

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of BlueMedicare Patriot (PPO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026.

This is an important legal document. Keep it in a safe place.

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). 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. This call is free.

This plan, BlueMedicare Patriot (PPO) is offered by Florida Blue Medicare. (When this *Evidence of Coverage* says "we," "us," or "our," it means Florida Blue Medicare. When it says "plan" or "our plan," it means BlueMedicare Patriot (PPO).)

This document is available for free in *Spanish*.

This information is available in an alternate format, including large print, audio and braille.

Benefits, premiums, deductibles and/or copayments/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: August 31, 2026)
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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of BlueMedicare Patriot (PPO)

Section 1.1 You're enrolled in BlueMedicare Patriot (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, BlueMedicare Patriot (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

BlueMedicare Patriot (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how BlueMedicare Patriot (PPO) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders or amendments*.

The contract is in effect for the months you're enrolled in BlueMedicare Patriot (PPO) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of BlueMedicare Patriot (PPO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve BlueMedicare Patriot (PPO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Section 2.2 Plan service area for BlueMedicare Patriot (PPO)

BlueMedicare Patriot (PPO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below:

Our service area includes these counties in Florida: Brevard, Broward, Flagler, Indian River, Martin, Miami-Dade, Orange, Osceola, Palm Beach, Seminole, St. Lucie, and Volusia

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services 1-800-926-6565 (TTY users call 1-800-955-8770) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

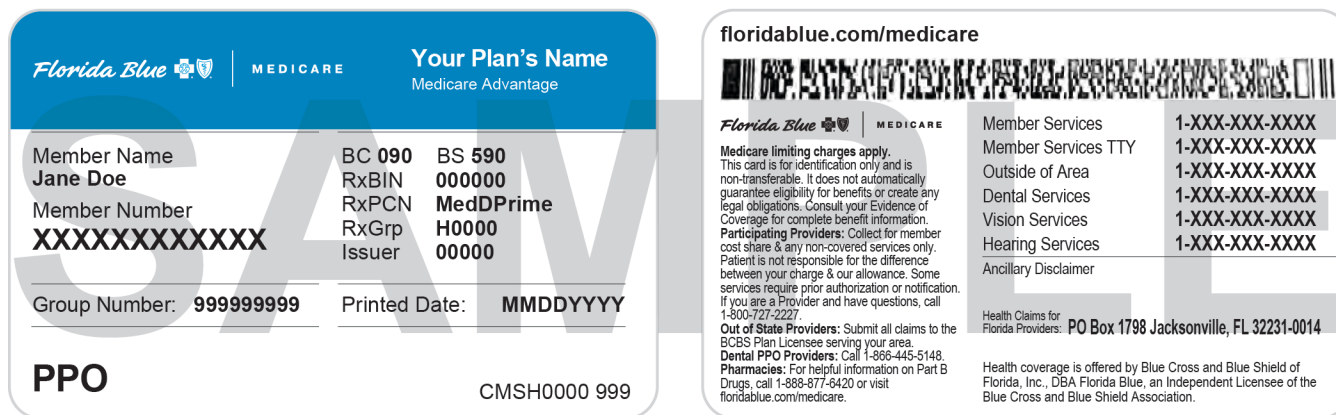
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify BlueMedicare Patriot (PPO) if you're not eligible to stay a member of our plan on this basis. BlueMedicare Patriot (PPO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your BlueMedicare Patriot (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* <https://providersearch.floridablue.com/> lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

Get the most recent list of providers and suppliers is available on our website at <https://providersearch.floridablue.com/>.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or paper form) from Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2026

Your Costs in 2026	
Monthly plan premium*	\$0
*Your premium can be higher than this amount. Go to Section 4.1 for details.	
Deductible	• \$950 for Medicare-covered services received out-of-network.
Maximum out-of-pocket amount	• From network providers: \$6,750 is the most you pay for Medicare-covered medical services from in-network providers for the year. • From in-network and out-of-network providers combined: \$10,100 is the most you pay for Medicare-covered medical services you receive from in- and out-of-network providers combined.
Primary care office visits	<u>In-Network</u> \$0 copay per visit <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
Specialist office visits	<u>In-Network</u> \$55 copay per visit <u>Out-of-Network</u>

Your Costs in 2026	
	50% of the total cost after you reach your \$950 out-of-network deductible.
Inpatient hospital stays	<u>In-Network</u> \$385 copay per day for days 1-7 \$0 copay per day for days 8-90 <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for BlueMedicare Patriot (PPO).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Medicare Part B Premium Reduction

As you know, your Medicare Part B premium is automatically deducted from your monthly Social Security check. While you're enrolled in this plan, Florida Blue will pay up to \$100 of your Medicare Part B premium. As a result, your monthly Social Security check will increase by this amount. You don't have to complete any paperwork to get this benefit. We'll take care of that for you.

It could take several months for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for several months after the effective date of this plan. Any missed increases will be added to your next check after processing is complete. Please note that if you disenroll from this plan, your Medicare Part B premium benefit will end on the

date of disenrollment. As mentioned above, it could take several months for the Social Security Administration to complete their processing. Any premium reductions you get after you disenroll will eventually be deducted from your Social Security check.

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage.

The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts.** Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). You can also update your information by visiting www.floridablue.com/medicare/member and click on the “Log In” button to access your online member account, then select “My Account.” You can then edit your member profile and send us messages to let us know about changes to your information.

It’s also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we’ll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it’s correct, you don’t need to do anything. If the information isn’t correct, or if you have other coverage that isn’t listed, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the “primary payer”) pays up to the limits of its coverage. The one that pays second (the “secondary payer”) only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you’re under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you’re over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

Chapter 1. Get started as a member

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 BlueMedicare Patriot (PPO) contacts

For help with claims, billing or member card questions, call or write to BlueMedicare Patriot (PPO) Member Services. We'll be happy to help you.

Method	Member Services - Contact Information
CALL	1-800-926-6565 Calls to this number are free. 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. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 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.
FAX	1-305-716-9333

Method	Member Services - Contact Information
WRITE	Florida Blue Medicare Member Services P.O. Box 45296 Jacksonville, FL 32232-5296
WEBSITE	<u>www.floridablue.com/medicare/member</u>

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care - Contact Information	
CALL	1-800-926-6565 Calls to this number are free. 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.
TTY	1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 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.
FAX	1-904-301-1614 for coverage decisions You may fax both standard and fast (expedited) coverage decision requests to us at this number. 1-305-437-7490 for appeals decisions

Coverage Decisions and Appeals for Medical Care - Contact Information**Please send only requests for fast (expedited) appeals by fax.****WRITE**

For coverage decisions use address below:

Florida Blue Medicare Utilization Management Department
 4800 Deerwood Campus Parkway
 Building 900, 5th Floor
 Jacksonville, FL 32246

For appeals use address below:

Florida Blue Medicare
 Attn: Medicare Appeals and Grievances Department
 P.O. Box 41629
 Jacksonville, FL 32203-1629

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how make a complaint about your medical care, go to Chapter 7.

Complaints About Medical Care - Contact Information**CALL****1-800-926-6565**

Calls to this number are free. 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.

TTY**1-800-955-8770**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. 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

Complaints About Medical Care - Contact Information

	are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.
FAX	1-305-437-7490 NOTE: Please send only requests for fast (expedited) complaints by fax.
WRITE	Florida Blue Medicare Attn: Medicare Appeals and Grievances Department P.O. Box 41629 Jacksonville, FL 32203-1629
MEDICARE WEBSITE	To submit a complaint about BlueMedicare Patriot (PPO) directly to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information

WRITE	<u>For requests related to medical care:</u> Florida Blue Medicare P. O. Box 1798 Jacksonville, FL 32231-0014
WEBSITE	<u>www.floridablue.com/medicare/forms</u>

SECTION 2 Get help from Medicare

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers.

You can also visit www.Medicare.gov to tell Medicare about any complaints you have about BlueMedicare Patriot (PPO).

Medicare – Contact Information

To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Florida, the SHIP is called Serving Health Insurance Needs of Elders (SHINE).

SHINE is an independent (not connected with any insurance company or health plan) that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHINE counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. SHINE counselors can also help with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

SHINE (Florida's SHIP) – Contact Information

CALL **1-800-963-5337**

TTY **1-800-955-8770**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE SHINE Program
Department of Elder Affairs
4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000

WEBSITE **www.FLORIDASHINE.org**

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Florida, the Quality Improvement Organization is called ACENTRA HEALTH.

ACENTRA HEALTH has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. ACENTRA HEALTH is an independent organization. It's not connected with our plan.

Contact ACENTRA HEALTH in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

ACENTRA HEALTH (Florida's Quality Improvement Organization) – Contact Information

CALL	<u>Toll-free Phone</u> 1-888-317-0751 Helpline hours of operation: Weekdays: 9:00 a.m. to 5:00 p.m. Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time. Weekends and Holidays: 10:00 a.m. to 4:00 p.m. Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	ACENTRA HEALTH 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609
FAX	1-844-878-7921
WEBSITE	<u>www.acentraqio.com</u>

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

Social Security– Contact Information

CALL

1-800-772-1213

Calls to this number are free.

