

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of BlueMedicare Value (PPO)

This document gives the details of your Medicare health and drug 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 and drug 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 Value (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 Value (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 formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that can 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 Value (PPO)

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

You're covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, BlueMedicare Value (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 Value (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.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how BlueMedicare Value (PPO) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), 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 Value (PPO) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of BlueMedicare Value (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 Value (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 Value (PPO)

BlueMedicare Value (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: Lake, Marion, and Sumter

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 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).

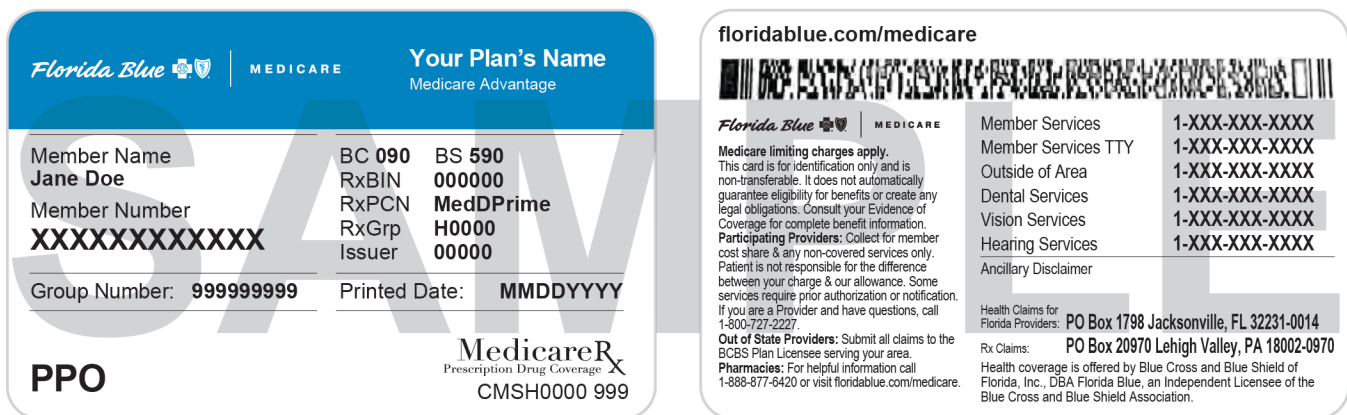
Section 2.3 U.S. citizen or lawful presence

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 Value (PPO) if you're not eligible to stay a member of our plan on this basis. BlueMedicare Value (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 and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan 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 Value (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 our 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.

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

Section 3.3

Pharmacy Directory

The *Pharmacy Directory* <https://providersearch.floridablue.com/> lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). You can also find this information on our website at www.floridablue.com/medicare.

Section 3.4

Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in BlueMedicare Value (PPO). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the BlueMedicare Value (PPO) Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit (www.floridablue.com/medicare/forms) or call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

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.	

Your Costs in 2026	
Deductible	\$500 for Medicare-covered services received out-of-network.
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1.3 for details.)	From network providers: \$5,900 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 \$500 out-of-network deductible
Specialist office visits	<u>In-Network</u> \$0 copay for basic balance evaluations to determine if referral is needed to a Medicare-covered Hearing Specialist. \$40 copay for consultation, diagnosis and treatment by a specialist. <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible
Inpatient hospital stays	<u>In-Network</u> \$320 copay per day for days 1-7 \$0 copay per day for days 8-90

Your Costs in 2026	
	<u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible
Part D drug coverage deductible (Go to Chapter 6 Section 4 Section for details.)	\$615 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: \$0 copay Drug Tier 2: \$0 copay Drug Tier 3: 21% coinsurance You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: 30% coinsurance You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% coinsurance You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 6: \$0 copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

Your costs can include the following:

Chapter 1. Get started as a member

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

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

If you already get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) and ask for the *LIS Rider*.

Section 4.2 Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

When you first enroll in BlueMedicare Value (PPO), we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may

Chapter 1. Get started as a member

get this information in a letter or in a newsletter from our plan. Keep this information because you may need it if you join a Medicare drug plan later.

- **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
- **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is \$38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times \$38.99, which equals \$5.4586. This rounds to \$5.46. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year**, because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay our plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

Section 5.1 How to pay your Part D late enrollment penalty

There are six ways you can pay the penalty.

Option 1: Paying by check

If you choose this option, you'll be billed (invoiced) for your Part D late enrollment penalty each month. Your monthly Part D late enrollment penalty payment is due on the first day of each month. You may mail your monthly Part D late enrollment penalty payments by check to the following address: Florida Blue Medicare, PO Box 660289, Dallas, TX 75266-0289. You may mail overnight payments to Florida Blue Medicare, Attn: CCR, Bldg. 100, 3rd Floor, 4800 Deerwood Campus Pkwy, Jacksonville, FL 32246-6498. You may also make check payments in person at any of our Florida Blue centers. Please visit www.floridablue.com/center to find the center closest to you. Be sure to make checks payable to Florida Blue, not to the Centers for Medicare & Medicaid Services (CMS), the federal agency in charge of Medicare, nor to CMS' parent agency, the Department of Health and Human Services (HHS).

