



MEDICARE

## 2027 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

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**BlueMedicare Premier (HMO) H1035-026**

**BlueMedicare Premier (HMO) H1035-048**

1/1/2027 – 12/31/2027

Our service area includes:

**Brevard and Orange Counties**

This is a summary of what our plan covers and what you pay. For a complete list of covered services, limitations and exclusions, you may view the **"Evidence of Coverage"**. For a complete list of the drugs we cover you may view the List of Covered Drugs (**"Formulary"**). The "Evidence of Coverage" and "Formulary" for these plans are on our website, [www.floridablue.com/medicare/forms](http://www.floridablue.com/medicare/forms) or you can call us for assistance.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You* 2027 handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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## 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 H1035-026 service area includes the following county in Florida: [Orange](#)**

**Our H1035-048 service area includes the following county in Florida: [Brevard](#)**

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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 (<https://providersearch.floridablue.com/>). 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: 711.**
- **If you are not a member of this plan, call us at 1-855-601-9465, TTY: 711.**
  - 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](http://www.floridablue.com/medicare).

## Important Information

Throughout 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 refer to the "Evidence of Coverage" for more information about services that require a referral and/or prior authorization from the plan.

## Monthly Premium, Deductible and Limits

|                                                                                             | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                   | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly Plan Premium</b>                                                                 | <ul style="list-style-type: none"> <li>\$0</li> </ul> <p>You must continue to pay your Medicare Part B premium.</p>                                                                                                                                                                 | <ul style="list-style-type: none"> <li>\$0</li> </ul> <p>You must continue to pay your Medicare Part B premium.</p>                                                                                                                                                                 |
| <b>Annual Deductible</b>                                                                    | <ul style="list-style-type: none"> <li>\$0 per year for medical services</li> <li>\$700 per year for Part D prescription drugs applies to Tier 3 (Preferred Brand), 4 (Non-Preferred Drug) and 5 (Specialty Tier) drugs</li> <li>There is no deductible for insulins.</li> </ul>    | <ul style="list-style-type: none"> <li>\$0 per year for medical services</li> <li>\$700 per year for Part D prescription drugs applies to Tier 3 (Preferred Brand), 4 (Non-Preferred Drug) and 5 (Specialty Tier) drugs</li> <li>There is no deductible for insulins.</li> </ul>    |
| <b>Maximum Out-of-Pocket Responsibility (MOOP)</b><br>(does not include prescription drugs) | <ul style="list-style-type: none"> <li>\$4,425</li> <li>This is the most you pay for Medicare-covered medical services from in-network providers for the year.</li> <li>Once you reach the maximum out-of-pocket (MOOP), our plan pays 100% of covered medical services.</li> </ul> | <ul style="list-style-type: none"> <li>\$3,500</li> <li>This is the most you pay for Medicare-covered medical services from in-network providers for the year.</li> <li>Once you reach the maximum out-of-pocket (MOOP), our plan pays 100% of covered medical services.</li> </ul> |

| BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                    | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                   |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Premium and prescription drug costs do not count toward your MOOP.</li> </ul> | <ul style="list-style-type: none"> <li>Premium and prescription drug costs do not count toward your MOOP.</li> </ul> |

## Medical and Hospital Benefits

|                                                                                                                 | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                      | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Hospital Coverage</b> ♦<br><br>(Covers an unlimited number of days for an inpatient hospital stay) | <ul style="list-style-type: none"> <li>\$185 copay per day for days 1-7</li> <li>\$0 copay per day for days 8-90</li> </ul>                                                                                                            | <ul style="list-style-type: none"> <li>\$325 copay per day for days 1-7</li> <li>\$0 copay per day for days 8-90</li> </ul>                                                                                                            |
| <b>Outpatient Hospital Coverage</b>                                                                             | <ul style="list-style-type: none"> <li>Medicare-covered services♦: \$175 copay per visit</li> <li>Observation Services: \$110 copay per visit</li> </ul>                                                                               | <ul style="list-style-type: none"> <li>Medicare-covered services♦: \$225 copay per visit</li> <li>Observation Services: \$150 copay per visit</li> </ul>                                                                               |
| <b>Ambulatory Surgical Center (ASC) Services</b>                                                                | <ul style="list-style-type: none"> <li>Surgery services♦: \$125 copay</li> </ul>                                                                                                                                                       | <ul style="list-style-type: none"> <li>Surgery services♦: \$175 copay</li> </ul>                                                                                                                                                       |
| <b>Doctor Visits</b>                                                                                            | <ul style="list-style-type: none"> <li>PCP: \$0 copay</li> <li>Specialist*: \$55 copay</li> <li>Physiatrist*: \$0 copay</li> </ul>                                                                                                     | <ul style="list-style-type: none"> <li>PCP: \$0 copay</li> <li>Specialist*: \$35 copay</li> </ul>                                                                                                                                      |
| <b>Preventive Care</b><br><br>(Medicare-covered Services)                                                       | \$0 copay<br><br><ul style="list-style-type: none"> <li>Abdominal aortic aneurysm screenings</li> <li>Alcohol misuse screenings &amp; counseling</li> <li>Bone mass measurements</li> <li>Cardiovascular disease screenings</li> </ul> | \$0 copay<br><br><ul style="list-style-type: none"> <li>Abdominal aortic aneurysm screenings</li> <li>Alcohol misuse screenings &amp; counseling</li> <li>Bone mass measurements</li> <li>Cardiovascular disease screenings</li> </ul> |