Available 8 am to 7 pm, Monday through Friday.

Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY

1-800-325-0778

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

Available 8 am to 7 pm, Monday through Friday.

WEBSITE

www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.
- **Full Benefit Dual Eligible (FBDE):** Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.

To find out more about Medicaid and Medicare Savings Programs, contact Florida's Agency for Health Care Administration (AHCA).

Agency for Health Care Administration (Florida's Medicaid program) – Contact Information

CALL	1-888-419-3456 Hours are Monday-Friday 8:00 a.m. to 5:00 p.m. Eastern time
TTY	1-800-955-8771 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308
WEBSITE	ahca.myflorida.com/Medicaid/

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board – Contact Information

CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.
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Railroad Retirement Board – Contact Information	
	If you press “1”, you may access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
WEBSITE	https://RRB.gov

SECTION 8

If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 **How to get medical care as a member of our plan**

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 **Network providers and covered services**

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 **Basic rules for your medical care covered by our plan**

As a Medicare health plan, BlueMedicare Patriot (PPO) must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

BlueMedicare Patriot (PPO) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.

- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get your care from either a network provider or an out-of-network provider (go to Section 2 for more information).
 - The providers in our network are listed in the *Provider Directory* <https://providersearch.floridablue.com/>.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get medical care

Section 2.1 How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

You don't need to obtain a referral before you see any type of specialists.

If you need certain types of covered services or supplies, your physician will need to get prior authorization (prior approval) from us. The Medical Benefits Chart in Section 2.1 of Chapter 4 indicates which services require prior authorization.

Prior authorization may be needed for certain services (go to Chapter 4 for information on which services require prior authorization). Authorization can be obtained from our plan. You or your provider, including a non-contracted provider, can ask our plan before a service is furnished whether

our plan will cover it. You or your provider can request this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

If you don't have an advanced determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside our plan's network for a service; provided that service isn't explicitly always excluded from plan coverage as discussed in Chapter 4.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

Section 2.2 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary. (Go to Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care. Go to Chapter 7 to learn how to make an appeal.
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 5).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to

prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) at the phone number listed on the back of your membership card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. **Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to verify if a provider that will conduct your follow-up care is currently in our network.** (Phone numbers are printed on the back cover of this booklet.)

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the

care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

What if you're in our plan's service area when you have an urgent need for care?

In most situations, if you're in our plan's service area and you use an out-of-network provider, you'll pay a higher share of the costs for your care.

However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we'll allow you to get covered services from an out-of-network provider and pay the lower in-network cost-sharing amount.

You may get urgent care services at a doctor's office or an urgent care center. For a list of the providers in our plan's network, see the *Provider Directory*. Refer to the online *Provider Directory* at <https://providersearch.floridablue.com/>. You may also call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to get more information (phone numbers are printed on the back cover of this booklet).

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- We cover emergency and urgent care services outside the United States and its territories. Coverage is limited to a \$25,000 combined maximum per calendar year and does not include coverage of emergency transportation services.
- Our plan covers the same emergency and urgent care services whether you receive them inside or outside the United States and its territories. You may be required to pay 100% of charges at the time services are rendered when received outside the United States and its territories. You may then submit your claims for reimbursement consideration. Proof of payment, translations and currency conversions will be required with the claim submission. We don't cover ambulance transportation outside of the US or its territories.

You should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) (follow the prompts for international provider), or call collect at 1-804-673-1177 for assistance in arranging a billing agreement with the foreign provider.

Our plan includes coverage of urgently needed services anywhere in the world. For additional information about coverage of urgently needed services outside the United States, Go to Chapter 4.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from your plan.

Visit www.floridablue.com/medicare/member for information on how to get care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

BlueMedicare Patriot (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Also, once you reach a benefit limit, any additional costs you pay for services that are covered under that benefit **will not** count toward any plan out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study?

Section 5.1 What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means

you'll pay the same amount for the services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would then notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you \$10. This makes your net payment for the test \$10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan covers *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you're admitted to the facility or your stay won't be covered.

Your stay in a religious non-medical health care institution isn't covered by our plan unless you obtain authorization (approval) in advance from our plan and will be subject to the same coverage limitations as the inpatient or skilled nursing facility care you would otherwise have received. Please refer to the benefits chart in Chapter 4 for coverage rules and additional information on cost-sharing and limitations for inpatient hospital and skilled nursing facility coverage.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of BlueMedicare Patriot (PPO), you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in your plan don't count toward these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage BlueMedicare Patriot (PPO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave BlueMedicare Patriot (PPO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If

you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of BlueMedicare Patriot (PPO). This section also gives information about medical services that aren't covered. It also explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about our plan deductible.)
- **Copayment** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan deductible

Your deductible is \$950. Until you've paid the deductible amount, you must pay the full cost for most of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services, and you'll pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The \$950 deductible mentioned above doesn't apply to any in-network services and certain out-of-network services including Medicare-covered preventive services. This means you must pay the full cost for those services you choose to get from an out-of-network provider. Once you reach your plan deductible, we'll pay our share of the costs for these services. The deductible doesn't apply to the following services:

- All in-network services

Out-of-Network:

- All Medicare-covered preventive services
- Emergency care
- Urgently needed services
- Supplemental Comprehensive dental services
- Supplemental Diagnostic and Preventive Dental Services
- Fitness Benefit
- Additional routine hearing exams
- Hearing aids
- Hearing Aid Fitting/Evaluation(s)
- Additional routine eyewear
- Worldwide ER and urgently needed services
- Ambulance
- Hospice care
- Kidney Disease education
- Glaucoma Screening

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is \$6,750. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay \$6,750 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is \$10,100. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay \$10,100 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers aren't allowed to balance bill you

As a member of BlueMedicare Patriot (PPO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services BlueMedicare Patriot (PPO) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization) from BlueMedicare Patriot (PPO).
 - Covered services that need approval in advance to be covered as in-network services are marked **in bold** in the Medical Benefits Chart.
 - You never need approval in advance for out-of-network services from out-of-network providers.

- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
 - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
 - If you get the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227. TTY users call 1-877-486-2048).
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	<u>In-Network</u> There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. <u>Out-of-Network</u> 50% of the total cost.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and	For Acupuncture services ONLY: Medical Necessity review is required for over 12 visits, in-network only. Contact Member Services for more information. <u>In-Network</u> \$20 copay for each Medicare-covered acupuncture service <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible

Covered Service	What you pay
Acupuncture for chronic low back pain (continued) auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. If an ambulance is called, and ambulance transport is refused, any billed services will not be covered.	Except for emergency care, Prior Authorization may be required for ambulance services, in-network only. Contact Member Services for more information. <u>In-Network</u> Ground Ambulance \$0 copay for facility-to-facility transfer via ground ambulance \$275 copay per one-way trip Air Ambulance 20% coinsurance per one-way trip <u>Out-of-Network</u> Ground Ambulance

Covered Service	What you pay
Ambulance services (continued)	\$275 copay per one-way trip Air Ambulance 20% of the total cost per one-way trip
 Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months. You may not receive an annual wellness visit provided by an OB/GYN and another one provided by your Provider of Choice (POC) within a single 12-month period. Florida Blue has chosen to extend this benefit to be offered once a calendar year even if it is within 12 months of your last visit. Our plan only covers Medicare accepted preventive care as outlined by the United States Task Force on Preventive Services. For routine women's healthcare, Medicare covers breast exams, screening mammograms, Pap tests and pelvic exams. All other routine physicals or preventive services, not specified as covered under Medicare, including OB/GYN routine physicals, are not covered by our plan.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the annual wellness visit. <u>Out-of-Network</u> 50% of the total cost.
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary:	<u>In-Network</u> There is no coinsurance, copay, or deductible for

Covered Service	What you pay
 Bone mass measurement (continued) procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	Medicare-covered bone mass measurement. <u>Out-of-Network</u> 50% of the total cost.
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months Note: Any diagnostic tests resulting from breast cancer screening (mammograms), or conducted along with mammograms (such as breast ultrasounds), are subject to the applicable cost-sharing amounts. See Outpatient diagnostic tests and therapeutic services and supplies in this Benefits Chart for more information.	<u>In-Network</u> There is no coinsurance, copay, or deductible for covered screening mammograms. <u>Out-of-Network</u> 50% of the total cost.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	<u>In-Network</u> \$35 copay for Medicare-covered cardiac rehabilitation visits at all outpatient places of service. \$50 copay for Medicare-covered intensive cardiac rehabilitation visits at all outpatient places of service. <u>Out-of-Network</u>

Covered Service	What you pay
Cardiac rehabilitation services (continued)	50% of the total cost after you reach your \$950 out-of-network deductible
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. <u>Out-of-Network</u> 50% of the total cost.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	<u>In-Network</u> There is no coinsurance, copay, or deductible for cardiovascular disease testing that is covered once every 5 years. <u>Out-of-Network</u> 50% of the total cost.
 Cervical and vaginal cancer screening Covered services include: - For all women: Pap tests and pelvic exams are covered once every 24 months - If you are at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	<u>In-Network</u> There is no coinsurance, copay, or deductible for Medicare-covered preventive Pap and pelvic exams.