Option 2: Have Part D late enrollment penalty deducted your monthly Social Security check

You can have the Part D late enrollment penalty taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your penalty this way. We'll be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Option 3: Have Part D late enrollment penalty deducted from your monthly Railroad Retirement Board check

You can have the Part D late enrollment penalty taken out of your monthly Railroad Retirement Board (RRB) check. Contact Member Services for more information on how to pay your penalty this way. We'll be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Option 4: Automatic Payment Option (APO)

You can have your Part D late enrollment penalty automatically withdrawn from your checking or savings account; or credit/debit card. Your payments will be withdrawn monthly. Deductions are made on the third day of the month.

You can enroll in the Automatic Payment Option (APO) in one of three ways:

1. Visit www.floridablue.com/medicare/member and click on the "Log In" button to access your online member account. Once you log in, select "My Plan", then "Pay my Bill".
2. Call Member Services (phone numbers are printed on the back cover of this booklet).
3. Mail us a completed authorization form. Visit www.floridablue.com/medicare/forms, click on "Medicare Advantage Plans (Part C)" then scroll down to the Automatic Payment Option (APO). Withholding from a checking/savings account will require a voided check attached to the form.

If you have questions about the APO or would like an authorization form, call Member Services (phone numbers are printed on the back cover of this booklet) or visit our plan website at www.floridablue.com/medicare/forms. Please allow up to four weeks for your enrollment to become effective. You may revoke the APO by notifying us and your financial institution 15 days prior to your Part D late enrollment penalty payment due date.

Option 5: You can pay online

You can also pay your monthly Part D late enrollment penalty on our plan website.

1. Visit www.floridablue.com/medicare/member and click on the “Log In” button to access your online member account.
2. Click Login
3. Click Pay Your Bill
4. Click Pay Now

Online payments are made using a PIN-less debit card that's part of the PULSE, STAR or NYCE networks. Payments made with these debit cards aren't considered credit card payments. These payments are due on the first day of each month. For more information about paying your Part D late enrollment penalty online, please call Member Services (phone numbers are printed on the back cover of this booklet) or visit www.floridablue.com/medicare and click on the “Log In” button to access your online member account.

Option 6: You can pay by telephone

You can pay the bill for your monthly Part D late enrollment penalty by telephone using either your checking or savings account number, along with your financial institution's nine-digit routing number. Like payments by check, these payments are due on the first day of each month. For more information about paying your Part D late enrollment penalty by phone, please call Member Services (phone numbers are printed on the back cover of this booklet).

Changing the way you pay your Part D late enrollment penalty. If you decide to change the option by which you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you're responsible for making sure that your Part D late enrollment penalty is paid on time. To change your payment method, contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

If you have trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the first day of the month. If we have not received your payment by the first day of the month, we'll send you a notice telling you that your plan

membership will end if we don't receive your Part D late enrollment penalty, if owed, within six months after the due date. If you're required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you're having trouble paying your Part D late enrollment penalty, if owed, on time, please contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to see if we can direct you to programs that will help with your costs.

If we end your membership with our plan because you didn't pay your Part D late enrollment penalty, if owed, you'll have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for penalties. We have the right to pursue collection of the amount you owe. If you want to enroll again in our plan (or another plan that we offer) in the future, you'll need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); Go to 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint or you can call us at 1-800-926-6565 between 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 users should call 1-800-955-8770. You must make your request no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

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

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

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 including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and the cost-sharing amounts.** Because of this, it's very important you 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 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.**

Chapter 1. Get started as a member

Once a year, we'll send you a letter that lists any other medical or drug insurance coverage we know about. Read over 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 not 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 insurance 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 the 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 is 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 that has more than 100 employees.
 - If you're over 65 and you or your spouse or domestic partner is 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.
- 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 Value (PPO) contacts

For help with claims, billing, or member card questions, call or write to BlueMedicare Value (PPO) Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). 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 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 or Part D drugs. 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 or Part D drugs, go to Chapter 9.

Method	Coverage Decisions 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 You may fax both standard and fast (expedited) coverage decision requests to us at this number.
WRITE	Florida Blue Medicare Utilization Management Department 4800 Deerwood Campus Parkway Building 900, 5th Floor Jacksonville, FL 32246

How make an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on how to make an appeal about your medical care, Go to Chapter 9.