| <b>BlueMedicare Premier (HMO)</b><br><b>Orange</b><br><b>H1035-026</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>BlueMedicare Premier (HMO)</b><br><b>Brevard</b><br><b>H1035-048</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <ul style="list-style-type: none"> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cervical &amp; vaginal cancer screenings</li> <li>• Colorectal cancer screenings               <ul style="list-style-type: none"> <li>◦ Blood-based biomarker tests</li> <li>◦ Colonoscopies</li> <li>◦ Computed tomography (CT) colonography</li> <li>◦ Fecal occult blood tests</li> <li>◦ Flexible sigmoidoscopies</li> <li>◦ Multi-target stool DNA tests</li> </ul> </li> <li>• Counseling to prevent tobacco use &amp; tobacco-caused disease</li> <li>• Depression screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma screenings</li> <li>• Hepatitis B shots</li> <li>• Hepatitis B Virus (HBV) infection screenings</li> <li>• Hepatitis C screening tests</li> <li>• HIV screenings</li> <li>• Lung cancer screenings</li> <li>• Mammograms (screening)</li> <li>• Medical nutrition therapy services</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Obesity behavioral therapy</li> <li>• One-time “Welcome to Medicare” preventive visit</li> <li>• Pre-exposure prophylaxis (PrEP) for HIV prevention</li> <li>• Prostate cancer screenings</li> <li>• Sexually transmitted infections screenings &amp; counseling</li> <li>• Shots:               <ul style="list-style-type: none"> <li>◦ COVID-19 vaccines</li> <li>◦ Flu shots</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cervical &amp; vaginal cancer screenings</li> <li>• Colorectal cancer screenings               <ul style="list-style-type: none"> <li>◦ Blood-based biomarker tests</li> <li>◦ Colonoscopies</li> <li>◦ Computed tomography (CT) colonography</li> <li>◦ Fecal occult blood tests</li> <li>◦ Flexible sigmoidoscopies</li> <li>◦ Multi-target stool DNA tests</li> </ul> </li> <li>• Counseling to prevent tobacco use &amp; tobacco-caused disease</li> <li>• Depression screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma screenings</li> <li>• Hepatitis B shots</li> <li>• Hepatitis B Virus (HBV) infection screenings</li> <li>• Hepatitis C screening tests</li> <li>• HIV screenings</li> <li>• Lung cancer screenings</li> <li>• Mammograms (screening)</li> <li>• Medical nutrition therapy services</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Obesity behavioral therapy</li> <li>• One-time “Welcome to Medicare” preventive visit</li> <li>• Pre-exposure prophylaxis (PrEP) for HIV prevention</li> <li>• Prostate cancer screenings</li> <li>• Sexually transmitted infections screenings &amp; counseling</li> <li>• Shots:               <ul style="list-style-type: none"> <li>◦ COVID-19 vaccines</li> <li>◦ Flu shots</li> </ul> </li> </ul> |

|                                                                                                                                                                                                                                                              | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                         | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                              | <ul style="list-style-type: none"> <li>◦ Hepatitis B shots</li> <li>◦ Pneumococcal shots</li> <li>• Yearly “Wellness” visit</li> <li>• Any additional preventive services approved by Medicare during the contract year will be covered</li> </ul>                                                                                                                        | <ul style="list-style-type: none"> <li>◦ Hepatitis B shots</li> <li>◦ Pneumococcal shots</li> <li>• Yearly “Wellness” visit</li> <li>• Any additional preventive services approved by Medicare during the contract year will be covered</li> </ul>                                                                                                                        |
| <b>Emergency Care</b>                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>• \$110 copay</li> <li>• Copay is waived if admitted to same hospital within 48 hours of an emergency room visit.</li> </ul>                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>• \$150 copay</li> <li>• Copay is waived if admitted to same hospital within 48 hours of an emergency room visit.</li> </ul>                                                                                                                                                                                                       |
| <b>Worldwide Emergency Care</b><br>(does not include emergency transportation)<br><b>If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.</b> | <ul style="list-style-type: none"> <li>• \$110 copay</li> <li>• Worldwide emergency and worldwide urgently needed services have a combined \$25,000 coverage limit. The copay for worldwide emergency care is waived if admitted to the same hospital.</li> <li>• There is no coverage for care outside of the emergency room or emergency hospital admission.</li> </ul> | <ul style="list-style-type: none"> <li>• \$150 copay</li> <li>• Worldwide emergency and worldwide urgently needed services have a combined \$25,000 coverage limit. The copay for worldwide emergency care is waived if admitted to the same hospital.</li> <li>• There is no coverage for care outside of the emergency room or emergency hospital admission.</li> </ul> |
| <b>Urgently Needed Services</b>                                                                                                                                                                                                                              | <ul style="list-style-type: none"> <li>• Urgent Care Center: \$50 copay</li> <li>• Convenient Care Center: \$50 copay</li> </ul>                                                                                                                                                                                                                                          | <ul style="list-style-type: none"> <li>• Urgent Care Center: \$65 copay</li> <li>• Convenient Care Center: \$65 copay</li> </ul>                                                                                                                                                                                                                                          |
| <b>Worldwide Urgent Care</b><br>(does not include emergency transportation)<br><b>If you have an urgently needed service outside</b>                                                                                                                         | <ul style="list-style-type: none"> <li>• \$110 copay</li> </ul>                                                                                                                                                                                                                                                                                                           | <ul style="list-style-type: none"> <li>• \$150 copay</li> </ul>                                                                                                                                                                                                                                                                                                           |