Covered Service	What you pay
 Cervical and vaginal cancer screening (continued)	<u>Out-of-Network</u> 50% of the total cost.
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation Note: Office visits, therapeutic modalities (i.e., physical therapy) and X-rays performed or ordered by a Chiropractor aren't covered.	<u>In-Network</u> \$15 copay for each Medicare-covered chiropractic service <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible
Chronic pain management and treatment service Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. <u>In-Network</u> \$0 copay for services in a physician's office \$55 copay for services in a physician specialist office \$40 copay for services during physical and occupational therapy <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
 Colorectal cancer screening The following screening tests are covered: - Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. - Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. - Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. - Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. - Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. - Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	<u>In-Network</u> There is no coinsurance, copay, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and subject to copayment. <u>Out-of-Network</u> 50% of the total cost for a colorectal cancer screening.

Covered Service	What you pay
 Colorectal cancer screening (continued) - Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. - Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) for Medicare-covered dental services.	Prior Authorization may be required for Medicare-covered comprehensive dental services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$55 copay for Medicare-covered non-routine dental care. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible
Dental services* (additional benefits) We also cover additional Supplemental Dental Services and supplies not covered by Medicare.	This plan covers additional Supplemental Dental Services. See the Supplemental Dental Services

Covered Service	What you pay
Dental services* (additional benefits) (continued)	description at the end of this benefits chart for details.
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	<u>In-Network</u> There is no coinsurance, copay, or deductible for an annual depression screening visit. <u>Out-of-Network</u> 50% of the total cost.
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the Medicare-covered diabetes screening tests. <u>Out-of-Network</u> 50% of the total cost.
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: - Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. - For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such	<u>In-Network</u> \$0 copay for Medicare-covered blood glucose monitors, blood glucose test strips, and lancet devices. \$0 copay for diabetic therapeutic shoes and inserts.

Covered Service	What you pay
 Diabetes self-management training, diabetic services and supplies (continued) shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • Important Notice: Coverage of all medically necessary DME items and supplies is covered under our plan and may require coordination by the plan or our contracted DME provider. • Florida Blue Medicare covers glucose meters, lancets, insulin for use in a pump, and test strips as part of your medical benefit (Medicare Part B). • Insulin for pump use may ONLY be obtained from a Florida Blue Medicare contracted retail pharmacy, not through DME. • Abbott (eg. Freestyle Lite) and Ascencia (Contour®) glucose meters and test strips may ONLY be obtained from a Florida Blue Medicare contracted retail pharmacy, not through DME. Coverage of medically necessary Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies may require prior authorization from Florida Blue Medicare. • CGMs may be obtained through your contracted retail or mail order pharmacy. • The initial fill of a CGM or insulin when being used with an insulin pump can be obtained through our participating DME provider. ◦ Additional refills may be obtained through your contracted retail or mail order pharmacy. • Important Note: Coverage of DME items and supplies may require coordination by Florida Blue Medicare or our contracted DME provider.	\$0 copay for diabetic self-management training. 20% coinsurance for drugs administered through use of a covered DME pump (NOTE: Prior Authorization may be required for certain items, in-network only. Contact Member Services for more information). You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. <u>Out-of-Network</u> 50% of the total cost for diabetes self-management training. 50% of the total cost for diabetic services and supplies after you reach your \$950 out-of-network deductible. 50% of the total cost for diabetic therapeutic shoes and inserts after you reach your \$950 out-of-network deductible. 50% of the total cost for drugs administered through use of a

Covered Service	What you pay
 Diabetes self-management training, diabetic services and supplies (continued)	covered DME pump after you reach your \$950 out-of-network deductible.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 as well as Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.floridablue.com/medicare. At the top navigation, click "Member Resources", then click "Find a Pharmacy". - Coverage of medically necessary DME items and supplies may require coordination through our DME provider. - We also cover insulin when used in an infusion pump as part of your DME benefit. Coverage of medically necessary Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies may require prior authorization from Florida Blue Medicare. - CGMs may be obtained through your contracted retail or mail order pharmacy. - The initial fill of a CGM or insulin when being used with an insulin pump can be obtained through our participating DME provider.	Prior Authorization may be required for certain items, in-network only. Contact Member Services for more information. <u>In-Network</u> Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month. Your cost-sharing will not change after being enrolled for 36 months. If prior to enrolling in BlueMedicare Patriot (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in BlueMedicare Patriot (PPO) is 20% coinsurance, every month. 20% coinsurance for plan-approved, Medicare-covered durable medical equipment. 20% coinsurance for all plan approved, Medicare-covered motorized wheelchairs and electric scooters.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) Additional refills may be obtained through your contracted retail or mail order pharmacy. Note: Contact Member Services for assistance in finding a contracted retail pharmacy.	20% coinsurance for drugs administered through use of a covered DME pump. 0% coinsurance for medical supplies. 20% coinsurance for Medicare-covered prosthetic devices, supplies related to prosthetic devices, and orthotics (NOTE: Prior authorization may be required for certain items, in-network only. Contact Member Services for more information). <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible
Emergency care Emergency care refers to services that are: - Furnished by a provider qualified to furnish emergency services, and - Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an	<u>In- and Out-of-Network</u> \$130 copay for Medicare-covered emergency room visits. This copay is waived if you're admitted to the hospital within 48 hours of getting these services. If you get emergency care at an out-of-network hospital and

Covered Service	What you pay
Emergency care (continued) unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that’s quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. See also "Urgently needed services".	need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you’re stabilized. If you stay at the out-of-network hospital, your stay will be covered but you’ll pay the out-of-network cost-sharing amount for the part of your stay after you’re stabilized.
Emergency Care (Worldwide) Except for worldwide emergency transportation, our plan covers the same emergency services whether you receive them inside or outside the United States and its territories. You may be required to pay 100% of charges at the time services are rendered when received outside the United States and its territories. You may then submit your claims for reimbursement consideration. Proof of payment, translations and currency conversions will be required with the claim submission. We do not cover ambulance transportation outside of the US or its territories. You should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) (follow the prompts for international provider), or call collect at 1-804-673-1177 for assistance in arranging a billing agreement with the foreign provider.	<u>Out-of-Network</u> \$130 copay for plan-covered emergency services received outside the United States and its territories. This copay is waived if you're admitted to the hospital within 48 hours of receiving these services. Benefits for emergency care and urgent care received outside the United States and its territories are limited to a combined \$25,000 maximum per calendar year and don't include coverage of emergency transportation services.

Covered Service	What you pay
 Health and wellness education programs Our plan covers the following health and wellness education benefits: SilverSneakers - Tivity Health's SilverSneakers® Fitness Program is designed exclusively for Medicare beneficiaries. Eligible members get a basic fitness membership with access to amenities and fitness classes including the signature SilverSneakers classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. For more information and to find a SilverSneakers participating location, visit silversneakers.com or call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET. - As an alternative for members who can't get to a SilverSneakers participating location, SilverSneakers® Steps is available. SilverSneakers Steps is a self-directed physical activity program that allows members to measure, track and increase physical activity doing activities of their choice. Steps provides the equipment, tools and motivation necessary for members to achieve a healthier lifestyle through increased physical activity. Eligible plan members may register for SilverSneakers Steps at silversneakers.com/member.	<u>In- and Out-of-Network</u> There is no cost to you for participating in our SilverSneakers Fitness Program. Coverage is limited to services from plan-approved vendors
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	<u>In-Network</u> \$55 copay for Medicare-covered hearing services. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible

Covered Service	What you pay
Hearing services* (additional benefits) We also cover the following additional hearing services not covered by Medicare: Routine hearing exam - One exam every year	<u>In-Network</u> \$0 copay <u>Out-of-Network</u> Member must submit receipts for reimbursement at 50% of maximum allowed
Hearing aid fitting evaluation - One hearing aid fitting/evaluation every year	<u>In-Network</u> \$0 copay <u>Out-of-Network</u> Member must submit receipts for reimbursement at 50% of maximum allowed
Hearing Aids - Up to 2 hearing aids every year. Additional hearing services must be obtained through our contracted, participating provider to be covered at the in-network benefit. Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) for further assistance. Hearing aid purchases include: • 3 follow-up visits within first year of initial fitting date with the original provider • 60-day trial period from date of fitting • 60 batteries per year per hearing aid (3-year supply. Non-rechargeable hearing aids only.) • 3-year manufacturer repair warranty • 1-time replacement coverage for lost, stolen or damaged hearing aid (deductible may apply per aid) • First set of ear molds (when needed)	<u>In-Network</u> <u>Technology Level: Copay Per Hearing Aid Device</u> ◦ Entry \$350.00 per device ◦ Basic \$525.00 per device ◦ Prime \$825.00 device ◦ Preferred \$1,125.00 per device ◦ Advanced \$1,425.00 per device ◦ Premium \$1,825.00 per device

Covered Service	What you pay
Hearing services* (additional benefits) (continued) Amounts you pay for these additional hearing care services and supplies do not count toward your in-network out-of-pocket maximum amount. Benefits can't be carried over to the following benefit year.	Member is responsible for any amount after the benefit maximum has been applied. <u>Out-of-Network</u> Member must submit receipts for reimbursement at 50% of customary price of approved entry-level hearing aid devices. Up to 2 devices a year.
 HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: - One screening exam every 12 months If you are pregnant, we cover: - Up to 3 screening exams during a pregnancy	<u>In-Network</u> There is no coinsurance, copay, or deductible for members eligible for Medicare-covered preventive HIV screening. <u>Out-of-Network</u> 50% of the total cost.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: - Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) - Physical therapy, occupational therapy, and speech therapy - Medical and social services	Prior Authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$0 copay for Medicare-covered home health visits (including home infusion services but excluding infusion drugs).