Method	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. NOTE: Only requests for fast (expedited) appeals are accepted by phone at 1-877-842-9118. For standard appeals, please call 1-800-926-6565.
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	1-305-437-7490 NOTE: Please send only requests for fast (expedited) appeals by fax.
WRITE	Florida Blue Medicare Attn: Medicare Appeals and Grievances Department P.O. Box 41629 Jacksonville, FL 32203-1629
WEBSITE	Log-in to your www.floridablue.com/medicare account by clicking on the black “Log in” box at the top right of the screen. OR if you want to print, mail or fax forms: www.floridablue.com/medicare/forms

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, 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 to make a complaint about your medical care, go to Chapter 9.

Method	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 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	You can submit a complaint about BlueMedicare Value (PPO) directly to Medicare. To submit an online complaint to Medicare go to <u>www.medicare.gov/MedicareComplaintForm/home.aspx</u>.

How to ask for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D drugs, Go to Chapter 9.

Method	Coverage Decisions for Part D Prescription Drugs – 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	1-800-693-6703 NOTE: You may request both standard and fast (expedited) Part D coverage decisions by fax.
WRITE	Prime Therapeutics, LLC Attention: Medicare D Clinical Review 2900 Ames Crossing Road Eagan, MN 55121
WEBSITE	<u>www.MyPrime.com</u>

How to make an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we've made. For more information on how to make an appeal about your Part D prescription drugs, Go to Chapter 9.

Method	Appeals for Part D Prescription Drugs – 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	1-800-693-6703 NOTE: You may fax requests for both standard and fast (expedited) appeals.
WRITE	Prime Therapeutics, LLC Attention: Medicare D Clinical Review 2900 Ames Crossing Road Eagan, MN 55121
WEBSITE	<u>www.MyPrime.com</u>

How to make a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section above about making an appeal.) For more information on how to make a complaint about your Part D prescription drugs, Go to Chapter 9.

Method	Complaints about Part D prescription drugs – 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	1-888-285-2242 NOTE: You may fax requests for both standard and fast (expedited) complaints.
WRITE	Florida Blue Medicare Attn: Medicare Grievance Dept P.O. Box 64813 St. Paul, MN 55164
MEDICARE WEBSITE	You can submit a complaint about BlueMedicare Value (PPO) directly to Medicare. To submit an online complaint to Medicare go to <u>www.medicare.gov/MedicareComplaintForm/home.aspx</u> .

How to ask us to pay our share of the cost for medical care or a drug 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 7 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 9 for more information.

Method	Payment Requests – Contact Information
WRITE	<u>For requests related to medical care:</u> Florida Blue Medicare P. O. Box 1798 Jacksonville, FL 32231-0014 <u>For requests related to Part D prescription drugs:</u> Prime Therapeutics (Med-D) P.O. Box 20970 Lehigh Valley, PA 18002-0970
WEBSITE	<u>www.floridablue.com/medicare</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.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048

Method	Medicare – Contact Information
	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 Value (PPO). 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 state program (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, help you make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. SHINE counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Method	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	<u>www.FLORIDASHINE.org</u>

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.

Method	ACENTRA HEALTH (Florida's Quality Improvement Organization)- Contact Information
CALL	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 West Kennedy Boulevard 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. Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213

Method	Social Security – Contact Information
	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. The programs offered through Medicaid 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're eligible for full Medicaid.

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

Method	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	www.ahca.myflorida.com/Medicaid/

SECTION 7 Programs to help people pay for their prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit <https://secure.ssa.gov/i1020/start> to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

If you can't provide evidence of eligibility for Extra Help:

- We'll ask you or your representative (for example, your pharmacist) for certain information, including when you'll run out of your medication.
- We'll submit your request to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, within one business day of receiving it. CMS will contact your state Medicaid office to determine your status and let us know the results before the date you indicated you would run out of medicine or within ten days, whichever comes first.
- If you have less than three days of medication left, CMS will contact your state Medicaid office within one day of receiving the request we submitted on your behalf and will inform us of the results within one business day of receiving a response from the state.
- We'll attempt to notify you of the results of CMS' inquiry within one business day of receiving them. If we aren't able to contact you the first time we try, we'll make up to three more attempts to notify you. Our fourth attempt will be in writing. Our notice will include contact information for CMS in case you don't agree with the results of the inquiry.
- We'll provide your medications at a reduced cost-sharing level as soon as we find out you're eligible for "Extra Help" with your prescription costs.

If you have evidence of eligibility for Extra Help:

- We must accept any of the following types of evidence as proof that you're eligible for "Extra Help." Evidence may be provided by you or your pharmacist, advocate, representative, family member or other individual acting on your behalf. Each item listed below must show that you were eligible for Medicaid during a month after June of the previous calendar year:
 - A copy of your Medicaid card including your name and an eligibility date;
 - A copy of a state document that confirms active Medicaid status;
 - A print-out from your state's electronic enrollment file showing Medicaid status;
 - A screen print from your state's Medicaid systems showing Medicaid status after June of the previous calendar year;
 - Other documentation provided by the state showing Medicaid status;

- A report of contact, including the date a verification call was made to the state Medicaid agency and the name, title and telephone number of the state staff person who verified the Medicaid status;
- A remittance from a long-term care facility showing Medicaid payment for you for a full calendar month;
- A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar year on your behalf;
- A screen print from your state's Medicaid systems showing your institutional status based on a stay of at least a full calendar month for Medicaid payment purposes;
- A copy of a state document that confirms your active Medicaid status and shows that you're receiving home- and community-based services;
- A Supplemental Security Income (SSI) Notice of Award with an effective date; or
- An Important Information letter from the Social Security Administration (SSA) confirming that you're "automatically eligible for "Extra Help."