|                                                                                                                                           | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                 | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.</b> | <ul style="list-style-type: none"> <li>Worldwide emergency and worldwide urgently needed services have a combined \$25,000 coverage limit. The copay for worldwide urgently needed services is not waived if admitted to the hospital.</li> </ul> | <ul style="list-style-type: none"> <li>Worldwide emergency and worldwide urgently needed services have a combined \$25,000 coverage limit. The copay for worldwide urgently needed services is not waived if admitted to the hospital.</li> </ul> |
| <b>Diagnostic Services/<br/>Labs/Imaging *◇</b>                                                                                           |                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                   |
| <b>Tests and Procedures</b>                                                                                                               | <ul style="list-style-type: none"> <li>Independent Diagnostic Testing Facility (IDTF): \$50 copay</li> <li>Outpatient Hospital Facility: \$50 copay</li> <li>Allergy Testing: \$0 copay</li> </ul>                                                | <ul style="list-style-type: none"> <li>Independent Diagnostic Testing Facility (IDTF): \$50 copay</li> <li>Outpatient Hospital Facility: \$50 copay</li> <li>Allergy Testing: \$0 copay</li> </ul>                                                |
| <b>Laboratory Services</b>                                                                                                                | <ul style="list-style-type: none"> <li>Independent Clinical Laboratory: \$0 copay</li> <li>Outpatient Hospital Facility: \$35 copay</li> </ul>                                                                                                    | <ul style="list-style-type: none"> <li>Independent Clinical Laboratory: \$0 copay</li> <li>Outpatient Hospital Facility: \$35 copay</li> </ul>                                                                                                    |
| <b>X-Rays</b>                                                                                                                             | <ul style="list-style-type: none"> <li>Physician's Office: \$0 copay</li> <li>IDTF: \$0 copay</li> <li>Outpatient Hospital Facility: \$100 copay</li> </ul>                                                                                       | <ul style="list-style-type: none"> <li>Physician's Office: \$0 copay</li> <li>IDTF: \$0 copay</li> <li>Outpatient Hospital Facility: \$100 copay</li> </ul>                                                                                       |
| <b>Advanced Imaging Services</b><br>(MRI, MRA, PET, CT scan, Nuclear Medicine Testing)                                                    | <ul style="list-style-type: none"> <li>Physician's Office: \$75 copay</li> <li>IDTF: \$100 copay</li> <li>Outpatient Hospital Facility: \$250 copay</li> </ul>                                                                                    | <ul style="list-style-type: none"> <li>Physician's Office: \$75 copay</li> <li>IDTF: \$100 copay</li> <li>Outpatient Hospital Facility: \$250 copay</li> </ul>                                                                                    |
| <b>Radiation Therapy</b>                                                                                                                  | <ul style="list-style-type: none"> <li>20% coinsurance</li> </ul>                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>20% coinsurance</li> </ul>                                                                                                                                                                                 |

|                                     | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                    | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                   |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------|---------------------|-------|---------------------|-------|---------------------|-----------|--------------------|----------|-----------------------|---------|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------|-------|---------------------|-------|---------------------|-------|---------------------|-----------|--------------------|----------|-----------------------|---------|-----------------------|
| Hearing Services Medicare-Covered * | <ul style="list-style-type: none"><li>\$55 copay</li></ul>                                                                                                                                                                                                                                                                                                                                                           | <ul style="list-style-type: none"><li>\$35 copay</li></ul>                                                                                                                                                                                           |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Additional Hearing Services         | <ul style="list-style-type: none"><li>Routine hearing exam: \$0 copay</li><li>Evaluation and fitting: \$0 copay</li><li>See chart below for copay of each hearing aid for up to 2 hearing aids every year.</li></ul>                                                                                                                                                                                                 | <ul style="list-style-type: none"><li>Routine hearing exam: \$0 copay</li><li>Evaluation and fitting: \$0 copay</li><li>See chart below for copay of each hearing aid for up to 2 hearing aids every year.</li></ul>                                 |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
|                                     | <table><tr><th>Technology Level</th><th>Copay Per Hearing Aid Device</th></tr><tr><td>Entry</td><td>\$350.00 per device</td></tr><tr><td>Basic</td><td>\$525.00 per device</td></tr><tr><td>Prime</td><td>\$825.00 per device</td></tr><tr><td>Preferred</td><td>\$1,125 per device</td></tr><tr><td>Advanced</td><td>\$1,425.00 per device</td></tr><tr><td>Premium</td><td>\$1,825.00 per device</td></tr></table> | Technology Level                                                                                                                                                                                                                                     | Copay Per Hearing Aid Device | Entry | \$350.00 per device | Basic | \$525.00 per device | Prime | \$825.00 per device | Preferred | \$1,125 per device | Advanced | \$1,425.00 per device | Premium | \$1,825.00 per device | <table><tr><th>Technology Level</th><th>Copay Per Hearing Aid Device</th></tr><tr><td>Entry</td><td>\$350.00 per device</td></tr><tr><td>Basic</td><td>\$525.00 per device</td></tr><tr><td>Prime</td><td>\$825.00 per device</td></tr><tr><td>Preferred</td><td>\$1,125 per device</td></tr><tr><td>Advanced</td><td>\$1,425.00 per device</td></tr><tr><td>Premium</td><td>\$1,825.00 per device</td></tr></table> | Technology Level | Copay Per Hearing Aid Device | Entry | \$350.00 per device | Basic | \$525.00 per device | Prime | \$825.00 per device | Preferred | \$1,125 per device | Advanced | \$1,425.00 per device | Premium | \$1,825.00 per device |
| Technology Level                    | Copay Per Hearing Aid Device                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Entry                               | \$350.00 per device                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Basic                               | \$525.00 per device                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Prime                               | \$825.00 per device                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Preferred                           | \$1,125 per device                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Advanced                            | \$1,425.00 per device                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Premium                             | \$1,825.00 per device                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Technology Level                    | Copay Per Hearing Aid Device                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Entry                               | \$350.00 per device                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Basic                               | \$525.00 per device                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Prime                               | \$825.00 per device                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Preferred                           | \$1,125 per device                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Advanced                            | \$1,425.00 per device                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Premium                             | \$1,825.00 per device                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                      |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
|                                     | <p>Subject to Benefit Maximum. Member is responsible for any amount after the benefit maximum has been applied.</p> <p><b>NOTE:</b> Hearing aids must be purchased through our participating provider to receive in-network benefits.</p>                                                                                                                                                                            | <p>Subject to Benefit Maximum. Member is responsible for any amount after the benefit maximum has been applied.</p> <p><b>NOTE:</b> Hearing aids must be purchased through our participating provider to receive in-network benefits.</p>            |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |
| Dental Services ♦ Medicare-Covered  | <ul style="list-style-type: none"><li>\$55 copay for non-routine dental care (dental services that are covered when medically necessary (e.g., jaw surgery, tooth extraction before radiation, or dental exam prior to kidney transplant).</li></ul>                                                                                                                                                                 | <ul style="list-style-type: none"><li>\$35 copay for non-routine dental care (dental services that are covered when medically necessary (e.g., jaw surgery, tooth extraction before radiation, or dental exam prior to kidney transplant).</li></ul> |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                              |       |                     |       |                     |       |                     |           |                    |          |                       |         |                       |

