

2021 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

BlueMedicare Complete (HMO D-SNP) H1035-029

BlueMedicare Complete (HMO D-SNP) H1035-030

1/1/2021 – 12/31/2021



The plans' service area includes:

Brevard, Hillsborough, Orange, Osceola, and Polk 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 current "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
- receive any level of assistance from the Florida Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual-eligible. BlueMedicare Complete (HMO D-SNP) may enroll dual-eligibles who are in the SMLB, SLMB Plus, QMB, QMB Plus, FBDE, QI and QDWI programs; and
- live in **our service area.**

Our H1035-029 service area includes the following counties in Florida: Brevard, Orange, and Osceola

Our H1035-030 service area includes the following counties in Florida: Hillsborough and Polk

Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

- 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.
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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.
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Important Information

Through this document you will see the symbols below.

- * Services with this symbol may require approval in advance (a referral) from your Primary Care Doctor (PCP) in order for the plan to cover them.
- ◇ Services with this symbol may require prior authorization from the plan before you receive services.

If you do not get a referral or prior authorization when required, you may have to pay the full cost of the services. Please contact your PCP or refer to the Evidence of Coverage (EOC) for more information about services that require a referral and/or prior authorization from the plan.

Monthly Premium, Deductible and Limits



	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
Monthly Plan Premium	\$0 or up to \$30.80 There may be some situations in which your premium increases. You will never pay more than a premium of \$30.80 . You must continue to pay your Medicare Part B premium.	\$0 or up to \$30.80 There may be some situations in which your premium increases. You will never pay more than a premium of \$30.80 . You must continue to pay your Medicare Part B premium.
Deductible	\$0 or up to \$445 per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic))	\$0 or up to \$445 per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic))
Maximum Out-of-Pocket Responsibility	\$2,500 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year	\$1,500 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year

Medical and Hospital Benefits



	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
Inpatient Hospital Care ◇	<u>This Plan</u> \$0 copay <u>Medicaid</u> \$3 copay, per visit, if not exempt from cost-sharing	<u>This Plan</u> \$0 copay
Outpatient Hospital Care ◇	<u>This Plan</u> \$0 copay <u>Medicaid</u> \$3 copay, per visit, if not exempt from cost sharing	<u>This Plan</u> \$0 copay
Ambulatory Surgery Center ◇	<u>This Plan</u> \$0 copay <u>Medicaid</u> \$3 copay for Medicaid-covered services	<u>This Plan</u> \$0 copay

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
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Doctor’s Office Visits

This Plan

- **\$0** copay per primary care visit
- **\$0** copay per specialist* visit

This Plan

- **\$0** copay per primary care visit
- **\$0** copay per specialist* visit

Medicaid

- **\$2** copay per provider or group provider, per day, if not exempt from cost-sharing
- **\$3** copay for practitioner services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing

Preventive Care

This Plan

\$0 copay for Medicare-covered services

This Plan

\$0 copay for Medicare-covered services

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual Wellness Visit
- Bone mass measurements
- Breast cancer screening (mammograms)
- Cardiovascular disease screening and intensive behavioral therapy
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening and self-management training
- Glaucoma screening
- Hepatitis B and C screening
- HIV screening
- Intensive Behavioral Therapy for Obesity
- Lung cancer screening
- Medical nutrition therapy
- Prostate cancer screening
- Sexually transmitted infections - screening and high-intensity behavioral counseling to prevent them
- Smoking and tobacco use cessation counseling
- Vaccines for influenza, pneumonia and Hepatitis B
- Welcome to Medicare preventive visit

Any additional preventive services approved by Medicare during the contract year will be covered.

Medicaid

\$3 copay for covered preventive screenings provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing.

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
Emergency Care	<p><u>This Plan</u> \$0 copay per visit, in- or out-of-network</p> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> ▪ \$3 copay, per visit, if not exempt from cost sharing ▪ 5% coinsurance up to the first \$300 of Medicaid payment for each visit in the emergency room for non-emergency services, not to exceed \$15 	<p><u>This Plan</u> \$0 copay per visit, in- or out-of-network</p>
Urgently Needed Services	<p><u>This Plan</u> \$0 copay at an Urgent Care Center or Convenient Care Center, in- or out-of-network</p> <p><u>Medicaid</u> \$2 copay for services in a practitioner office setting, per provider or group provider, per day, if not exempt from cost sharing</p> <p>Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.</p>	<p><u>This Plan</u> \$0 copay at an Urgent Care Center or Convenient Care Center, in- or out-of-network</p>
Diagnostic Services/ Labs/Imaging*◇	<p><u>This Plan</u></p> <p>Laboratory Services</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>X-Rays</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>Advanced Imaging Services Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>Radiation Therapy</p> <ul style="list-style-type: none"> ▪ \$0 copay <p><u>Medicaid</u></p> <ul style="list-style-type: none"> ▪ \$1 copay for independent laboratory services per provider, per day, if not exempt from cost sharing ▪ \$1 copay for portable X-Ray services per provider, per day, if not exempt from cost sharing ▪ \$2 copay per provider or group provider, per day, if not exempt from cost sharing. ▪ \$3 copay for services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing 	<p><u>This Plan</u></p> <p>Laboratory Services</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>X-Rays</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>Advanced Imaging Services Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan</p> <ul style="list-style-type: none"> ▪ \$0 copay <p>Radiation Therapy</p> <ul style="list-style-type: none"> ▪ \$0 copay