When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the *Florida AIDS Drug Assistance Program*.

Note: To be eligible for the ADAP in your State, people must meet certain criteria, including proof of State residence and HIV status, low income (as defined by the State), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call 1-800-352-2437 (TTY 1-888-503-7118) or mail them at HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan

with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or visit www.Medicare.gov.

Method	The Medicare Prescription Payment Plan – 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	www.floridablue.com/medicare/member

SECTION 8 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.

Method	Railroad Retirement Board (RRB) – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Press “0” to 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. Press “1” to 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	<u>https://RRB.gov/</u>

SECTION 9 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. 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.

If you have other drug coverage through your (or your spouse or domestic partner’s) employer or retiree group, contact **that group’s benefits administrator**. The benefits administrator can help you understand how your current prescription drug coverage will work with our plan.

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 have 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 equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

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

BlueMedicare Value (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's eligible to provide services under Original Medicare.** As a member of our plan, you can get 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/> a Provider.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - Note: 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 isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. 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

Prior authorization may be needed for certain services (please go to Chapter 4 for information 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 that this determination be in writing. This process is called an advanced determination. If we say we'll not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 9 (*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.

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.

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 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 that 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 9).

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 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 covered services may be higher.** Here are 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 get. 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 are medically necessary (go to Chapter 9, Section 4). This is important because:
 - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we'll not cover your services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- 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 7).
- 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 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 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 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.

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 the service area of our plan's, 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. 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 receive covered services from an out-of-network provider and pay the lower in-network cost-sharing amount.

You may receive 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 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 received outside the United States and its territories. Coverage is limited to a \$25,000 combined maximum per calendar year and doesn't 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.

For additional information about coverage of urgently needed services outside the United States, Go to Chapter 4, Section 2, Medicare Benefits Chart.

Section 3.3 Get 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 our plan.

Visit www.floridablue.com/medicare/member for information on how to get needed 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. If you can't use a network pharmacy during a disaster, you may be able to fill your prescription at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

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 get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

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

BlueMedicare Value (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 have used 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 (care that's 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 Medicare 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 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 7 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 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 will *not* pay for the new item or service that 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 wouldn'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
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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's **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 you get that's *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 only covers non-religious aspects of care.
- If you get services from this institution 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 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 Value (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 made while enrolled in our plan don't count towards 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 items 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 Value (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 Value (PPO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our 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 Value (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 your covered services include.

- **Deductible** is 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 \$500. Until you have 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 \$500 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 have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is \$5,900. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for copayments, deductibles and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for Part D prescription drugs and 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 have paid \$5,900 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 you got from both in-network and out-of-network providers. The amounts you pay for copayments, deductibles and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs don't count toward your 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 will not 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 Value (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, then you pay the coinsurance amount 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 Value (PPO) covers and what you pay out of pocket for each service (Part D drug coverage is covered in Chapter 5). 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 can't 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 Value (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 receive the services from:
 - If you get 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 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.
- 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 should call 1-877-486-2048.)
- For preventive services that are 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 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've 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's no coinsurance, copay, 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 isn't improving or is regressing. Provider Requirements:	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 \$500 out-of-network deductible.

Covered Service	What you pay
Acupuncture for chronic low back pain (continued) 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 auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters 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 \$410 copay per one-way trip Air Ambulance

Covered Service	What you pay
Ambulance services (continued)	20% coinsurance per one-way trip Out-of-Network Ground Ambulance \$410 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’s 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	In-Network There's no coinsurance, copay, or deductible for the annual wellness visit. Out-of-Network 50% of the total cost.

Covered Service	What you pay
 Annual wellness visit (continued) Medicare, including OB/GYN routine physicals, aren't covered by our plan.	
 Bone mass measurement For qualified individuals (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: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	<u>In-Network</u> There's no coinsurance, copay, or deductible for 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's 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

Covered Service	What you pay
Cardiac rehabilitation services (continued)	visits at all outpatient places of service. <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 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's 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's no coinsurance, copay, or deductible for cardiovascular disease screening tests that are 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	<u>In-Network</u> There's no coinsurance, copay, or deductible for

Covered Service	What you pay
 Cervical and vaginal cancer screening (continued) If you're 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	Medicare-covered preventive Pap and pelvic exams. <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 \$500 out-of-network deductible.
Chronic pain management and treatment services 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

Covered Service	What you pay
Chronic pain management and treatment services (continued)	services provided under the course of treatment. <u>In-Network</u> \$0 copay for services in a physician's office \$40 copay for services in a physician specialist office \$50 copay for services during physical and occupational therapy <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible.
 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.	<u>In-Network</u> There's 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.