|                                                                                    | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional Dental Services</b>                                                  | <ul style="list-style-type: none"> <li>• <b>Preventive Dental:</b> You pay \$0 per service. Your preventive dental services include routine exams, cleanings, fluoride treatment, silver diamine fluoride (medicine applied to a tooth to help stop a cavity from growing) and X-rays per calendar year.</li> <li>• <b>Comprehensive Dental:</b> You pay \$0 per service. Your comprehensive dental services include fillings, crown (only provided following root canal treatment on the same tooth), root canal treatment, deep cleanings, full mouth debridement, periodontal maintenance, complete and partial dentures, denture adjustment, repair, reline and extractions per calendar year.</li> <li>• <i>See the Evidence of Coverage for full details, including frequency limits and provider network information.</i></li> </ul> | <ul style="list-style-type: none"> <li>• <b>Preventive Dental:</b> You pay \$0 per service. Your preventive dental services include routine exams, cleanings, fluoride treatment, silver diamine fluoride (medicine applied to a tooth to help stop a cavity from growing) and X-rays per calendar year.</li> <li>• <b>Comprehensive Dental:</b> You pay \$0 per service. Your comprehensive dental services include fillings, crown (only provided following root canal treatment on the same tooth), root canal treatment, deep cleanings, full mouth debridement, periodontal maintenance, complete and partial dentures, denture adjustment, repair, reline and extractions per calendar year.</li> <li>• <i>See the Evidence of Coverage for full details, including frequency limits and provider network information.</i></li> </ul> |
| <b>Vision Services Medicare-Covered</b>                                            | <ul style="list-style-type: none"> <li>• Physician Services*: \$55 copay</li> <li>• Glaucoma Screening: \$0 copay</li> <li>• Diabetic Retinal Exam: \$0 copay</li> <li>• Eyeglasses or Contact Lenses: \$0 copay<br/>One pair after cataract surgery</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>• Physician Services*: \$35 copay</li> <li>• Glaucoma Screening: \$0 copay</li> <li>• Diabetic Retinal Exam: \$0 copay</li> <li>• Eyeglasses or Contact Lenses: \$0 copay<br/>One pair after cataract surgery</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Additional Vision Services</b><br>(subject to annual maximum benefit allowance) | <ul style="list-style-type: none"> <li>• Routine Eye Exam: \$0 copay</li> <li>• Lenses, frames or contacts: \$0 copay</li> <li>• Member responsible for any amounts in excess of the \$225 annual maximum plan benefit allowance.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>• Routine Eye Exam: \$0 copay</li> <li>• Lenses, frames or contacts: \$0 copay</li> <li>• Member responsible for any amounts in excess of the \$225 annual maximum plan benefit allowance.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                         | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                       | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                      |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Mental Health</b>                    |                                                                                                                                                                                                                         |                                                                                                                                                                                                                         |
| <b>Services ♦</b>                       |                                                                                                                                                                                                                         |                                                                                                                                                                                                                         |
| <b>Inpatient Psychiatric Hospital</b>   | <ul style="list-style-type: none"> <li>• \$300 copay per day for days 1-7</li> <li>• \$0 copay per day for days 8-90</li> </ul> 90 days maximum per stay with a lifetime maximum of 190 days                            | <ul style="list-style-type: none"> <li>• \$350 copay per day for days 1-7</li> <li>• \$0 copay per day for days 8-90</li> </ul> 90 days maximum per stay with a lifetime maximum of 190 days                            |
| <b>Outpatient Mental Health Therapy</b> | <ul style="list-style-type: none"> <li>• Individual sessions: \$30 copay</li> <li>• Group sessions: \$30 copay</li> </ul>                                                                                               | <ul style="list-style-type: none"> <li>• Individual sessions: \$40 copay</li> <li>• Group sessions: \$30 copay</li> </ul>                                                                                               |
| <b>Skilled Nursing Facility (SNF) ♦</b> | <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1-20</li> <li>• \$221 copay per day for days 21-100</li> </ul> (Covers up to 100 days per benefit period)                                           | <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1-20</li> <li>• \$221 copay per day for days 21-100</li> </ul>                                                                                      |
| <b>Physical Therapy *♦</b>              | <ul style="list-style-type: none"> <li>• Physician's Office: \$45 copay</li> <li>• Specialist Office: \$45 copay</li> <li>• Outpatient Rehab Facility: \$45 copay</li> <li>• Outpatient Hospital: \$45 copay</li> </ul> | <ul style="list-style-type: none"> <li>• Physician's Office: \$55 copay</li> <li>• Specialist Office: \$55 copay</li> <li>• Outpatient Rehab Facility: \$55 copay</li> <li>• Outpatient Hospital: \$55 copay</li> </ul> |
| <b>Speech Therapy *♦</b>                | <ul style="list-style-type: none"> <li>• Physician's Office: \$45 copay</li> <li>• Specialist Office: \$45 copay</li> <li>• Outpatient Rehab Facility: \$45 copay</li> <li>• Outpatient Hospital: \$45 copay</li> </ul> | <ul style="list-style-type: none"> <li>• Physician's Office: \$55 copay</li> <li>• Specialist Office: \$55 copay</li> <li>• Outpatient Rehab Facility: \$55 copay</li> <li>• Outpatient Hospital: \$55 copay</li> </ul> |
| <b>Occupational Therapy *♦</b>          | <ul style="list-style-type: none"> <li>• Physician's Office: \$45 copay</li> <li>• Specialist Office: \$45 copay</li> <li>• Outpatient Rehab Facility: \$45 copay</li> <li>• Outpatient Hospital: \$45 copay</li> </ul> | <ul style="list-style-type: none"> <li>• Physician's Office: \$50 copay</li> <li>• Specialist Office: \$50 copay</li> <li>• Outpatient Rehab Facility: \$50 copay</li> <li>• Outpatient Hospital: \$50 copay</li> </ul> |
| <b>Lymphedema Therapy *♦</b>            | <ul style="list-style-type: none"> <li>• \$13 copay for Lymphedema Therapy</li> </ul>                                                                                                                                   | <ul style="list-style-type: none"> <li>• \$13 copay for Lymphedema Therapy</li> </ul>                                                                                                                                   |
| <b>Ambulance</b>                        | <u>In-Network♦</u> <ul style="list-style-type: none"> <li>• Ground: \$275 copay</li> </ul>                                                                                                                              | <u>In-Network♦</u> <ul style="list-style-type: none"> <li>• Ground: \$345 copay</li> </ul>                                                                                                                              |

