Florida Blue
Your Health Solutions Partner

MEDICARE

2025 Summary of Benefits

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

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BlueMedicare Select (PPO) H5434-045
BlueMedicare Patriot (PPO) H5434-041

1/1/2025 – 12/31/2025

The plans' service area includes:
Alachua County

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the **"Evidence of Coverage."** You may also view the "Evidence of Coverage" for this plan on our website, **www.floridablue.com/medicare/forms**.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You* 2025 handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

To join, you must:

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

Our **H5434-045** service area includes the following **counties in Florida: Alachua**
Our **H5434-041** service area includes the following **counties in Florida: Alachua**

Which doctors, hospitals, and pharmacies can I use?

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

- You can see our plan's provider and pharmacy directory on our website (**www.floridablue.com/medicare**). At the top navigation, click Member Resources, then click Find a Doctor or Find a Pharmacy. Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- **If you are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.**
- **If you are not a member of this plan, call us at 1-855-601-9465, TTY: 1-800-955-8770.**
  - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
  - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at **www.floridablue.com/medicare**.

Important Information

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

Monthly Premium, Deductible and Limits

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
Monthly Plan Premium	• $28.00 You must continue to pay your Medicare Part B premium.	• $0 You must continue to pay your Medicare Part B premium.
Part B Premium Buy-Down	• This plan does not include a Part B premium buy-down.	• BlueMedicare Patriot will reduce your monthly Medicare Part B premium by up to $75.
Deductible	• $0 per year for In-Network health care services • $950 per year for Out-of-Network (OON) health care services • $590 per year for Part D prescription drugs applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) • There is no deductible for insulins.	• $0 per year for health care services • This plan does not include Part D Prescription Drug Benefits
Maximum Out-of-Pocket Responsibility	• $6,750 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.	• $5,500 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year.

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
	• $10,100 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers combined.	• $8,950 is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers combined.

Medical and Hospital Benefits

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
Inpatient Hospital Coverage	In-Network ◊ • $345 copay per day for days 1-5 • $0 copay per day, after day 5 Out-of-Network • $495 copay per day after $950 out-of-network deductible for days 1-27 • $0 copay per day, days 28-90	In-Network ◊ • $350 copay per day for days 1-4 • $0 copay per day, after day 4 Out-of-Network 42% of the Medicare-allowed amount
Outpatient Hospital Coverage	In-Network • $125 copay per visit for Medicare-covered observation services • $150 copay for all other services ◊ • 20% coinsurance for all surgeries • $0 copay for diagnostic colonoscopy Out-of-Network • 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network • $125 copay per visit for Medicare-covered observation services • $300 copay for all other services ◊ • $0 copay for diagnostic colonoscopy Out-of-Network 42% of the Medicare-allowed amount

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
Ambulatory Surgical Center (ASC) Services	In-Network • $120 copay for surgery services provided at an Ambulatory Surgical Center ◊ • $0 copay for diagnostic colonoscopy Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network • $300 copay for surgery services provided at an Ambulatory Surgical Center ◊ • $0 copay for diagnostic colonoscopy Out-of-Network 42% of the Medicare-allowed amount
Doctor Visits	In-Network • $0 copay per provider of choice visit • $49 copay per specialist visit Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network • $0 copay per provider of choice visit • $45 copay per specialist visit Out-of-Network 42% of the Medicare-allowed amount
Preventive Care	In-Network $0 copay for Medicare-covered services Out-of-Network 42% of the Medicare-allowed amount • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening	In-Network $0 copay for Medicare-covered services Out-of-Network 42% of the Medicare-allowed amount • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
	• Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C Screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • "Welcome to Medicare" preventive visit	• Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C Screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • "Welcome to Medicare" preventive visit
Emergency Care	**Medicare-Covered Emergency Care** • $125 copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** • $125 copay for Worldwide Emergency Care	**Medicare-Covered Emergency Care** • $125 copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** • $125 copay for Worldwide Emergency Care

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
	• $25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	• $25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.
Urgently Needed Services	**Medicare-Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. • $50 copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. • $50 copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** • $125 copay for Worldwide Urgently Needed Services • $25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	**Medicare-Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. • $30 copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. • $30 copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** • $125 copay for Worldwide Urgently Needed Services • $25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.
Diagnostic Services/ Labs/Imaging	In-Network ◊ **Diagnostic Procedures and Tests** • $50 copay at an Independent Diagnostic Testing Facility (IDTF) • $50 copay at an outpatient hospital facility	In-Network ◊ **Diagnostic Procedures and Tests** • $75 copay at an Independent Diagnostic Testing Facility (IDTF) • $75 copay at an outpatient hospital facility

