay for Urgently Needed Services ▪ Level 1 **$0** copay, Level 2 **$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 ▪ Level 1 **$35** copay, Level 2 **$49** 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	In-Network ▪ **$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

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
	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 Out-of-Network **50%** of the Medicare-allowed amount	outpatient Substance Abuse Specialty Services ▪ **$0** copay for Diabetes Self-Management Training ▪ **$0** copay for Dietician Services Out-of-Network **50%** of the Medicare-allowed amount

You Get More with BlueMedicare

	BlueMedicare Value (PPO) Brevard, Orange, Osceola and Seminole H5434-033	BlueMedicare Patriot (PPO) Brevard and Orange H5434-044
Health Education	In- and Out-of-Network meQuilibrium's digital coaching platform delivers clinically validated and highly personalized resilience solutions to help people improve their ability to manage stress and successfully cope with life's challenges. To get started go to FloridaBlue.com/Medicare log in, click on My Health and select HealthyBlue Rewards.	In- and Out-of-Network meQuilibrium's digital coaching platform delivers clinically validated and highly personalized resilience solutions to help people improve their ability to manage stress and successfully cope with life's challenges. To get started go to FloridaBlue.com/Medicare log in, click on My Health and select HealthyBlue Rewards.
Over-the-Counter Items	▪ **$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	▪ **$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
HealthyBlue Rewards	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.

SilverSneakers® Fitness Program	▪ 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	▪ 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

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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Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770. اتصل برقم 1-800-333-2227.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.
ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiík'eh, ná hóló̜. Koji̜' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí koji̜' hodíílnih 1-800-333-2227.