Covered Service	What you pay
Home health agency care (continued) Medical equipment and supplies	<u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: - Professional services, including nursing services, furnished in accordance with the plan of care - Patient training and education not otherwise covered under the durable medical equipment benefit - Remote monitoring - Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	<u>In-Network</u> \$0 copay for each home infusion of Avastin or Allergy injections plus any applicable copayment depending on the location of service. Up to 20% coinsurance for chemotherapy drugs, infusion drugs, and all other drugs covered under Medicare Part B <i>(NOTE: Prior Authorization may be required for Medicare Part B drugs (except allergy injections), in-network only.</i> <i>Contact Member Services for more information.</i> <i>Certain Part B drugs may be subject to step therapy requirements. A list of Medicare Part B drugs subject to step therapy requirements is available on our website, https://www.floridablue.com/providers/medical-pharmacy-</i>

Covered Service	What you pay
Home infusion therapy (continued)	<u>info/part-b-step-therapy.</u> <i>You may also call Member Services to find out which Part B drugs have these requirements (phone numbers are printed on the back cover of this booklet)).</i> <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not BlueMedicare Patriot (PPO). <u>In- and Out-of-Network</u> \$0 copay for physician consultation for the election of hospice services.

Covered Service	What you pay
Hospice care (continued) hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare For services covered by BlueMedicare Patriot (PPO) but not covered by Medicare Part A or B: BlueMedicare Patriot (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
 Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary	
	<u>In-Network</u> There is no coinsurance, copay, or deductible for the pneumonia, flu/influenza,

Covered Service	What you pay
 Immunizations (continued) - Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B - COVID-19 vaccines - Other vaccines if you're at risk and they meet Medicare Part B coverage rules	Hepatitis B, and COVID-19 vaccines. <u>Out-of-Network</u> 50% of the total cost.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of covered hospital days. Covered services include but aren't limited to: - Semi-private room (or a private room if medically necessary) - Meals including special diets - Regular nursing services - Costs of special care units (such as intensive care or coronary care units) - Drugs and medications - Lab tests - X-rays and other radiology services - Necessary surgical and medical supplies - Use of appliances, such as wheelchairs - Operating and recovery room costs - Physical, occupational, and speech language therapy - Inpatient substance use disorder services - Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a	Prior Authorization may be required for non-emergency inpatient hospital care, in-network only. Contact Member Services for more information. A deductible and/or other cost-sharing is charged for each inpatient stay. Cost-sharing also applies if you are readmitted for the same condition. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. <u>In-Network</u> Days 1-7: \$385 per day (per Medicare-covered stay). You'll not be charged a copay for the day of discharge.

Covered Service	What you pay
Inpatient hospital care (continued) candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If BlueMedicare Patriot PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i>. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	After the 7th day, the plan pays 100% of the covered expenses. If you get <i>authorized</i> inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital. \$0 copay for blood services including storage and administration Out-of-Network 50% of the total cost after you reach your \$950 out-of-network deductible
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. • Medicare limits covered inpatient mental health services provided in a psychiatric hospital to a maximum of 190 days. These 190 days are referred to as a "Lifetime Limit". • The 190-day Lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	Prior Authorization may be required for non-emergency inpatient mental health care, in-network only. Contact Member Services for more information. A deductible and/or other cost-sharing is charged for each inpatient stay.

Covered Service	What you pay
Inpatient services in a psychiatric hospital (continued) Our plan covers 90 days of inpatient mental health care services per admission. We also cover 60 extra days over your Lifetime. These are called “Lifetime reserve days.” If you need more than 90 days of inpatient mental health care, you may use your Lifetime reserve days. Once these Lifetime reserve days have all been used, your coverage for inpatient mental health care will be limited to 90 days per admission.	Cost-sharing also applies if you're readmitted for the same condition. <u>In-Network</u> Days 1-6: \$350 per day (per Medicare-covered stay. You will not be charged a copay for the day of discharge. Days 7-90: \$0 per day (per Medicare-covered stay). Lifetime Reserve Days: The plan pays 100% of covered expenses. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you’ve exhausted your inpatient benefits or if the inpatient stay isn’t reasonable and necessary, we won’t cover your inpatient stay. In some cases, we’ll cover certain services you get while you’re in the hospital or the skilled nursing facility (SNF). Covered services include, but aren’t limited to: - Physician services - Diagnostic tests (like lab tests) - X-ray, radium, and isotope therapy including technician materials and services - Surgical dressings - Splints, casts and other devices used to reduce fractures and dislocations	When your inpatient stay is no longer covered, you pay the applicable cost sharing for other services as though they were provided on an outpatient basis as described throughout the benefits chart.

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay (continued) • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	
 Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	<u>In-Network</u> There is no coinsurance, copay, or deductible for members eligible for Medicare-covered medical nutrition therapy services. <u>Out-of-Network</u> 50% of the total cost.
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the MDPP benefit.

Covered Service	What you pay
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. (continued)	<u>Out-of-Network</u> 50% of the total cost.
Medicare Part B drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could	Prior Authorization may be required for Medicare Part B drugs (except allergy injections), in-network only. Contact Member Services for more information. Certain Part B drugs may be subject to step therapy requirements. A list of Medicare Part B drugs subject to step therapy requirements is available on our website, https://www.floridablue.com/providers/medical-pharmacy-info/part-b-step-therapy. You may also call Member Services to find out which Part B drugs have these requirements (phone numbers are printed on the back cover of this booklet). <i>Insulin cost-sharing is subject to a coinsurance cap of \$35 for one-month's supply of insulin and plan level deductibles do not apply.</i>

Covered Service	What you pay
Medicare Part B drugs (continued) be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.floridablue.com/providers/medical-pharmacy-info/part-b-step-therapy	<u>In-Network</u> • \$0 copay for Avastin® (bevacizumab) for eye injections • \$0 copay for Medicare-covered allergy antigen serums. • Up to 20% coinsurance for chemotherapy drugs, infusion drugs, and all other drugs covered under Medicare Part B. You'll also pay cost-sharing for any associated professional services provided at a doctor's office or outpatient facility, depending on the location of service (excluding chemotherapy drugs). Exception: Medicare-covered inpatient stays are subject only to the per-day copay; any Medicare Part B drugs are included except for drugs approved for self-administration. Contact Member Services for more information. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
Medicare Part B drugs (continued) We also cover some vaccines under our Part B prescription drug benefit.	
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	<u>In-Network</u> There is no coinsurance, copay, or deductible for preventive obesity screening and therapy. <u>Out-of-Network</u> 50% of the total cost.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	Prior Authorization may be required for non-emergency services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$40 copay for each Medicare-covered session <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays	Prior authorization may be required for services, in-network only. Contact

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) - Radiation (radium and isotope) therapy including technician materials and supplies - Surgical supplies, such as dressings - Splints, casts and other devices used to reduce fractures and dislocations - Laboratory tests - Blood - including storage and administration. Coverage begins with the first pint of blood that you need - Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. - Other outpatient diagnostic tests including Advanced Imaging Services (e.g., Magnetic Resonance Imaging [MRI], Magnetic Resonance Angiography [MRA], Positron Emission Tomography [PET], Computed Tomography [CT] scans and Nuclear Medicine Testing)	Member Services for more information. <u>In-Network</u> <i>Provider and Professional Services</i> - Physician’s Office: \$0 copay - Specialist: \$55 copay <i>X-Rays</i> - Physician’s Office: \$15 copay - Independent Diagnostic Testing facility (IDTF): \$15 copay - Outpatient Hospital Facility: \$150 copay <i>Radiation Therapy</i> 20% coinsurance <i>Blood Services (including storage and administration)</i> \$0 copay <i>Diagnostic Procedures and Tests</i> \$75 copay