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	• $0 copay for allergy testing **Laboratory Services** • $0 copay at an Independent Clinical Laboratory • $40 copay at an outpatient hospital facility **X-Rays** • $50 copay at a physician's office or at an IDTF • $150 copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Computer Tomography (CT) scan or Nuclear Medicine testing. • $30 copay at a physician's office or at an IDTF • $150 copay at an outpatient hospital facility **Radiation Therapy** • 20% of the Medicare-allowed amount <u>Out-of-Network</u> 42% of the Medicare-allowed amount after $950 out-of-network deductible	• $0 copay for allergy testing **Laboratory Services** • $0 copay at an Independent Clinical Laboratory • $40 copay at an outpatient hospital facility **X-Rays** • $15 copay at a physician's office or at an IDTF • $150 copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Computer Tomography (CT) scan or Nuclear Medicine testing. • $0 copay at a physician's office or at an IDTF • $75 copay at an outpatient hospital facility **Radiation Therapy** • 20% of the Medicare-allowed amount <u>Out-of-Network</u> 42% of the Medicare-allowed amount
Hearing Services	**Medicare-Covered Hearing Services** <u>In-Network</u> • $49 copay for exams to diagnose and treat hearing and balance issues <u>Out-of-Network</u> • 42% of the Medicare-allowed amount after $950 out-of-network deductible	**Medicare-Covered Hearing Services** <u>In-Network</u> • $45 copay for exams to diagnose and treat hearing and balance issues

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	Additional Hearing Services In-Network • $0 copay for one routine hearing exam per year • $0 copay for evaluation and fitting of hearing aids • See chart below for copay of each hearing aid for up to 2 hearing aids every year. **Technology Level** / **Copay Per Hearing Aid Device** **Entry $350.00 per device** **Basic $525.00 per device** **Prime $825.00 per device** **Preferred $1,125.00 per device** **Advanced $1,425.00 per device** **Premium $1,825.00 per device** **Subject to Benefit Maximum.** **Member is responsible for any amount after the benefit maximum has been applied.** **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits. Out-of-Network • Member must submit receipts for reimbursement at 58% of maximum allowed for one routine hearing exam per year.	Out-of-Network 42% of the Medicare-allowed amount **Additional Hearing Services** In-Network • $0 copay for one routine hearing exam per year • $0 copay for evaluation and fitting of hearing aids • See chart below for copay of each hearing aid for up to 2 hearing aids every year. **Technology Level** / **Copay Per Hearing Aid Device** **Entry $350.00 per device** **Basic $525.00 per device** **Prime $825.00 per device** **Preferred $1,125.00 per device** **Advanced $1,425.00 per device** **Premium $1,825.00 per device** **Subject to Benefit Maximum.** **Member is responsible for any amount after the benefit maximum has been applied.** **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits.

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	• Member must submit receipts for reimbursement at 58% of maximum allowed for evaluation and fitting of hearing aids. • Member must submit receipts for reimbursement at 58% of customary price of approved entry-level hearing aid devices. Up to 2 devices a year.	Out-of-Network • Member must submit receipts for reimbursement at 58% of maximum allowed for one routine hearing exam per year. • Member must submit receipts for reimbursement at 58% of maximum allowed for evaluation and fitting of hearing aids. • Member must submit receipts for reimbursement at 58% of customary price of approved entry-level hearing aid devices. Up to 2 devices a year.
Dental Services	**Medicare-Covered Dental Services** In-Network ◊ $49 copay for non-routine dental care Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible **Additional Dental Services** In-Network • $0 copay for covered preventive dental services • $0 copay for covered comprehensive dental services Out-of-Network • Member pays up front and is reimbursed 58% of non-participating rates for covered preventive dental services. • Member pays up front and is reimbursed 58% of non-participating rates for covered comprehensive dental services.	**Medicare-Covered Dental Services** In-Network ◊ $45 copay for non-routine dental care Out-of-Network 42% of the Medicare-allowed amount **Additional Dental Services** In-Network • $0 copay for covered preventive dental services • $0 copay for covered comprehensive dental services Out-of-Network • Member pays up front and is reimbursed 58% of non-participating rates for covered preventive dental services. • Member pays up front and is reimbursed 58% of non-participating rates for covered comprehensive dental services.