BlueMedicare Complete (HMO D-SNP)
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Hearing Services



This Plan

Medicare-Covered Hearing Services*

- **\$0** copay for exams to diagnose and treat hearing and balance issues

Additional Hearing Services

- **\$0** copay for one routine hearing exam per year
- **\$0** copay for evaluation and fitting of hearing aids
- **\$1,000 per ear.** Up to 2 hearing aids every year with a maximum benefit allowance of \$1000 per ear.

NOTE: Hearing aids must be purchased through NationsHearing to have access to the benefit.

- Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.

This Plan

Medicare-Covered Hearing Services*

- **\$0** copay for exams to diagnose and treat hearing and balance issues

Additional Hearing Services

- **\$0** copay for one routine hearing exam per year
- **\$0** copay for evaluation and fitting of hearing aids
- **\$1,000 per ear.** Up to 2 hearing aids every year with a maximum benefit allowance of \$1000 per ear.

NOTE: Hearing aids must be purchased through NationsHearing to have access to the benefit.

- Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.

Medicaid

\$0 copay for recipients who have moderate hearing loss or greater, including the following services:

- One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient
- Up to three pairs of ear molds per year, per recipient
- One fitting and dispensing service per ear, every three years, per recipient

Dental Services



This Plan

Medicare-Covered Dental Services

- **\$0** copay for non-routine dental care ◇

Additional Dental Services

- **\$0** copay for covered preventive dental services
- **\$0** copay for covered comprehensive dental services

This Plan

Medicare-Covered Dental Services

- **\$0** copay for non-routine dental care ◇

Additional Dental Services

- **\$0** copay for covered preventive dental services
- **\$0** copay for covered comprehensive dental services

Medicaid

- **\$2** copay for oral and maxillofacial surgery services per practitioner office visit, per day
- **\$3** copay for dental services provided at a Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing

Covered Adult Services (Ages 21 and Over)

- One comprehensive evaluation every three years, per recipient. For recipients age 21 years and older, a comprehensive evaluation is reimbursed for determining the need for full or partial dentures, or problem focused services
- Limited evaluations, as medically indicated
- One complete series of intraoral radiographs every three years, per recipient.
- One panoramic radiograph every three years, per recipient
- Prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:
 - ✓ One upper, lower, or complete set of full or removable partial dentures per recipient
 - ✓ One reline, per denture, per 366 days, per recipient

Traditional Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

Vision Services



This Plan

Medicare-Covered Vision Services

- **\$0** 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

Additional Vision Services

- **\$0** copay for an annual routine eye examination
- **\$400** allowance per year towards the purchase of lenses, frames or contact lenses

Medicaid

- **\$0** copay for visual aid services
- **\$2** copay for optometrist services, per provider or group provider, per day, if not exempt from cost sharing
- **\$3** copay for optometrist services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing

Florida Medicaid covers one frame every two years and two lenses every 365 days.

This Plan

Medicare-Covered Vision Services

- **\$0** 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

Additional Vision Services

- **\$0** copay for an annual routine eye examination
- **\$400** allowance per year towards the purchase of lenses, frames or contact lenses