Covered Service	What you pay
 Colorectal cancer screening (continued) - 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 received 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. - 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.	<u>Out-of-Network</u> 50% of the total cost for a colorectal cancer screening.

Covered Service	What you pay
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 beneficiary's primary medical condition. Examples include reconstruction of the jaw following 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> \$40 copay for Medicare-covered non-routine dental care. <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 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 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's no coinsurance, copay, or deductible for an annual depression screening visit. <u>Out-of-Network</u> 50% of the total cost.

Covered Service	What you pay
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following 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's 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 shoes) and two additional pairs of inserts, or one pair of depth shoes and three 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 needles, syringes or Insulin for self-injection as part of your pharmacy benefit (Medicare Part D). You can get these items from your local network retail pharmacy or through one of our <u>mail-order</u>	<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. \$0 copay for diabetic self-management training. 20% coinsurance for drugs administered through use of a covered DME pump (<i>NOTE: Prior Authorization may be required for certain items, in-network only. Contact Member Services for more information.</i>) You won't pay more than a \$35 copay for a one-month supply of each covered insulin product

Covered Service	What you pay
 Diabetes self-management training, diabetic services and supplies (continued) pharmacies. Your cost share is based on the approved tier placement of the product on the drug list (Formulary) for the plan year. - 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.	regardless of the cost-sharing tier, even if you haven't paid your Part D deductible. Out-of-Network 50% of the total cost for diabetes self-management training. 50% of the total cost for diabetic services and supplies after you reach your \$500 out-of-network deductible. 50% of the total cost for diabetic therapeutic shoes and inserts after you reach your \$500 out-of-network deductible. 50% of the total cost for drugs administered through use of a covered DME pump after you reach your \$500 out-of-network deductible. For cost-sharing applicable to insulin and syringes Go to Chapter 6.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, Go to Chapter 12 and Chapter 3)	Prior Authorization may be required for certain items, in-network only. Contact

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) 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. - Additional refills may be obtained through your contracted retail or mail order pharmacy. For more information, please contact Member Services (phone numbers are printed on the back cover of this booklet). Important Note: <u>Syringes are covered under the prescription drug (Part D) benefit only when purchased with insulin. Please contact Member Services with any questions regarding this coverage.</u> Your	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 Value (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in BlueMedicare Value (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. 20% coinsurance for drugs administered through use of a covered DME pump.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) cost-share for these syringes is based on the approved tier placement on the drug list (Formulary) for our plan year.	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). Out-of-Network 50% of the total cost after you reach your \$500 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've 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. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.	<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 receiving these services. If you receive emergency care at an out-of-network hospital and 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

Covered Service	What you pay
Emergency care (continued) Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Oral and other drugs approved for self-administration received during an emergency room visit or given at discharge following an inpatient admission may be covered under your pharmacy (Part D) benefit. Coverage is based on the pharmacy benefits in effect at the time of your visit. Contact Member Services to request a claim form. See also "Urgently needed services".	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 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.	Out-of-Network \$130 copay for plan-covered emergency services received outside the United States and its territories. This copay is waived if you are 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 do not 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 receive 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 furnished by a physician, audiologist, or other qualified provider.	<u>In-Network</u> \$0 copay for diagnostic hearing and balance evaluations. \$40 copay for consultation, diagnosis and treatment.

Covered Service	What you pay
Hearing services (continued)	<u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible.
Hearing services* (additional benefits) We also cover the following additional hearing services and supplies 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. Please contact Member Services for further assistance. Hearing aid purchases include: • 3 follow-up visits within first year of initial fitting date with 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	<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 per device ◦ Preferred \$1,125.00 per device

Covered Service	What you pay
Hearing services* (additional benefits) (continued) • 1-time replacement coverage for lost, stolen or damaged hearing aid (deductible may apply per aid) • First set of ear molds (when needed) 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.	◦ Advanced \$1,425.00 per device ◦ Premium \$1,825.00 per device 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's 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 are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care	Prior Authorization may be required for services, in-network only. Contact Member Services for more information.

Covered Service	What you pay
Home health agency care (continued) 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 • Medical equipment and supplies	<u>In-Network</u> \$0 copay for Medicare-covered home health visits (including home infusion services but excluding infusion drugs). <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 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 are not 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 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</i>

Covered Service	What you pay
Home infusion therapy (continued)	<i>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> <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 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 may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including those the MA organization owns, controls, or has 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 remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.	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 Value (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) For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not 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 (such as if there is a requirement to obtain prior authorization). • If you get the covered services from a network provider and follow plan rules for obtaining service, you only pay the 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 Value (PPO) but not covered by Medicare Part A or B: BlueMedicare Value (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost-sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, Go to Chapter 5, section 9.4 (<i>What if you're in a Medicare-certified hospice</i>).	