|                                | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                    | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                   |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (one-way trip)                 | <ul style="list-style-type: none"> <li>Facility-to-facility transfers: \$0 copay for transfer via ground ambulance</li> <li>Air: 20% of the total cost</li> </ul>                                                                    | <ul style="list-style-type: none"> <li>Facility-to-facility transfers: \$0 copay for transfer via ground ambulance</li> <li>Air: 20% of the total cost</li> </ul>                                                                    |
|                                | <u>Out-of-Network</u> <ul style="list-style-type: none"> <li>Ground: \$275 copay</li> <li>Facility-to-facility transfers: \$275 copay for transfer via ground ambulance</li> <li>Air: 20% of the total cost</li> </ul>               | <u>Out-of-Network</u> <ul style="list-style-type: none"> <li>Ground: \$345 copay</li> <li>Facility-to-facility transfers: \$345 copay for transfer via ground ambulance</li> <li>Air: 20% of the total cost</li> </ul>               |
| <b>Transportation</b>          | <ul style="list-style-type: none"> <li><u>Not</u> Covered</li> </ul>                                                                                                                                                                 | <ul style="list-style-type: none"> <li><u>Not</u> Covered</li> </ul>                                                                                                                                                                 |
| <b>Medicare Part B Drugs</b> ◊ | <ul style="list-style-type: none"> <li>Allergy Injections: 0% coinsurance</li> <li>Chemotherapy drugs: Up to 20% coinsurance</li> <li>Other Part B drugs: Up to 20% coinsurance</li> <li>Part B Insulin: Up to \$35 copay</li> </ul> | <ul style="list-style-type: none"> <li>Allergy Injections: 0% coinsurance</li> <li>Chemotherapy drugs: Up to 20% coinsurance</li> <li>Other Part B drugs: Up to 20% coinsurance</li> <li>Part B Insulin: Up to \$35 copay</li> </ul> |

## Part D Prescription Drug Benefits

|                          | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible Stage:</b> | <ul style="list-style-type: none"> <li>The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of \$700 which applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs. You must pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs until you reach the plan's deductible amount. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. For all other drugs, you will not have to pay any deductible. The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.</li> <li>Once you have paid \$700 which applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.</li> </ul> | <ul style="list-style-type: none"> <li>The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of \$700 which applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs. You must pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs until you reach the plan's deductible amount. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. For all other drugs, you will not have to pay any deductible. The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.</li> <li>Once you have paid \$700 which applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.</li> </ul> |