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Vision Services	**Medicare-Covered Vision Services** In-Network • $49 copay for physician services to diagnose and treat diseases and conditions of the eye • $0 copay for glaucoma screening (once per year for members at high risk of glaucoma) • $0 copay for one diabetic retinal exam per year • $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible **Additional Vision Services** In-Network • $0 copay for one routine eye exam per year Out-of-Network • Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 58% of the in-network allowed amount.	**Medicare-Covered Vision Services** In-Network • $45 copay for physician services to diagnose and treat diseases and conditions of the eye • $0 copay for glaucoma screening (once per year for members at high risk of glaucoma) • $0 copay for one diabetic retinal exam per year • $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery Out-of-Network 42% of the Medicare-allowed amount **Additional Vision Services** In-Network • $0 copay for one routine eye exam per year • For lenses, frames or contacts, $0 copay • Subject to the annual maximum plan benefit allowance. • Member responsible for any amounts in excess of the annual maximum plan benefit allowance. • $200 Allowance per year towards the purchase of lenses, frames or contacts • Member responsible for costs exceeding the Benefit Maximum allowance per year towards the purchase of lenses, frames or contacts.

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		Out-of-Network • Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 58% of the in-network allowed amount. • Member is responsible for all amounts in excess of the 58% 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.
Mental Health Services	**Inpatient Mental Health Services** In-Network ◊ • $318 copay per day for days 1-5 • $0 copay per day for days 6-90 190-day lifetime benefit maximum in a psychiatric hospital Out-of-Network • $495 copay per day after $950 out-of-network deductible for days 1-27 • $0 copay per day for days 28-90 **Outpatient Mental Health Services** In-Network ◊ $20 copay Out-of-Network $40 copay after $950 out-of-network deductible	**Inpatient Mental Health Services** In-Network ◊ • $318 copay per day for days 1-5 • $0 copay per day for days 6-90 190-day lifetime benefit maximum in a psychiatric hospital Out-of-Network 42% of the Medicare-allowed amount **Outpatient Mental Health Services** In-Network ◊ $20 copay Out-of-Network 42% of the Medicare-allowed amount
Skilled Nursing Facility (SNF)	In-Network ◊ • $0 copay per day for days 1-20	In-Network ◊ • $0 copay per day for days 1-20

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	• $214 copay per day for days 21-100 Out-of-Network • $250 copay per day after $950 out-of-network deductible for days 1-58 • $0 copay per day for days 59-100 Our plan covers up to 100 days in a SNF per benefit period.	• $214 copay per day for days 21-100 Out-of-Network 42% of the Medicare-allowed amount Our plan covers up to 100 days in a SNF per benefit period.
Physical Therapy	In-Network ◊ • $40 copay per visit • $0 copay for Lymphedema Therapy Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network ◊ • $40 copay per visit • $0 copay for Lymphedema Therapy Out-of-Network 42% of the Medicare-allowed amount
Ambulance	In-Network ◊ $155 copay for each Medicare-covered trip (one-way) Out-of-Network $155 copay for each Medicare-covered trip (one-way)	In-Network ◊ $250 copay for each Medicare-covered trip (one-way) Out-of-Network $250 copay for each Medicare-covered trip (one-way)
Transportation	• Not Covered	• Not Covered
Medicare Part B Drugs	In-Network • $0 copay for allergy injections • Up to 20% of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ • 20% up to $35 per month for insulin if you use an insulin pump that's covered under Medicare Part B's durable medical equipment benefit ◊	In-Network • $0 copay for allergy injections • Up to 20% of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ • 20% up to $35 per month for insulin if you use an insulin pump that's covered under Medicare Part B's durable medical equipment benefit ◊

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	Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	Out-of-Network 42% of the Medicare-allowed amount

Additional Benefits

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
Caregiver Support for Member	Provides coverage for digital coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits include: • A web-based tool that contains educational content covering topics on health, wealth, senior living, in-home care and lifestyle • Access for caregivers and family members to post updates and videos; tools to manage documents, stay organized and on top of upcoming tasks and appointments. Search tools (i.e., senior housing search and in-home care search). See the *Evidence of Coverage* for benefit details.	Provides coverage for digital coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits include: • A web-based tool that contains educational content covering topics on health, wealth, senior living, in-home care and lifestyle • Access for caregivers and family members to post updates and videos; tools to manage documents, stay organized and on top of upcoming tasks and appointments. Search tools (i.e., senior housing search and in-home care search). See the *Evidence of Coverage* for benefit details.