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	<i>Allergy Testing</i> • \$0 copay <i>Lab Services</i> • Independent Clinical Laboratory (ICL): \$0 copay • Outpatient Hospital Facility: \$40 copay <i>Advanced Imaging Services</i> • Physician's Office: \$75 copay • IDTF: \$100 copay • Outpatient Hospital Facility: \$250 copay • Diagnostic Ultrasound: \$0 copay <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state	<u>In-Network</u> \$130 copay for outpatient hospital observation services. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
Outpatient hospital observation (continued) licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an	Prior authorization may be required for services, in-network only. Contact Member Services for more information. <u>In- and Out-of-Network</u> <i>Emergency Services</i> \$130 copay <i>Dialysis Services</i> 20% coinsurance <u>In-Network</u> <i>Physician Services</i> \$0 copay for an office visits to a provider of choice at a

Covered Service	What you pay
Outpatient hospital services (continued)	
outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	facility-operated professional clinic
	\$55 copay for an visit to a specialist at a facility operated professional clinic
	Observation Services
	\$130 copay
	X-Ray Services
	\$150 copay at an outpatient hospital facility
	Radiation Therapy
	20% coinsurance at an outpatient hospital facility
	Lab Services
	\$40 copay at an outpatient hospital facility
	Advanced Imaging Services
	\$250 copay
	Diagnostic Ultrasound
	\$0 copay at an outpatient hospital facility
	Partial Hospitalization and Intensive Outpatient Services
	\$50 copay

Covered Service	What you pay
Outpatient hospital services (continued)	Chemotherapy drugs, Infusion drugs, and all other drugs covered under Medicare Part B 20% coinsurance at an outpatient hospital facility Avastin® (bevacizumab) for eye injections and Allergy Injections \$0 copay at an outpatient hospital facility Cardiac Rehabilitation \$35 copay at an outpatient hospital facility Intensive Cardiac Rehabilitation \$50 copay at an outpatient hospital facility Pulmonary Rehabilitation \$15 copay at an outpatient hospital facility Diagnostic Procedures and Tests \$75 copay at an outpatient hospital facility \$0 copay for allergy testing Mental Health Services \$40 copay for individual session at an outpatient hospital facility

Covered Service	What you pay
Outpatient hospital services (continued)	\$30 copay for group session at an outpatient hospital facility Physical Therapy \$40 copay at an outpatient hospital facility Lymphatic Therapy \$0 copay at an outpatient hospital facility Speech Therapy \$40 copay at an outpatient hospital facility Occupational Therapy \$40 copay at an outpatient hospital facility Supervised Exercise Therapy (SET) \$25 copay at an outpatient hospital facility Substance Use Disorder Services \$40 copay for individual session at an outpatient hospital facility \$30 copay for group session at an outpatient hospital facility Out-of-Network 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	Prior Authorization may be required for non-emergency services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$30 copay for each Medicare-covered group session \$40 copay for each Medicare-covered individual session <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible for each individual or group therapy visit.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Prior Authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> • \$40 copay for Occupational Therapy at all locations of service

Covered Service	What you pay
Outpatient rehabilitation services (continued)	• \$40 copay for Physical Therapy at all locations of service • \$40 copay for Speech Therapy at all locations of service • \$0 copay for Lymphedema Therapy at all locations of service <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
Outpatient substance use disorder services Substance use disorder treatment services that are provided in the outpatient hospital or office setting to patients for the treatment of substance use disorder or who require treatment but don't require the availability and intensity of services found only in the inpatient hospital setting.	Prior Authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$30 copay for each Medicare-covered group session \$40 copay for each Medicare-covered individual session <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
Outpatient substance use disorder services (continued)	deductible for each individual or group therapy visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i> .	Prior authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$300 copay for each Medicare-covered visit to an ambulatory surgical center. \$350 copay for each Medicare-covered visit to an Outpatient hospital facility. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
Over-the-Counter (OTC) Items You get a \$50 benefit allowance every three months to use toward the purchase of eligible items. Any unused or remaining allowance amount is forfeited and does not roll over to the next quarter. You'll get more information about this benefit, including instructions for using it.	\$0 copay for the over-the-counter product allowance.

Covered Service	What you pay
Partial hospitalization services and Intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	Prior Authorization may be required for non-emergency services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$50 copay for Medicare-covered partial hospitalization and intensive outpatient services. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
Physician/Practitioner services, including doctor's office visits Covered services include: - Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location - Consultation, diagnosis, and treatment by a specialist - Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment - Certain telehealth services, including: Primary and Urgent Care, Dermatology, Behavioral Health (including Opioid Treatment and Outpatient Substance Use Disorder Services), Home Based Therapy (including Speech, Occupational, and Physical), Nutritional and Dietician Services - You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	<u>In-Network</u> <u>Office Visits</u> \$0 copay for office visits to a provider of choice. \$55 copay for office visits to specialists. <i>NOTE: Laboratory testing and diagnostic testing in a POC's office or in a specialist's office is included as a part of the applicable office visit copay.</i> \$0 copay for all other professional services not otherwise specified in this chart.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued) - You must use one of our preferred vendors or a plan approved provider. See the "Telehealth" section of this Benefits Chart for more information. - Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare - Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home - Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location - Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location - Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: - You have an in-person visit within 6 months prior to your first telehealth visit - You have an in-person visit every 12 months while receiving these telehealth services - Exceptions can be made to the above for certain circumstances - Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers - Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: - You're not a new patient and - The check-in isn't related to an office visit in the past 7 days and - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment - Evaluation of video and/or images you send, and interpretation and follow-up by your doctor within 24 hours if:	Medicare-covered Hearing Services \$55 copay for Medicare-covered hearing services. Medicare-covered Dental Services \$55 copay for Medicare-covered non-routine dental care (NOTE: Prior Authorization may be required for Medicare-covered comprehensive dental services, in-network only. Contact Member Services for more information). Chemotherapy and Other Medicare Part B Drugs Medicare Part B drugs are subject to applicable cost-sharing for the drug plus any applicable copay for professional services to administer the drug, depending on the location of service (excluding chemotherapy drugs). \$0 copay for Medicare-covered allergy injections. \$0 copay for Avastin® (bevacizumab) for eye injections.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued) ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation isn't related to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Telehealth services provided by qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists • Allergy injections, chemotherapy and other Medicare Part B drugs • X-rays Note: A primary care doctor is a General Practitioner, Family Physician, Internal Medicine Physician, a Geriatrician, or a Pediatrician. All other physicians are considered specialists.	Up to 20% coinsurance for chemotherapy drugs, infusion drugs, and all other drugs covered under Medicare Part B (NOTE: Prior Authorization may be required for Medicare Part B drugs (except allergy injections), in-network only. Contact Member Services for more information. Certain Part B drugs may be subject to step therapy requirements. A list of Medicare Part B drugs subject to step therapy requirements is available on our website, https://www.floridablue.com/providers/medical-pharmacy-info/part-b-step-therapy. You may also call Member Services to find out which Part B drugs have these requirements (phone numbers are printed on the back cover of this booklet)). <u>In- and Out-of-Network</u> Facility-based Professional Services \$0 copay for professional services provided at a facility, when cost-sharing applies to

Covered Service	What you pay
Physician/Practitioner services, including doctor’s office visits (continued)	the facility bill for the same service. Out-of-Network 50% of the total cost after you reach your \$950 out-of-network deductible for office visits to provider of choice. 50% of the total cost after you reach your \$950 out-of-network deductible for office visits to specialists. Medicare-covered Hearing Services 50% of the total cost after you reach your \$950 out-of-network deductible. Medicare-covered Dental Services 50% of the total cost after you reach your \$950 out-of-network deductible. Allergy Injections, Chemotherapy and Other Medicare Part B Drugs Medicare Part B drugs are subject to applicable cost-sharing for the drug plus any applicable copay for professional services to administer the drug, depending on the location of service

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued)	(excluding chemotherapy drugs). 50% of the total cost after you reach your \$950 out-of-network deductible.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	<u>In-Network</u> \$35 copay for each Medicare-covered podiatry visit. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months A one-time hepatitis B virus screening.	<u>In-Network</u> There is no coinsurance, copayment, or deductible for the PrEP benefit. <u>Out-of-Network</u> 50% of the total cost.

Covered Service	What you pay
 Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test Note: Any diagnostic tests resulting from prostate cancer screening exams are subject to the applicable cost-sharing amounts. See Outpatient diagnostic tests and therapeutic services and supplies in this Benefits Chart for more information.	<u>In-Network</u> There is no coinsurance, copay, or deductible for an annual PSA test. <u>Out-of-Network</u> 50% of the total cost.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.	Prior authorization may be required for certain items, in-network only. Contact Member Services for more information. Orthotics are included in this category. <u>In-Network</u> 20% coinsurance for Medicare-covered prosthetic devices, supplies related to prosthetic devices, and orthotics. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	<u>In-Network</u> \$15 copay for Medicare-covered pulmonary rehabilitation visits at all places of service. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. <u>Out-of-Network</u> 50% of the total cost.
 Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. <u>Out-of-Network</u> 50% of the total cost.