### Initial Coverage Stage

|                                           | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                              | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                             |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>During the Initial Coverage Stage:</b> | <ul style="list-style-type: none"> <li>You begin in this stage after you meet your deductible (if applicable). During this stage, the plan pays its</li> </ul> | <ul style="list-style-type: none"> <li>You begin in this stage after you meet your deductible (if applicable). During this stage, the plan pays its</li> </ul> |

| BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                                                    | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>share of the cost of your drugs, and you pay your share of the cost.</p> <ul style="list-style-type: none"><li>• In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you have paid a combined total of <b>\$2,400</b>, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. You may get your drugs at network retail and mail order pharmacies.</li></ul> | <p>share of the cost of your drugs, and you pay your share of the cost.</p> <ul style="list-style-type: none"><li>• In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you have paid a combined total of <b>\$2,400</b>, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. You may get your drugs at network retail and mail order pharmacies.</li></ul> |

|                             | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026 |                                                   | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048 |                                                   |
|-----------------------------|---------------------------------------------------|---------------------------------------------------|----------------------------------------------------|---------------------------------------------------|
| Tier Drug Coverage          | 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) |
| Tier 1 - Preferred Generic  | \$0 copay                                         | \$0 copay                                         | \$0 copay                                          | \$0 copay                                         |
| Tier 2 - Generic            | \$0 copay                                         | \$0 copay                                         | \$0 copay                                          | \$0 copay                                         |
| Tier 3 - Preferred Brand    | 19% coinsurance                                   | 19% coinsurance                                   | 19% coinsurance                                    | 19% coinsurance                                   |
| Tier 4 - Non-Preferred Drug | 26% coinsurance                                   | 26% coinsurance                                   | 26% coinsurance                                    | 26% coinsurance                                   |
| Tier 5 - Specialty Tier     | 25% coinsurance                                   | N/A                                               | 25% coinsurance                                    | N/A                                               |
| Tier 6 - Select Care Drugs  | \$0 copay                                         | \$0 copay                                         | \$0 copay                                          | \$0 copay                                         |

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the drug tier, even if you haven't paid your deductible.

|                                     | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                     | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                    |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Catastrophic Coverage Stage:</b> | <ul style="list-style-type: none"> <li>You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the <b>\$2,400</b> limit for the calendar year. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You will stay in this payment stage until the end of the calendar year.</li> </ul> | <ul style="list-style-type: none"> <li>You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the <b>\$2,400</b> limit for the calendar year. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You will stay in this payment stage until the end of the calendar year.</li> </ul> |

|                                                   | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional Information About Drug Coverage</b> | <ul style="list-style-type: none"> <li>For a complete list of the drugs we cover see the plan's <b>"Formulary"</b> and to see information about the cost of drugs see the plan's <b>"Evidence of Coverage"</b>. These documents are on our website, (<a href="http://www.floridablue.com/medicare/forms">www.floridablue.com/medicare/forms</a>) or you can call us. If you request a formulary exception, and the plan approves it, you will pay <b>Tier 4 (Non-Preferred Drug)</b> cost-sharing.</li> <li>Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.</li> <li>Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.</li> </ul> | <ul style="list-style-type: none"> <li>For a complete list of the drugs we cover see the plan's <b>"Formulary"</b> and to see information about the cost of drugs see the plan's <b>"Evidence of Coverage"</b>. These documents are on our website, (<a href="http://www.floridablue.com/medicare/forms">www.floridablue.com/medicare/forms</a>) or you can call us. If you request a formulary exception, and the plan approves it, you will pay <b>Tier 4 (Non-Preferred Drug)</b> cost-sharing.</li> <li>Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.</li> <li>Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.</li> </ul> |
| <b>Medicare Prescription Payment Plan</b>         | <ul style="list-style-type: none"> <li>The Medicare Prescription Payment Plan is a payment option to help Medicare beneficiaries spread out their out-of-pocket drug costs across the calendar year (January to December). Participation is voluntary and there is no cost to enroll. You can enroll in the payment plan by speaking with your Agent of Record (AOR) or by calling our dedicated Election support line at 1-800-926-6565 or 1-833-696-2087, (TTY – 711) 8am — 8pm ET Mon – Fri, (voicemails monitored on weekends), 8am — 8pm ET 7 days a week (during Annual Enrollment Period (AEP)).</li> </ul>                                                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>The Medicare Prescription Payment Plan is a payment option to help Medicare beneficiaries spread out their out-of-pocket drug costs across the calendar year (January to December). Participation is voluntary and there is no cost to enroll. You can enroll in the payment plan by speaking with your Agent of Record (AOR) or by calling our dedicated Election support line at 1-800-926-6565 or 1-833-696-2087, (TTY – 711) 8am — 8pm ET Mon – Fri, (voicemails monitored on weekends), 8am — 8pm ET 7 days a week (during Annual Enrollment Period (AEP)).</li> </ul>                                                                                                                                                                                                                            |

**BlueMedicare Premier (HMO)**  
**Orange**  
**H1035-026**

- For more information about the payment plan, speak with agent or visit our website at <https://www.floridablue.com/medicare/member/prescription-drug-payments>.