Covered Service	What you pay
Hospice care (continued) Note: If you need non-hospice care (care that isn't related to your terminal prognosis), you should 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 • 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 We also cover most other adult vaccines under our Part D prescription drug benefit. Refer to Chapter 6, Section 7 for additional information.	<u>In-Network</u> There's no coinsurance, copay, or deductible for the pneumonia, flu/influenza, 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 are formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There's no limit to the number of covered hospital days. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services	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.

Covered Service	What you pay
Inpatient hospital care (continued) - 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 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 Value (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 outpatient. If you aren't sure if you are an inpatient or an outpatient, you should ask the hospital staff.	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: \$320 copay per day per Medicare-covered stay. You'll not be charged a copay for the day of discharge. After the 7th day, our 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 would pay at a network hospital. \$0 copay for blood including storage and administration <u>Out-of-Network</u>

Covered Service	What you pay
Inpatient hospital care (continued) 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. Oral and other drugs approved for self-administration given at discharge following an inpatient admission or received during an emergency room visit may be covered under your pharmacy (Part D) benefit. Coverage is based on the pharmacy benefits in effect at the time of your visit. Please contact Member Services to obtain a claim form.	50% of the total cost after you reach your \$500 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 doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • 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.	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. Cost-sharing also applies if you are readmitted for the same condition. <u>In-Network</u> Days 1-6: \$350 copay per day (per Medicare-covered stay). You will not be charged a copay for the day of discharge. Days 7-90: \$0 copay per day (per Medicare-covered stay).

Covered Service	What you pay
Inpatient services in a psychiatric hospital (continued)	Lifetime Reserve Days: Our plan pays 100% of covered expenses. <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we'll not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not 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 • 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	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
 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 your first year that you receive 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 receive 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's 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 will be covered for eligible Medicare beneficiaries 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's no coinsurance, copay, or deductible for the MDPP benefit. <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 receive 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	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

Covered Service	What you pay
Medicare Part B drugs (continued) • 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. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 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. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • 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	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> <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 for any associated professional services provided at a doctor's office or outpatient facility, depending on the location of

Covered Service	What you pay
Medicare Part B drugs (continued) • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • 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. We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. Oral and other drugs approved for self-administration received during an emergency room visit or given at discharge following an inpatient admission aren't covered under the hospital bill. They may be covered under your pharmacy (Part D) benefit. Coverage is	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. Out-of-Network 50% of the total cost after you reach your \$500 out-of-network deductible.

Covered Service	What you pay
Medicare Part B drugs (continued) based on the pharmacy benefits in effect at the time of your visit. Please contact Member Services to obtain a claim form.	
 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's 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 receive 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 disorder 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 \$500 out-of-network deductible.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays	Prior Authorization may be required for certain items,

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)	in-network only. Contact Member Services for more information. <u>In-Network</u> <i>Provider and Professional Services</i> • Physician's Office: \$0 copay • Specialist: \$40 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 <i>Lab Services</i>

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	- Independent Clinical Laboratory (ICL): \$0 copay - Outpatient Hospital Facility: \$40 copay Advanced Imaging Services - Physician's Office: \$75 copay - IDTF: \$100 copay - Outpatient Hospital Facility: \$250 copay - Diagnostic Ultrasound: \$0 copay Allergy Testing \$0 copay Diagnostic Bronchoscopy Outpatient Hospital Facility: \$0 copay <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 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 the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state	<u>In-Network</u> \$130 copay for outpatient hospital observation services.

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 are 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 are an outpatient, you should 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.	<u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible.
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 are not 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 are 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 <i>outpatient</i>. If you aren't sure if you are an outpatient, you should ask the hospital staff.	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) Get more information in the Medicare fact sheet Medicare Hospital Benefits. 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.	 facility-operated professional clinic \$40 copay for a visit to a specialist at a facility operated professional clinic Diagnostic Bronchoscopy \$0 copay at an outpatient hospital facility 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)	<i>Chemotherapy drugs, Infusion drugs, and all other drugs covered under Medicare Part B</i> 20% coinsurance at an outpatient hospital facility <i>Avastin® (bevacizumab) for eye injections and Allergy Injections</i> \$0 copay at an outpatient hospital facility <i>Cardiac Rehabilitation</i> \$35 copay at an outpatient hospital facility <i>Intensive Cardiac Rehabilitation</i> \$50 copay at an outpatient hospital facility <i>Pulmonary Rehabilitation</i> \$15 copay at an outpatient hospital facility <i>Diagnostic Procedures and Tests</i> \$75 copay at an outpatient hospital facility \$0 copay for allergy testing <i>Mental Health Services</i> \$40 copay for individual session at an outpatient hospital facility \$30 copay for group session at an outpatient hospital facility