Covered Service	What you pay
 Screening for lung cancer with low dose computed tomography (LDCT) (continued) <i>For LDCT lung cancer screenings after the initial LDCT screening: the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</i>	
 Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	<u>In-Network</u> There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. <u>Out-of-Network</u> 50% of the total cost.
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	<u>In-Network</u> There is no coinsurance, copay, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (continued) We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	<u>Out-of-Network</u> 50% of the total cost.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.	<u>In- and Out-of-Network</u> 20% coinsurance for dialysis services in all places of service. <u>In-Network</u> \$0 copay for Medicare-covered kidney disease education services. <u>Out-of-Network</u> 50% of the total cost for Medicare-covered kidney disease education services.

Covered Service	What you pay
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) Coverage is limited to 100 days per benefit period. No prior hospital stay is required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	Prior Authorization may be required for all inpatient admissions to skilled nursing facilities, in-network only. Contact Member Services for more information. <u>In-Network</u> Days 1-20: \$0 per day (per benefit period). Days 21-100: \$218 per day (per benefit period). \$0 copay for blood services including storage and administration A "benefit period" starts the day you go into a SNF. It ends when you go for 60 days in a row without an inpatient admission. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	<u>In-Network</u> There is no coinsurance, copay, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. <u>Out-of-Network</u> 50% of the total cost.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques	Prior Authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$25 copay for each Medicare-covered Supervised Exercise Therapy (SET) session. <u>Out-of-Network</u> 50% of the total cost after you reach your \$950 out-of-network deductible.

Covered Service	What you pay
Supervised Exercise Therapy (SET) (continued) SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Telehealth (additional benefits) Telehealth is a convenient way to access healthcare services remotely using technology such as phones, computers, or smart devices. With our plan you have the option to receive certain services through either in-person visits or telehealth. The following services are available through telehealth: • Primary and Urgent Care • Dermatology • Behavioral Health (including Opioid Treatment and Outpatient Substance Use Disorder Services) • Home-Based Therapy (including Speech, Occupational, and Physical) • Nutritional and Dietician Services To receive these services through telehealth, you must: • Use a network provider who offers the service through telehealth • Obtain a prescription from your ordering clinician Some plan-approved services, beyond the list above, may offer Part B covered telehealth services and have the same cost-sharing as in-person visits. These services vary by individual clinician.	Prior Authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> • \$50 copay for Urgently Needed Services • \$0 copay for Provider of Choice • \$40 copay for Occupational Therapy • \$40 copay for Physical Therapy • \$40 copay for Speech Therapy • \$55 copay for Dermatology Services • \$40 copay for individual sessions for outpatient Mental Health Specialty Services • \$40 copay for individual sessions for outpatient Psychiatry Specialty Services • \$40 copay for Opioid treatment program services

Covered Service	What you pay
Telehealth (additional benefits) (continued)	• \$40 copay for individual sessions for outpatient Substance Use Disorder Services • \$0 copay for Diabetes Self-Management Training • \$0 copay for Dietician Services Out-of-Network • Urgently Needed Services: \$50 copay • Provider of Choice: 50% of the total cost after you reach your \$950 out-of-network deductible • Occupational Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible • Physical Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible • Speech Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible • Dermatology Services: 50% of the total cost after you reach your \$950 out-of-network deductible

Covered Service	What you pay
Telehealth (additional benefits) (continued)	• Mental Health Specialty Services: 50% of the total cost after you reach your \$950 out-of-network deductible • Psychiatry Specialty Services: 50% of the total cost after you reach your \$950 out-of-network deductible • Opioid Treatment: 50% of the total cost after you reach your \$950 out-of-network deductible • Substance Use Disorder Services: 50% of the total cost after you reach your \$950 out-of-network deductible • Diabetes Self-Management Training: 50% of the total cost • Dietician Services: 50% of the total cost after you reach your \$950 out-of-network deductible
Urgently needed services	A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plan’s service area, or, even if you’re inside our plan’s service area, it’s unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are <u>In- and Out-of-Network</u> \$50 copay for Medicare-covered urgently needed care when services are provided at an Urgent Care Center.

Covered Service	What you pay
Urgently needed services (continued) unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. For necessary urgently needed services furnished out-of-area your cost-sharing is the same as for such services furnished in-network. For out of country urgently needed services, see below for Urgently needed services (Worldwide). See section 2.2 "Getting care using our plan's optional visitor/traveler benefit". For more information regarding accessing care outside our network. Convenient Care Centers Convenient Care Centers are walk-in healthcare clinics that specialize in the treatment of common illnesses and provide basic health screening services.	\$50 copay for Medicare-covered services provided at a Convenient Care Center. Copay <u>not</u> waived if admitted to the hospital.
Urgently needed services (Worldwide) Except for worldwide emergency and urgently needed transportation, our plan covers the same emergency services whether you receive them inside or outside the United States and its territories. You may be required to pay 100% of charges at the time services are rendered when received outside the United States and its territories. You may then submit your claims for reimbursement consideration. Proof of payment, translations and currency conversions will be required with the claim submission.	<u>Out-of-Network</u> \$130 copay for plan-covered urgently needed services you got outside the US or its territories. Benefits for urgent care and emergency care you got outside the United States and its territories are limited to a combined \$25,000 maximum

Covered Service	What you pay
Urgently needed services (Worldwide) We don't provide ambulance transportation outside of the US or its territories. You should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) (follow the prompts for international provider), or call collect at 1-804-673-1177 so Florida Blue can assist in arranging a billing agreement with the foreign provider.	per calendar year and do not include coverage of emergency transportation services. Copay <u>not</u> waived if admitted to the hospital.
 Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have 2 separate cataract operations, you cannot reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.)	<u>In-Network</u> • \$55 copay for physician services to diagnose and treat diseases and conditions of the eye. • \$0 copay for Medicare-covered glaucoma screening. • \$0 copay for diabetic retinal exams. • \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. ◦ Basic frames will be covered up to the Medicare fee schedule amount. ◦ Basic lenses will be covered in full based on the prescription. Additional items (e.g., anti-glare or transitional coatings) will not be covered.

Covered Service	What you pay
 Vision care (continued)	Eye refractions performed solely for the purpose of prescribing eyewear aren't covered under our plan's Medicare-covered Vision Care benefits. See also 'Vision care* (additional benefits)'. <u>Out-of-Network</u> 50% of the total cost for glaucoma screening. 50% of the total cost after you reach your \$950 out-of-network deductible for Medicare-covered physician services to diagnose and treat diseases and conditions of the eye and diabetic retinal exams.
Vision care* (additional benefits) We also cover the following additional vision services not covered by Medicare: Routine Eye Exam (eye refraction) - 1 per year Contact Lens Fittings - 1 per year	<u>In-Network</u> \$0 copay <u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount.

Covered Service	What you pay
Vision care* (additional benefits)	
Eyewear - \$200 Allowance per year towards the purchase of lenses, frames or contacts Member responsible for costs exceeding the Benefit Maximum Additional vision services must be obtained through our participating provider to receive in-network benefits, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) for further assistance. Eyewear upgrades are subject to the provider's usual and customary fee. Amounts you pay for these additional vision services and supplies do not count toward your in-network or combined out-of-network out-of-pocket maximum amount. Benefits can't be carried over to the following benefit year.	<u>In-Network</u> \$0 copay Subject to the annual maximum plan benefit allowance. Member responsible for any amounts in excess of the annual maximum plan benefit allowance. <u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount. Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance. Total reimbursement is subject to the annual maximum plan benefit allowance.
 Welcome to Medicare preventive visit	
Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you	<u>In-Network</u> There is no coinsurance, copay, or deductible for the <i>Welcome to Medicare</i> preventive visit. <u>Out-of-Network</u> 50% of the total cost.

Covered Service	What you pay
 Welcome to Medicare preventive visit (continued) make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	

Supplemental Dental Services

We also cover the following additional dental services and supplies not covered by Medicare.