**BlueMedicare Premier (HMO)**  
**Brevard**  
**H1035-048**

- For more information about the payment plan, speak with agent or visit our website at <https://www.floridablue.com/medicare/member/prescription-drug-payments>.

## Additional Medical Benefits

|                                                             | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Podiatry</b>                                             | \$10 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Medicare-covered</b>                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Chiropractic</b>                                         | \$15 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$15 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| (manual manipulation of the spine to correct subluxation)   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Telehealth *◇</b>                                        | <ul style="list-style-type: none"> <li>Urgently Needed Services: \$50 copay</li> <li>PCP: \$0 copay</li> <li>Occupational Therapy: \$45 copay</li> <li>Physical Therapy: \$45 copay</li> <li>Speech Therapy: \$45 copay</li> <li>Dermatology Services: \$55 copay</li> <li>Mental Health Specialty Services: \$30 copay</li> <li>Psychiatry Specialty Services: \$30 copay</li> <li>Opioid Treatment: \$20 copay</li> <li>Substance Use Disorder Services: \$30 copay</li> <li>Diabetes Self-Management Training: \$0 copay</li> <li>Dietician Services: \$0 copay</li> </ul> | <ul style="list-style-type: none"> <li>Urgently Needed Services: \$65 copay</li> <li>PCP: \$0 copay</li> <li>Occupational Therapy: \$50 copay</li> <li>Physical Therapy: \$55 copay</li> <li>Speech Therapy: \$55 copay</li> <li>Dermatology Services: \$35 copay</li> <li>Mental Health Specialty Services: \$40 copay</li> <li>Psychiatry Specialty Services: \$40 copay</li> <li>Opioid Treatment: \$40 copay</li> <li>Substance Use Disorder Services: \$40 copay</li> <li>Diabetes Self-Management Training: \$0 copay</li> <li>Dietician Services: \$0 copay</li> </ul> |
| A referral may be needed for certain services.              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| A Prior Authorization may be required for certain services. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Diabetic Supplies</b>                                    | Available at Florida Blue Medicare contracted retail or mail-order pharmacies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Available at Florida Blue Medicare contracted retail or mail-order pharmacies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Preferred Brands:</b>                                    | <ul style="list-style-type: none"> <li>0% coinsurance Abbott (eg. Freestyle Lite) and Ascensia (Contour®) glucose meters, test strips, and lancets.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>0% coinsurance Abbott (eg. Freestyle Lite) and Ascensia (Contour®) glucose meters, test strips, and lancets.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                                    | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                    | <ul style="list-style-type: none"> <li>0% coinsurance Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies (other brands may require prior authorization)</li> </ul> <p><b>Non-Preferred Brands:</b></p> <ul style="list-style-type: none"> <li>20% coinsurance Glucose meters, test strips, lancets, and continuous glucose monitors. All others, such as LifeScan (OneTouch), MiniMed CGM may require prior authorization.</li> </ul> <p><b>Insulin, alcohol swabs, insulin syringes, and needles for self-administration in the home are covered under Medicare Part D pharmacy benefit, with applicable co-pays and deductibles.</b></p> <p>Please note: Medical supplies (e.g. alcohol swabs, gauze, syringes) are not covered under Part D unless used for insulin administration.</p> <p>Glucose meters and test strips can also be obtained through our participating DME network.</p> <p>Initial fill of a CGM with an insulin pump can be obtained through our participating DME provider.</p> | <ul style="list-style-type: none"> <li>0% coinsurance Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies (other brands may require prior authorization)</li> </ul> <p><b>Non-Preferred Brands:</b></p> <ul style="list-style-type: none"> <li>20% coinsurance Glucose meters, test strips, lancets, and continuous glucose monitors. All others, such as LifeScan (OneTouch), MiniMed CGM may require prior authorization.</li> </ul> <p><b>Insulin, alcohol swabs, insulin syringes, and needles for self-administration in the home are covered under Medicare Part D pharmacy benefit, with applicable co-pays and deductibles.</b></p> <p>Please note: Medical supplies (e.g. alcohol swabs, gauze, syringes) are not covered under Part D unless used for insulin administration.</p> <p>Glucose meters and test strips can also be obtained through our participating DME network.</p> <p>Initial fill of a CGM with an insulin pump can be obtained through our participating DME provider.</p> |
| <b>Medicare Diabetes Prevention Program (MDPP)</b> | <ul style="list-style-type: none"> <li>\$0 copay</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>\$0 copay</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                                       | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                        | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                       |
|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Durable Medical Equipment (DME) and Supplies ♦</b> | <ul style="list-style-type: none"> <li>• Standard Raised Toilet Seat &amp;/or Standard Tub Seat: 0% coinsurance</li> <li>• Motorized Wheelchairs/Electric Scooters: 20% coinsurance</li> <li>• All Other DME: 20% coinsurance</li> </ul> | <ul style="list-style-type: none"> <li>• Standard Raised Toilet Seat &amp;/or Standard Tub Seat: 0% coinsurance</li> <li>• Motorized Wheelchairs/Electric Scooters: 20% coinsurance</li> <li>• All Other DME: 20% coinsurance</li> </ul> |