Covered Service	What you pay
Outpatient hospital services (continued)	
	<i>Physical Therapy</i> \$50 copay at an outpatient hospital facility <i>Lymphatic Therapy</i> \$0 copay at an outpatient hospital facility <i>Speech Therapy</i> \$50 copay at an outpatient hospital facility <i>Occupational Therapy</i> \$50 copay at an outpatient hospital facility <i>Supervised Exercise Therapy (SET)</i> \$25 copay at an outpatient hospital facility <i>Substance Use Disorder Services</i> \$40 copay for individual session at an outpatient hospital facility \$30 copay for group session at an outpatient hospital facility <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 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 \$500 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> • \$50 copay for Occupational Therapy at all locations of service

Covered Service	What you pay
Outpatient rehabilitation services (continued)	• \$50 copay for Physical Therapy at all locations of service • \$50 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 \$500 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 do not 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 \$500 out-of-network deductible for each individual or group therapy visit.

Covered Service	What you pay
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 will 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 outpatient.	Prior authorization may be required for services, in-network only. Contact Member Services for more information. <u>In-Network</u> \$225 copay for each Medicare-covered visit to an ambulatory surgical center. \$275 copay for each Medicare-covered visit to an outpatient hospital facility. \$0 copay for Bronchoscopy provided in an outpatient hospital. <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible.
Over-the-Counter (OTC) Items You receive a \$35 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 will receive more information about this benefit, including instructions for using it.	\$0 copay for the over-the-counter product allowance.
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	Prior Authorization may be required for non-emergency

Covered Service	What you pay
Partial hospitalization services and Intensive outpatient services (continued) community mental health center, that is more intense than the care received 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</i> service 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 is more intense than the care received 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.	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 \$500 out-of-network deductible.
Physician/Practitioner services, including doctor's office visits Covered services include: - Medically-necessary medical care or surgery services furnished 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> <i>Office Visits</i> \$0 copay for office visits to a provider of choice. \$40 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 to your doctor, and interpretation and follow-up by your doctor within 24 hours if:	Medicare-covered Hearing Services \$0 copay for basic hearing and balance exam at a specialist office \$40 copay for Medicare-covered hearing services. Medicare-covered Dental Services \$40 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).

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 doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other 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.	\$0 copay for Medicare-covered allergy injections. \$0 copay for Avastin® (bevacizumab) for eye injections. 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

Covered Service	What you pay
Physician/Practitioner services, including doctor’s office visits (continued)	<i>are printed on the back cover of this booklet)).</i> <u>In- and Out-of-Network</u> <i>Facility-based Professional Services</i> \$0 copay for professional services provided at a facility, when cost-sharing applies to the facility bill for the same service. <u>Out-of-Network</u> 50% of the total cost after you reach your \$500 out-of-network deductible for office visits to provider of choice. 50% of the total cost after you reach your \$500 out-of-network deductible for office visits to specialists.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued)	<i>Medicare-covered Hearing Services</i> 50% of the total cost after you reach your \$500 out-of-network deductible. <i>Medicare-covered Dental Services</i> 50% of the total cost after you reach your \$500 out-of-network deductible. <i>Allergy Injections, Chemotherapy and Other Medicare Part B Drugs</i> 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). 50% of the total cost of the total cost after you reach your \$500 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.

Covered Service	What you pay
Podiatry services (continued)	<u>Out-of-Network</u> 50% of the total cost of the total cost after you reach your \$500 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's no coinsurance, copayment, or deductible for the PrEP benefit. <u>Out-of-Network</u> 50% of the total cost.
 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's no coinsurance, copay, or deductible for an annual PSA test. <u>Out-of-Network</u> 50% of the total cost.

Covered Service	What you pay
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 – see <i>Vision Care</i> later in this section 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 \$500 out-of-network deductible.
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 \$500 out-of-network deductible.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.	<u>In-Network</u> There's no coinsurance, copay, or deductible for the

Covered Service	What you pay
 Screening and counseling to reduce alcohol misuse (continued) 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.	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 individuals, a LDCT is covered every 12 months. Eligible members are: people aged 50 – 77 years 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 receive 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. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive 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 subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	<u>In-Network</u> There's 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.
 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:	<u>In-Network</u> There is no coinsurance, copayment, or deductible for

Covered Service	What you pay
 Screening for Hepatitis C Virus infection (continued) - 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.	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. 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 will 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>In-Network</u> There's no coinsurance, copay, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. <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 six sessions of kidney disease education services per lifetime - Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in	<u>In- and Out-of-Network</u> 20% coinsurance for dialysis services in all places of service. <u>In-Network</u>

Covered Service	What you pay
Services to treat kidney disease (continued) 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 your Medicare Part B drug benefit. For information about coverage for Part B Drugs, go to Medicare Part B prescription drugs in this table.	\$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.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. 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 are not 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 your 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	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 copay per day (per benefit period). Days 21-100: \$218 copay 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