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Diagnostic and Preventive Dental						
Oral Exams	D0120	Routine dental check-up to monitor your oral health	2 per calendar year	Combined limit with D0120, D0150	\$0 copay	You'll pay the full cost upfront and will be reimbursed 50% of the allowed amount for out-of-network care.
	D0150	Full dental exam for new patients or those who haven't been seen in a while	1 per lifetime per dentist			
Prophylaxis (Cleaning)	D1110	Routine professional teeth cleaning for adults	2 per calendar year	N/A	\$0 copay	
X-Rays	D0210	Full set of dental X-rays to check all teeth and bone structures	1 set every 3 calendar years	Combined limit with D0210, D0330 and D0270, D0272, D0273, D0274, D0277	\$0 copay	
	D0330	Single X-ray showing your entire mouth, including jaw and teeth				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Diagnostic and Preventive Dental (continued)						
	D0270	One X-ray to check for cavities between teeth	1 set per calendar year			
	D0272	Two X-rays to check for cavities between teeth				
	D0273	Three X-rays to check for cavities between teeth				
	D0274	Four X-rays to check for cavities between teeth				
	D0277	Multiple X-rays to check for cavities and bone loss around the teeth				
Comprehensive Dental						
Prosthodontics, removeable	D5410	Adjustment to improve the fit of upper full denture	1 per calendar year	Combined limit with D5410, D5411, D5421, D5422	\$0 copay	You'll pay the full cost upfront and will be reimbursed 50% of the allowed amount for out-of-network care.
	D5411	Adjustment to improve the fit of lower full denture				
	D5421	Adjustment to improve the fit of upper partial denture				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
	D5422	Adjustment to improve the fit of lower partial denture				
Oral and Maxillofacial Surgery	D7140	Removing a tooth that has come through the gums or an exposed root	1 per calendar year	N/A	\$0 copay	

Benefits are subject to the terms of coverage in effect on the date services are received and may change if the benefits or the proposed treatment plan changes. Predeterminations or pre-estimates are not a guarantee of payment. Benefits may change from one year to the next if a treatment plan spans two years. Please check your benefits in effect for the date services are rendered to determine what coverage is in effect.

NOTE: Dental codes not listed in this chart are not covered.

Section 2.1 Getting care using our plan's optional visitor/traveler benefit

If you don't permanently move, but you're continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a Visitor/Traveler Program. The Visitor/Traveler Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. For some of the states listed, MA PPO networks are only available in portions of the state, which will allow you to remain enrolled when you're outside of our service area for less than 12 months. Under our visitor/traveler program you may get all plan covered services at in-network cost-sharing. Please contact our plan for assistance in locating a provider when using the visitor/traveler benefit.

The states and territories listed above are subject to change at any time. If you need help finding a provider in a certain area, call Member Services. The Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) number is on the back of your ID card. It is also on the back cover of this Evidence of Coverage booklet. Or you can call 1-800-810-BLUE (1-800-810-2583).

If you're in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to our plan's service area within 12 months, you'll be disenrolled from our plan.

If you would like help in finding a network provider, you may:

- Call 1-800-810-BLUE (1-800-810-2583), 24 hours a day, 7 days a week to find a Blue Medicare Advantage PPO provider. TTY users should call 1-800-955-8770. (Calls to these numbers are free.);
- Visit "Find a Doctor or Hospital" at www.bcbs.com to find a Blue Medicare Advantage PPO provider; or
- Call our Member Services Department at 1-800-926-6565. 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. (TTY: 1-800-955-8770.) Calls to these numbers are free.

When you see Medicare Advantage PPO providers in any area where the Visitor/Traveler Program is offered, you'll pay the same cost-sharing level (in-network cost-sharing) you pay when you get covered benefits from in-network providers in your home service area.

When the cost-sharing for a service under the Visitor/Traveler Program is coinsurance (a percent of the service's cost):

Your Liability Calculation

The cost of the service, on which your liability (coinsurance) is based, will be either:

- The Medicare-allowable amount for covered service, or
- The amount either Florida Blue negotiates with the provider or the local Blue Medicare Advantage PPO plan negotiates with its providers on behalf of our members, if applicable. The amount negotiated may be higher than, lower than or equal to the Medicare-allowable amount.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition
Full-time nursing care in your home.	Not covered under any condition
Home-delivered meals	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments).	Not covered under any condition
Non-routine dental care	<u>Medicare-Covered Services</u> - Dental care required to treat illness or injury may be covered as inpatient or outpatient care. <u>Our plan includes additional coverage for non-routine dental services not covered by Medicare.</u> - See the "Dental services* (additional benefits)" section of the Benefit Chart in this chapter for additional information about this coverage.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition
Private room in a hospital	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	<u>Our plan includes additional coverage for routine dental services not covered by Medicare.</u>

Services not covered by Medicare	Covered only under specific conditions
	See the "Dental services* (additional benefits)" section of the Benefit Chart in this chapter for additional information about this coverage.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	<u>Medicare-Covered Services</u> - One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. <u>Our plan includes additional coverage for vision care not covered by Medicare.</u> - See the "Vision care* (additional benefits)" section of the Benefits Chart in this chapter for additional information about this coverage.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.	<u>Our plan includes additional coverage for hearing services not covered by Medicare.</u> See the "Hearing services* (additional services)" section of the Benefits Chart in this chapter for additional information about this coverage.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. When you got medical care from a provider who isn't in our plan's network

When you get care from a provider who isn't part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called *balance billing*. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by either calling us or sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

You must submit your claim to us within 12 months of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the claim form from our website www.floridablue.com/medicare/forms or call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

For requests related to medical care:

Florida Blue Medicare
P. O. Box 1798
Jacksonville, FL 32231-0014

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the medical care, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we

made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)
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Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in languages other than English including Spanish and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-926-6565. (TTY users call 1-800-955-8770).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Florida Blue Appeals and Grievance Department at 1-800-926-6565. You can also file a complaint with

Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Sección 1.1	Debemos proporcionar información de una manera que funcione para usted y que sea coherente con sus sensibilidades culturales (en idiomas que no sean inglés, braille, letra grande u otros formatos alternativos, etc.)
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Nuestro plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de manera culturalmente competente y sean accesibles para todos los inscritos, incluidos aquellos con dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. Algunos ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder las preguntas de los miembros que no hablan inglés. También podemos brindarle materiales en otros idiomas además del inglés, incluidos español y braille, en letra grande u otros formatos alternativos sin costo si los necesita. Tenemos la obligación de brindarle información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener información de nuestra parte de una manera que funcione para usted, llame a Servicios para Miembros al 1-800-926-6565 (los usuarios de TTY deben llamar al 1-877-955-8773).

Nuestro plan está obligado a brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para las mujeres.

Si los proveedores de la red de nuestro plan para una especialidad no están disponibles, es responsabilidad de nuestro plan localizar proveedores de especialidades fuera de la red que le brindarán la atención necesaria. En este caso, solo pagará los costos compartidos dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran un servicio que necesita, llame a nuestro plan para obtener información sobre dónde ir para recibir este servicio en costos compartidos dentro de la red.

Si tiene problemas para obtener información de nuestro plan en un formato accesible y apropiado para usted, para consultar a un especialista en salud de la mujer o para encontrar un especialista de la red, llame para presentar una queja ante el Departamento de Apelaciones y Quejas de Florida Blue al 1-800-926-6565. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we're required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.

- o Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective as of April 6, 2021.

We understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we'll post a revised notice on our website by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We'll disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We'll disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We'll disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:

We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we'll make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they're involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an

emergency or in situations where you're incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we'll only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this notice) may involve our disclosure of your PHI to certain other individuals or entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, get, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we'll have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health

and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you're a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to get such governmental protection.
- **Inmates:** We may use or disclose your PHI if you're an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to our plan sponsor of your group health plan. We may also disclose certain PHI to our plan sponsor to perform plan administration functions. We may disclose summary health information to our plan sponsor so that our plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that our plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of getting such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:

We'll obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of

nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this notice. There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential.

Our intent is to meet the requirements of these more stringent privacy laws, and we'll only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you're incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you're or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:

To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We'll provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and get a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and isn't otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We'll agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."

Note: If you choose to have confidential communications sent to you at a PHI address, we'll only respond to inquiries from you. If you get services from any health care providers, you're responsible for notifying those providers directly if you would like a PHI address from them.

- **Privacy Notice:** You have the right to request and get a copy of this notice at any time. For more information or if you have questions about this notice, please contact us using the information listed at the end of this notice.
- **Breach:** You have the right to get, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to get the notification by electronic mail, we'll provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to get a paper copy of this notice, upon request, even if you have previously agreed to get the Notice electronically.

Complaints

If you're concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We'll provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We'll not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact:

Business Ethics, Integrity & Compliance

Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of BlueMedicare Patriot (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give your directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Florida Agency for Health Care Administration, Division of Health Quality Assurance, 2727 Mahan Drive, Tallahassee, FL 32308.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do —ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770)**
- **Call your local SHIP** at 1-800-963-5337 (TTY 1-800-955-8770)
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).**
- **Call your local SHIP** at 1-800-963-5337 (TTY 1-800-955-8770)
- **Contact Medicare**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at [Medicare Rights & Protections](#))
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must continue to pay your Medicare Part B Premium to stay a member of our plan.
 - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1	Legal terms
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There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You'll find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS**SECTION 4 A guide to coverage decisions and appeals**

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover a medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a

request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help when asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at <https://www.floridablue.com/medicare/forms>.)
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at <https://www.floridablue.com/medicare/forms>.) The form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you're not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines, we give the details for each one of these situations in this chapter:

- **Section 5** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to ask for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2

How to ask for a coverage decision

Legal Terms

A coverage decision that involves your medical care is called an **organization determination**.