## Additional Benefits

|                                                       | BlueMedicare Premier (HMO)<br>Orange<br>H1035-026                                                                                                                                                                                                                                                                                                                                     | BlueMedicare Premier (HMO)<br>Brevard<br>H1035-048                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SilverSneakers® Fitness Program</b>                | <ul style="list-style-type: none"> <li>You get a basic membership to any SilverSneakers® participating fitness facility. Gym membership and classes available at fitness locations across the country, including national chains and local gyms.</li> <li>Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.</li> </ul> | <ul style="list-style-type: none"> <li>You get a basic membership to any SilverSneakers® participating fitness facility. Gym membership and classes available at fitness locations across the country, including national chains and local gyms.</li> <li>Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.</li> </ul>                                                                       |
| <b>Over-the-Counter Items</b>                         | <ul style="list-style-type: none"> <li><u>Not</u> Covered</li> </ul>                                                                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>\$30 every 3 months benefit allowance on your Blue Dollars Benefits MasterCard® Prepaid Card to use toward the purchase of eligible items.</li> <li>You can shop for eligible products at participating retail locations or you can shop for eligible products online or by phone using our participating vendors.</li> <li>Any unused allowance is forfeited and does not roll over to the next quarter.</li> </ul> |
| <b>HealthyBlue Rewards</b>                            | <ul style="list-style-type: none"> <li>Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars Benefits MasterCard® Prepaid Card for completing and/or reporting certain preventive care and screenings.</li> <li>Rewards are available after opting in to the program.</li> </ul>                                      | <ul style="list-style-type: none"> <li>Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars Benefits MasterCard® Prepaid Card for completing and/or reporting certain preventive care and screenings.</li> <li>Rewards are available after opting in to the program.</li> </ul>                                                                                                            |
| <b>Blue Dollars Benefits MasterCard® Prepaid Card</b> | <ul style="list-style-type: none"> <li><i>See Healthy Blue Rewards</i></li> </ul>                                                                                                                                                                                                                                                                                                     | <ul style="list-style-type: none"> <li><b>Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.</b></li> </ul>                                                                                                                                                                                                                                                                                |

**BlueMedicare Premier (HMO)**  
**Orange**  
**H1035-026**

**BlueMedicare Premier (HMO)**  
**Brevard**  
**H1035-048**

- Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan.
- Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply.
- The Blue Dollars card will be mailed directly to you and replenished depending on your plan benefits.
- *See Healthy Blue Rewards*
- *See Over-the-Counter Items*

## 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 number at 1-800-926-6565 (TTY users should call 711). 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.

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

The Benefits Mastercard® Prepaid Card, is issued by The Bancorp Bank, N.A., pursuant to license by Mastercard International Incorporated and Card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated. Valid only in the U.S. No cash access. Eligible allowance and rewards amounts cannot be combined. Additional limitations or restrictions may apply. Subscription type services like Walmart+, Instacart, Shipt, Amazon are not eligible.

Participation in HealthyBlue Rewards is voluntary and offered at no additional cost to you.

HealthyBlue Rewards Program (HealthyBlue) restrictions and limitations may apply. Eligible members who opt in to participate in HealthyBlue Rewards must complete the activity and redeem rewards no later than December 31st of the benefit year. Unredeemed rewards will expire by December 31st of the benefit year or if you disenroll from the plan. If you need help with your HealthyBlue Rewards account or for full details on current program rules, visit [FloridaBlue.com/HealthyBlue](https://FloridaBlue.com/HealthyBlue) or call 1-800-926-6565 (TTY: 711).

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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, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Postal Employee Program (PEP): 1-844-960-2583
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

### **Health and vision coverage (including FEP and PEP 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@bcbsfl.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 or Civil Rights 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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or 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](http://www.hhs.gov/ocr/office/file/index.html)

Visit [www.floridablue.com/disclaimer/ndnotice](http://www.floridablue.com/disclaimer/ndnotice) to view an electronic version of this notice.  
87768 0825R

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-800-352-2583, a FEP al 1-800-333-2227, a Medicare al 1-800-926-6565, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòm ki disponib gratis. Rele nan 1-800-352-2583, FEP 1-800-333-2227, oswa rele Medicare nan 1-800-926-6565 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-800-352-2583 联邦雇员计划(FEP)1-800-333-2227 医疗保险 (Medicare)1-800-926-6565 听障专线 (TTY)711.

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-800-352-2583, le FEP au 1-800-333-2227, le Medicare au 1-800-926-6565 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على:

TTY: 1-800-926-6565 (الإعاقة السمعية) Medicare: 1-800-926-6565 برنامج FEP: 1-800-333-2227 برنامج 1-800-352-2583 711)

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-800-352-2583, FEP: 1-800-333-2227, Medicare: 1-800-926-6565, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-800-352-2583, FEP 1-800-333-2227, 메디케어 1-800-926-6565, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે.

1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711) પર કોલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-800-352-2583、FEP 1-800-333-2227、メディケア 1-800-926-6565 (TTY 711) までお電話ください。

خدمات رایگان زبانی، کمک‌های جانبی، و قالب‌های جایگزین در دسترس هستند. با شماره 1-800-352-2583 تماس بگیرید. برای FEP 2227-333-800-1 و برای Medicare 6565-926-800-1 با (TTY: 711) تماس بگیرید.

T'áá free yíníłta'go saad bee áká anilyeedígíí, ałk'ida'ánígíí, dóó t'áá ajilii hane' bee áká anilyeedígíí t'éiyá éí hołne'. 1-800-352-2583 bich'í' náhodooni, FEP bich'í' 1-800-333-2227 bich'í' náhodooni, Medicare bich'í' 1-800-926-6565 bich'í' náhodooni, (TTY 711).