Diabetic Supplies	In-Network
	• $0 copay at a Florida Blue contracted retail or mail-order pharmacy for Diabetic Supplies such as:
	  • Lifescan (One Touch®) and Ascensia (Contour ®) glucose meters and test strips are preferred. Other brands will require prior authorization ◊
	  • Lancets
		In-Network
		• $0 copay at a Florida Blue contracted retail or mail-order pharmacy for Diabetic Supplies such as:
		  • Lifescan (One Touch®) and Ascensia (Contour ®) glucose meters and test strips are preferred. Other brands will require prior authorization ◊
		  • Lancets

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
	• Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, (and supplies) are preferred. Other brands may require prior authorization ◊ **Important Note:** • **Insulin, alcohol swabs, insulin syringes and needles for self-administration in the home are obtained from an in-network retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply. • Please note: Medical supplies i.e. alcohol swabs, gauze, and/or syringes are not coverable if not used for the administration of insulin. • The initial fill of a CGM or insulin when being used with an insulin pump can be obtained through our participating DME provider. Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible amount	• Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, (and supplies) are preferred. Other brands may require prior authorization ◊ **Important Note:** • The initial fill of a CGM or insulin when being used with an insulin pump can be obtained through our participating DME provider. Out-of-Network 42% of the Medicare-allowed amount
Medicare Diabetes Prevention Program	In-Network $0 copay for Medicare-covered services Out-of-Network 42% of the Medicare-allowed amount	In-Network $0 copay for Medicare-covered services Out-of-Network 42% of the Medicare-allowed amount
Podiatry	In-Network $40 copay for each Medicare-covered podiatry visit	In-Network $35 copay for each Medicare-covered podiatry visit

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	Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	Out-of-Network 42% of the Medicare-allowed amount
Chiropractic	In-Network $15 copay for each Medicare-covered chiropractic service Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network $20 copay for each Medicare-covered chiropractic service Out-of-Network 42% of the Medicare-allowed amount
Medical Equipment and Supplies	In-Network ◊ • 20% of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters • 0% of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network ◊ • 20% of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters • 0% of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment Out-of-Network 42% of the Medicare-allowed amount
Outpatient Occupational and Speech Therapy	In-Network ◊ $40 copay per visit Out-of-Network 42% of the Medicare-allowed amount after $950 out-of-network deductible	In-Network ◊ $40 copay per visit Out-of-Network 42% of the Medicare-allowed amount
Telehealth	In-Network ◊ • $50 copay for Urgently Needed Services • $0 copay for Primary Care Services • $40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location	In-Network ◊ • $30 copay for Urgently Needed Services • $0 copay for Primary Care Services • $40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location

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	• $40 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital • $49 copay for Dermatology Services • $20 copay for individual sessions for outpatient Mental Health Specialty Services • $20 copay for individual sessions for outpatient Psychiatry Specialty Services • $20 copay for Opioid Treatment Program Services • $150 copay for individual sessions for outpatient Substance Abuse Specialty Services • $0 copay for Diabetes Self-Management Training • $0 copay for Dietician Services <u>Out-of-Network</u> • $50 copay for Urgently Needed Services • 42% of the Medicare-allowed amount after the $950 yearly out-of-network deductible for Primary Care Services • 42% of the Medicare-allowed amount after the $950 yearly out-of-network deductible for Occupational Therapy/Physical Therapy/Speech Therapy • 42% of the Medicare-allowed amount after the $950 yearly out-of-network deductible for Dermatology Services • $40 copay after the $950 yearly out-of-network deductible for individual sessions for outpatient Mental Health Specialty Services	• $40 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital • $45 copay for Dermatology Services • $20 copay for individual sessions for outpatient Mental Health Specialty Services • $20 copay for individual sessions for outpatient Psychiatry Specialty Services • $20 copay for Opioid Treatment Program Services • $20 copay for individual sessions for outpatient Substance Abuse Specialty Services • $0 copay for Diabetes Self-Management Training • $0 copay for Dietician Services <u>Out-of-Network</u> • $30 copay for Urgently Needed Services • 42% of the Medicare-allowed amount

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	• $40 copay after the $950 yearly out-of-network deductible for individual sessions for outpatient Psychiatry Specialty Services • $40 copay after the $950 yearly out-of-network deductible for Opioid treatment program services • $40 copay after the $950 yearly out-of-network deductible for individual sessions for outpatient Substance Abuse Specialty Services • 42% of the Medicare-allowed amount for Diabetes Self-Management Training • 42% of the Medicare-allowed amount after the $950 yearly out-of-network deductible for Dietician Services	
Blue Dollars Benefits MasterCard® Prepaid Card *NOTE: See Healthy Blue Rewards*	• **Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.** • Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan. • Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply. • The Blue Dollars card will be mailed directly to you and replenished at the beginning of each month.	• **Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.** • Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan. • Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply. • The Blue Dollars card will be mailed directly to you and replenished at the beginning of each month.
Over-the-Counter Items	• Not Available	• $50 benefit allowance every three months to use toward the purchase of eligible items. Any unused or remaining allowance