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
Mental Health Care ◇	<p><u>This Plan</u></p> <p>Inpatient Mental Health Services</p> <ul style="list-style-type: none"> ▪ \$0 copay ▪ 190-day lifetime benefit maximum in a psychiatric hospital <p>Outpatient Mental Health Services</p> <ul style="list-style-type: none"> ▪ \$0 copay <p><u>Medicaid</u></p> <ul style="list-style-type: none"> ▪ \$2 copay per provider, per day, if not exempt from cost sharing ▪ \$3 copay for outpatient mental health services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing 	<p><u>This Plan</u></p> <p>Inpatient Mental Health Services</p> <ul style="list-style-type: none"> ▪ \$0 copay ▪ 190-day lifetime benefit maximum in a psychiatric hospital <p>Outpatient Mental Health Services</p> <ul style="list-style-type: none"> ▪ \$0 copay
Skilled Nursing Facility (SNF) ◇	<p><u>This Plan</u></p> <p>\$0 copay</p> <p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p><u>Medicaid</u></p> <p>\$0 copay</p>	<p><u>This Plan</u></p> <p>\$0 copay</p> <p>Our plan covers up to 100 days in a SNF per benefit period.</p>
Physical Therapy* ◇	<p><u>This Plan</u></p> <p>\$0 copay</p> <p><u>Medicaid</u></p> <p>Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services.</p> <ul style="list-style-type: none"> ▪ \$0 copay for respiratory system services ▪ \$0 copay for physical therapy services ▪ \$2 copay per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost sharing ▪ \$3 copay for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing ▪ \$3 copay, per visit to an outpatient hospital, if not exempt from cost sharing 	<p><u>This Plan</u></p> <p>\$0 copay</p>
Ambulance ◇	<p><u>This Plan</u></p> <p>\$0 copay for each Medicare-covered trip (one-way)</p> <p><u>Medicaid</u></p> <p>\$0 copay for Medicaid-covered services</p>	<p><u>This Plan</u></p> <p>\$0 copay for each Medicare-covered trip (one-way)</p>

BlueMedicare Complete (HMO D-SNP)
Brevard, Orange, and Osceola
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Transportation



This Plan

- **\$0** copay for unlimited one-way trips for rides to your doctor, hospital or pharmacy
- These services can accommodate wheelchairs, walkers, oxygen tanks and service animals

Medicaid

\$1 copay per one-way trip.

Non-Emergency Medical Transportation (NEMT) services are available only to eligible beneficiaries who cannot obtain transportation through any other means (such as family, friends or community resources).

This Plan

- **\$0** copay for unlimited one-way trips for rides to your doctor, hospital or pharmacy
- These services can accommodate wheelchairs, walkers, oxygen tanks and service animals

**Medicare Part B
Drugs** ◇

This Plan

- **\$0** copay for allergy injections
- **0%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs

Medicaid

- **\$0** copay for prescription drugs obtained through the Prescription Drug Services program
- **\$2** copay for practitioner services, per provider or group provider, per day, if not exempt from cost sharing
- **\$3** copay for Part B prescription drug administration provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing

This Plan

- **\$0** copay for allergy injections
- **0%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs

Part D Prescription Drug Benefits



Most of our members qualify for and are getting “**Extra Help**” from Medicare to pay for their prescription drug plan costs. If you are in the “Extra Help” program, we sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

Deductible Stage

The deductible does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic). **In most cases you will pay \$0 or \$92.** The deductible for those who do not qualify for “Extra Help” is \$445.

Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **\$4,130**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost sharing below applies to a one-month (31 day) supply.

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029		BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030	
	Preferred Retail/Mail Order	Standard Retail/Mail Order	Preferred Retail/Mail Order	Standard Retail/Mail Order
Tier 1 - Preferred Generic	\$0	\$0 or \$10 copay depending on the level of “Extra Help” you receive.	\$0	\$0 or \$10 copay depending on the level of “Extra Help” you receive.
Tier 2 - Generic	\$0	\$0 or \$11 copay depending on the level of “Extra Help” you receive.	\$0	\$0 or \$11 copay depending on the level of “Extra Help” you receive.
Tier 3 - Preferred Brand	\$0 or \$40 copay depending on the level of “Extra Help” you receive.	\$0 or \$47 copay depending on the level of “Extra Help” you receive.	\$0 or \$40 copay depending on the level of “Extra Help” you receive.	\$0 or \$47 copay depending on the level of “Extra Help” you receive.
Tier 4 - Non- Preferred Drug	\$0 or \$92 copay depending on the level of “Extra Help” you receive.	\$0 or \$99 copay depending on the level of “Extra Help” you receive.	\$0 or \$92 copay depending on the level of “Extra Help” you receive.	\$0 or \$99 copay depending on the level of “Extra Help” you receive.
Tier 5 - Specialty Tier	\$0 copay or up to 25%, depending on the level of “Extra Help” you receive.	\$0 copay or up to 25%, depending on the level of “Extra Help” you receive.	\$0 copay or up to 25%, depending on the level of “Extra Help” you receive.	\$0 copay or up to 25%, depending on the level of “Extra Help” you receive.

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 **\$4,130**. You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **\$6,550**.