A fast coverage decision is called an **expedited determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only* ask for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 of this chapter for information on complaints.)

For fast Coverage decisions we use an expedited timeframe

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.

- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed, and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. Go to Section 9 of this chapter for more information on complaints.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term

The formal name for the *independent review organization* is the **Independent Review Entity**. It is sometimes called the **IRE**.

The independent review organization is an independent organization hired by Medicare. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**

- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2

- For the *fast appeal* the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5	If you're asking us to pay you for our share of a bill you got for medical care
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Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.

- **If we say no to your request:** If the medical care isn't covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.
- If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you have already received and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all of your covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll also help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any

hospital employee for it. If you need help, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048.)

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns, you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2	How to make a Level 1 appeal to change your hospital discharge date
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To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**

- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-926-6565 (TTY 1-800-955-8770). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going on to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the Federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by **noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline and you still want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3	How to make a Level 2 appeal to have our plan cover your care for a longer time
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full

cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you it's decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3, 4 and 5

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way at the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?

Complaint	Example
Respecting your privacy	Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	- Has someone been rude or disrespectful to you? - Are you unhappy with our Member Services? - Do you feel you are being encouraged to leave the plan?
Waiting times	- Are you having trouble getting an appointment, or waiting too long to get it? - Have you been kept waiting too long by doctors, pharmacists or other health professionals? Or by our Member Services or other staff at our plan? - Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	- Did we fail to give you a required notice? - Is our written information hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: - You asked us for a <i>fast coverage</i> decision or a <i>fast appeal</i>, and we have said no; you can make a complaint. - You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. - You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. - You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint**Legal Terms**

- A **complaint** is also called a **grievance**.
- **Making a complaint** is also called **filing a grievance**.
- **Using the process for complaints** is called **using the process for filing a grievance**.
- A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **Procedures and instructions, you need to follow if you want to use the process for making a complaint:**

If you send us your complaint in writing, it means that we'll use our formal procedure for answering grievances. Here's how it works:

For complaints related to your medical care:

1. Please send your complaint to one of the addresses showing Chapter 2, Section 1. Look for the section called, *How to contact us when you're making a complaint about your medical care*. We have a Grievance (Complaint) Form for you to use when making a formal complaint. You're not required to use the form, but we encourage you to do so.
2. You must submit all grievances within 60 calendar days after the event or incident leading to your complaint. We'll answer your grievance no later than 30 days after we get it (sooner if your health requires it). If we need more information and a delay is in your interest or you request a delay, we can take 14 more calendar days to give you an answer.
3. If our plan denies your request for a "fast" coverage decision or a "fast" first-level appeal about medical care or prescription drugs and you believe that waiting longer would endanger your health, you may submit a request for a "fast" complaint either in writing or by phone. We must answer these requests within 24 hours.

If you make an oral complaint over the phone, here's how it works:**For complaints related to your medical care:**

1. Contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) within 60 calendar days after the event or incident leading to your complaint.
 2. Have the following prepared for the representative:
 - Your name
 - Your address
 - Your Member ID Number
 - A description of your complaint/grievance
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3	You can also make complaints about quality of care to the Quality Improvement Organization
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When your complaint is about *quality of care*, you also have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.4	You can also tell Medicare about your complaint
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You can submit a complaint about BlueMedicare Patriot (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in BlueMedicare Patriot (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 gives information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 **You can end your membership during the Open Enrollment Period**

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan with or without drug coverage,
 - Original Medicare *with* a separate Medicare drug plan,
 - Original Medicare *without* a separate Medicare drug plan.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare enrollees who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of BlueMedicare Patriot (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit the Medicare website www.Medicare.gov.

- Usually, when you move.
- If you have Medicaid.
- If we violate our contract with you.
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
 - Original Medicare *with* a separate Medicare drug plan;
 - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will usually end** on the first day of the month after we get your request to change our plan.

Section 2.4 **Get more information about when you can end your membership**

If you have questions about ending your membership you can:

- **Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770)**
- Find the information in the **Medicare & You 2026** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227, TTY 1-877-486-2048).

SECTION 3 **How to end your membership in our plan**

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan.	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from BlueMedicare Patriot (PPO) when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan.	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from BlueMedicare Patriot (PPO) when your new plan's coverage begins.

To switch from our plan to:	Here's what to do:
Original Medicare <i>without</i> a separate Medicare drug plan.	• Send us a written request to disenroll. Contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) if you need more information on how to do this. • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from BlueMedicare Patriot (PPO) when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

SECTION 4 **Until your membership ends, you must keep getting your medical items and services through our plan**

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 **BlueMedicare Patriot (PPO) must end our plan membership in certain situations**

BlueMedicare Patriot (PPO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you're away from our service area for more than 12 months

- If you move or take a long trip, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- Non-payment of plan premiums
 - All past due balances may need to be paid to automatically renew your policy for the next calendar year.
- If you don't pay our plan premiums for 6 months after the due date you'll be disenrolled for non-payment.
 - We must notify you in writing that you have 6 months after the due date to pay our plan premium before we end your membership.

If you have questions or would like more information on when we can end your membership, call Member Services 1-800-926-6565 (TTY users call 1-800-955-8770).

Section 5.1 We can't ask you to leave our plan for any health-related reason

BlueMedicare Patriot (PPO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, BlueMedicare Patriot (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the

Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

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
- 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 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)

civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator 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

Visit www.floridablue.com/disclaimer/ndnotice to view an electronic version of this notice.

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Form Approved

OMB# 0938-1421

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: 1-800-352-2583 (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' náhodoonih, FEP bich'í' 1-800-333-2227 bich'í' náhodoonih, Medicare bich'í' 1-800-926-6565 bich'í' náhodoonih, (TTY 711).

SECTION 4 Additional subrogation rights

As part of this Agreement, Florida Blue retains its right to collect from any third party, amounts paid for benefits for you under this Agreement that the third party is obligated to pay. This right is Florida Blue's Subrogation right. In the event any payments, services or supplies are rendered to or on behalf of a Member, Florida Blue, to the extent of any such payment, or services or supplies rendered, shall be subrogated to all causes of action and rights of recovery such Member may have or has against any persons and/or organizations as a result of such payment, or services or supplies rendered. Such subrogation rights shall extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated. The Member shall promptly execute and deliver such instruments and papers with respect to such subrogation rights as may be requested by Florida Blue. Further, the Member shall promptly notify Florida Blue of any settlement negotiations prior to entering into a settlement agreement affecting any subrogation rights of Florida Blue. Additionally, in no event shall a Member fail to take any action where action is appropriate, or take any action that may prejudice the subrogation rights of Florida Blue. No waiver, release of liability, settlement, or other documents executed by a Member without prior notice to and approval by Florida Blue shall be binding upon Florida Blue. In any event, Florida Blue retains the right to recover such payments and/or the reasonable value of the Covered Services provided from any person or organization to the fullest extent permitted by law. With respect to Covered Services

provided, Florida Blue shall be entitled to reimbursement for the reasonable value of such Covered Services as determined on a fee-for-service basis.

SECTION 5 Notice about Florida Blue and the Blue Cross and Blue Shield Association

You as a member of this plan hereby expressly acknowledge your understanding that this plan constitutes a contract solely between you and Florida Blue, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Florida Blue to use the Blue Cross and Blue Shield Service Marks in the State of Florida, and that Florida Blue isn't contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Plan based upon representations by any person other than Florida Blue and that no person, entity, or organization other than Florida Blue shall be held accountable or liable to you for any of Florida Blue's obligations to you created under this Plan. This paragraph shall not create any additional obligations whatsoever on the part of Florida Blue other than those obligations created under other provisions of this agreement.

Chapter 10:

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of BlueMedicare Patriot (PPO) you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.2, for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for *making a complaint* is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about to quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed copayment amount that a plan requires when a specific service is gotten; or (3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic

supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year.

However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Low Income Subsidy (LIS) – Go to Extra Help.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare –The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period –The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services –Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Prior Authorization – Approval in advance to get covered services based on a specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

BlueMedicare Patriot (PPO) Member Services

Method	Member Services – Contact Information
CALL	1-800-926-6565 Calls to this number are free. 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. Member Services 1-800-926-6565 (TTY users call 1-800-955-8770) also has free language interpreter services available for non-English speakers.
TTY	1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 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.
FAX	1-305-716-9333
WRITE	Florida Blue Medicare Member Services P.O. Box 45296 Jacksonville, FL 32232-5296
WEBSITE	<u>www.floridablue.com/medicare</u>

SHINE (Florida's SHIP)

SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-963-5337
TTY	1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	SHINE Program Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000
WEBSITE	<u>www.FLORIDASHINE.org</u>

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.