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		amount is forfeited and does not roll over to the next quarter. You will receive more information about this benefit, including instructions for using it.
SilverSneakers® Fitness Program	• Gym membership and classes available at fitness locations across the country, including national chains and local gyms. • Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.	• Gym membership and classes available at fitness locations across the country, including national chains and local gyms. • Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.
HealthyBlue Rewards	• Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars card for completing and/or reporting preventive care and screenings. • Rewards are available after opting in to the program.	• Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars card for completing and/or reporting preventive care and screenings. • Rewards are available after opting in to the program.

Part D Prescription Drug Benefits

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
Deductible Stage:	• The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You will pay a yearly deductible of $590 which applies to Tier 3 (Preferred Brand), 4 (Non-Preferred Drug) and 5 (Specialty Tier) drugs. You must pay the full cost of your Tier 3 (Preferred Brand), 4 (Non-Preferred Drug) and 5 (Specialty Tier) drugs until you reach the plan's deductible amount. For all other drugs, you will not have to pay any deductible. The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies. • Once you have paid $590 which applies to Tier 3 (Preferred Brand), 4 (Non-Preferred Drug) and 5 (Specialty Tier) drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.	• This plan does not include Part D Prescription Drug Benefits

Initial Coverage Stage

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
During the Initial Coverage Stage:	• You begin in this stage after you meet your deductible (if applicable). During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,000**. You then move on to the Catastrophic Coverage Stage. You may get your drugs at network retail pharmacies and mail order pharmacies.	• This plan does not include Part D Prescription Drug Benefits

	BlueMedicare Select (PPO) Alachua H5434-045		BlueMedicare Patriot (PPO) Alachua H5434-041	
See Evidence of Coverage for details.	**Standard Retail/LTC/Mail Order (31-day supply)**	**Standard Retail/Mail Order (90 to 100-day supply)**	**Standard Retail/LTC/Mail Order (31-day supply)**	**Standard Retail/Mail Order (90 to 100-day supply)**
Tier 1 - Preferred Generic	**$0 copay**	**$0 copay**	**N/A**	**N/A**
Tier 2 - Generic	**$10 copay**	**$30 copay**	**N/A**	**N/A**
Tier 3 - Preferred Brand	**21% of the cost**	**21% of the cost**	**N/A**	**N/A**
Tier 4 - Non-Preferred Drug	**25% of the cost**	**25% of the cost**	**N/A**	**N/A**
Tier 5 - Specialty Tier	**25% of the cost**	**N/A**	**N/A**	**N/A**
Tier 6 - Select Care Drugs	**$0 copay**	**$0 copay**	**N/A**	**N/A**

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please Note: Patriot plan does not include Part D Prescription Drug Benefits.

	BlueMedicare Select (PPO) Alachua H5434-045	BlueMedicare Patriot (PPO) Alachua H5434-041
Catastrophic Coverage Stage	• You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$2,000** limit for the calendar year. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You will stay in this payment stage until the end of the calendar year.	• This plan does not include Part D Prescription Drug Benefits
Additional Drug Coverage	• Please call us or see the plan's "*Evidence of Coverage*" on our website (**www.floridablue.com/medicare/forms**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (**Non-Preferred Drug**) cost-sharing. • Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug. • Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.	• This plan does not include Part D Prescription Drug Benefits

Disclaimers

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

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

PPO coverage is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue, an Independent Licensee of the Blue Cross and Blue Shield Association.

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

The Blue Dollars Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. Mastercard and the circles design is a trademark of Mastercard International Incorporated.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. View the Discrimination and Accessibility Notice at floridablue.com/ndnotice, plus information on our free language assistance services. Or call 1-800-352-2583 (TTY: 1-800-955-8770).

Puede ver la notificación de no discriminación y accesibilidad, además de información sobre nuestros servicios gratuitos de asistencia lingüística en floridablue.com/es/ndnotice. O llame al 1-800-352-2583 (TTY: 1-877-955-8773).

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Multi-language Interpreter Services

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

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-926-6565 (TTY: 1-877-955-8773). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

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

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

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

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

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

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

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

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

Form CMS-10802
(Expires 12/31/25)

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

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

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

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

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

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

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-926-6565 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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(Expires 12/31/25)