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
During the Coverage Gap Stage:	<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 2 (Generic) – or 25% of the cost, whichever is lower ▪ 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) 	<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 2 (Generic) – or 25% of the cost, whichever is lower ▪ 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)

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach **\$6,550**, you pay the *greater* of:

- **\$3.70** copay for generic drugs in all tiers (including brand drugs treated as generic) and a **\$9.20** copay for all other drugs in all tiers, or **5%** of the cost.

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 Brand/Drug) cost sharing.
- Your cost-sharing may be different if you use a Long-Term Care 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.

Additional Benefits

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
At Home Care	<p>We offer this benefit through our partnership with Papa who connects college students to older adults who require assistance with transportation, companionship, household chores, use of electronic devices, and exercise and activity.</p> <p>Benefits include the following:</p> <p>At Home Care, 60 hours per year.</p> <p>Services include support with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).</p>	
Diabetic Supplies ◇	<p>\$0 copay at your network retail or mail-order pharmacy for Diabetic Supplies such as:</p> <ul style="list-style-type: none"> • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips <p>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 you Medicare Part D pharmacy benefit. Applicable co-pays and deductibles apply.</p>	
Medicare Diabetes Prevention Program	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services
Podiatry	<p><u>This Plan</u> \$0 copay</p> <p><u>Medicaid</u> \$2 copay per provider, per day</p>	<p><u>This Plan</u> \$0 copay</p>
Chiropractic	<p><u>This Plan</u> \$0 copay</p> <p><u>Medicaid</u> \$1 copay per provider/group, per day</p>	<p><u>This Plan</u> \$0 copay</p>
Medical Equipment and Supplies ◇	<p><u>This Plan</u></p> <ul style="list-style-type: none"> ▪ 0% 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 <p><u>Medicaid</u> \$0 copay</p>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> ▪ 0% 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

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Outpatient Occupational and Speech Therapy*◇	<u>This Plan</u> \$0 copay	<u>This Plan</u> \$0 copay
	<u>Medicaid</u> Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services. <ul style="list-style-type: none"> ▪ \$0 copay for respiratory system services ▪ \$0 copay for physical therapy services ▪ \$2 copay per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost sharing ▪ \$3 copay for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost sharing ▪ \$3 copay, per visit to an outpatient hospital, if not exempt from cost sharing 	
Telehealth	<u>This Plan</u>	<u>This Plan</u>
	<ul style="list-style-type: none"> ▪ \$0 copay for Urgently Needed Services ▪ \$0 copay for Primary Care Services ▪ \$0 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location ▪ \$0 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital ▪ \$0 copay for Dermatology Services ▪ \$0 copay for individual sessions for outpatient Mental Health Specialty Services ▪ \$0 copay for individual sessions for outpatient Psychiatry Specialty Services ▪ \$0 copay for Opioid Treatment Program Services ▪ \$0 copay for individual sessions for outpatient Substance Abuse Specialty Services ▪ \$0 copay for Diabetes Self-Management Training ▪ \$0 copay for Dietician Services 	
	<u>Medicaid</u> \$0 copay	

You Get More with BlueMedicare

	BlueMedicare Complete (HMO D-SNP) Brevard, Orange, and Osceola H1035-029	BlueMedicare Complete (HMO D-SNP) Hillsborough and Polk H1035-030
Over-the-Counter Items 	<ul style="list-style-type: none"> ▪ \$100 monthly allowance for the purchase of non-prescription items, such as vitamins and aspirin ▪ Any balance not used for a month will not carry over to the next month 	<ul style="list-style-type: none"> ▪ \$100 monthly allowance for the purchase of non-prescription items, such as vitamins and aspirin ▪ Any balance not used for a month will not carry over to the next month
HealthyBlue Rewards 	<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 	
SilverSneakers® Fitness Program 	<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 	
Meal Benefit	<ul style="list-style-type: none"> ▪ 10 meals after each hospital discharge 	<ul style="list-style-type: none"> ▪ 10 meals after each hospital discharge

Disclaimers

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

If you have any questions, please contact our Member Services 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.

HMO coverage is offered by Florida Blue Medicare, Inc., dba Florida Blue Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

Sponsored by Florida Blue Medicare, Inc., d/b/a Florida Blue Medicare, and the State of Florida, Agency for Health Care Administration.

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)
civilrightscordinator@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 1-800-352-253-008 (رقم هاتف الصم والبكم: 1-0778-559-008). اتصل برقم 1-800-333-008-1.

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 โดยติดต่อหมายเลขโทรศัพท์ **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 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojí' hodíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éi kojí' hodíłnih 1-800-333-2227.