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • 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 will get your SNF care from network facilities. However, 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.	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 \$500 out-of-network deductible.
 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's 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.	Prior Authorization may be required for services, in-network only. Contact

Covered Service	What you pay
Supervised Exercise Therapy (SET) (continued) 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 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.	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 \$500 out-of-network deductible.
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	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 • \$50 copay for Occupational Therapy

Covered Service	What you pay
Telehealth (additional benefits) (continued) 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.	
	• \$50 copay for Physical Therapy • \$50 copay for Speech Therapy • \$40 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 • \$40 copay for individual sessions for outpatient Substance Use Disorder Services • \$0 copay for Diabetes Self-Management Training • \$0 copay for Dietician Services <u>Out-of-Network</u> • Urgently Needed Services: \$50 copay • Provider of Choice: 50% of the total cost after you reach your \$500 out-of-network deductible

Covered Service	What you pay
Telehealth (additional benefits) (continued)	• Occupational Therapy: 50% of the total cost after you reach your \$500 out-of-network deductible • Physical Therapy: 50% of the total cost after you reach your \$500 out-of-network deductible • Speech Therapy: 50% of the total cost after you reach your \$500 out-of-network deductible • Dermatology Services: 50% of the total cost after you reach your \$500 out-of-network deductible • Mental Health Specialty Services: 50% of the total cost after you reach your \$500 out-of-network deductible • Psychiatry Specialty Services: 50% of the total cost after you reach your \$500 out-of-network deductible • Opioid Treatment: 50% of the total cost after you reach your \$500 out-of-network deductible

Covered Service	What you pay
Telehealth (additional benefits) (continued)	• Substance Use Disorder Services: 50% of the total cost after you reach your \$500 out-of-network deductible • Diabetes Self-Management Training: 50% of the total cost • Dietician Services: 50% of the total cost after you reach your \$500 out-of-network deductible
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you're temporarily outside the service area of the plan, or even if you're inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. 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, are not considered urgently needed even if you're outside the service area of the plan or the 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). Go to section 2.2 "Getting care using our plan's optional visitor/traveler benefit". For more information regarding accessing care outside our network.	<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)	
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 is <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. 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.	<u>Out-of-Network</u> \$130 copay for plan-covered urgently needed services received outside the US or its territories. Benefits for urgent care and emergency care received outside the United States and its territories are limited to a combined \$25,000 maximum per calendar year and do not include coverage of emergency transportation services. Copay is <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	<u>In-Network</u> \$40 copay for physician services to diagnose and treat diseases and conditions of the eye. \$0 copay for Medicare-covered glaucoma screening.

Covered Service	What you pay
 Vision care (continued) 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 two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	\$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. Eye refractions performed solely for the purpose of prescribing eyewear are not 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 \$500 out-of-network deductible for Medicare-covered physician services to diagnose and treat

Covered Service	What you pay
 Vision care (continued)	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 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, please contact Member Services 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
	<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.
	<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

Covered Service	What you pay
Vision care* (additional benefits) (continued)	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 The 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 the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your <i>Welcome to Medicare</i> preventive visit.	<u>In-Network</u> There's no coinsurance, copay, or deductible for the <i>Welcome to Medicare</i> preventive visit. <u>Out-of-Network</u> 50% of the total cost.

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

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Diagnostic and Preventive Dental (continued)						
	D0150	Full dental exam for new patients or those who haven't been seen in a while	1 per lifetime per dentist			out-of-network care.
	D0140	Dental exam focused on a specific issue or concern	As necessary	N/A		
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 D0220, D0230, D0240 and D0270, D0272, D0273, D0274, D0277	\$0 copay	
	D0330	Single X-ray showing your entire mouth, including jaw and teeth				
	D0220	First close-up X-ray of a specific tooth and surrounding bone	1 set per calendar year			
	D0230	Extra close-up X-ray of another specific tooth				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Diagnostic and Preventive Dental (continued)						
	D0240	X-ray showing the roof or floor of the mouth to check tooth placement	1 set per calendar year			
	D0270	One X-ray to check for cavities between teeth				
	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				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Diagnostic and Preventive Dental (continued)						
Prophylaxis (Cleaning)	D1110	Routine professional teeth cleaning for adults	2 per calendar year	N/A	\$0 copay	
Fluoride Treatment	D1206	Painted-on fluoride to help prevent cavities	1 per calendar year	Combined limit with D1206, D1208	\$0 copay	
	D1208	Rinse or gel fluoride treatment to strengthen teeth				
Other	D1354	Medicine applied to a tooth to help stop a cavity from growing	2 per calendar year	N/A	\$0 copay	
Comprehensive Dental						
Restorative Services - Fillings	D2140	Silver filling for one part of a tooth	1 per calendar year	Combined limit with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392,	\$0 copay	You'll pay the full cost upfront and will be reimbursed 50% of the allowed amount for out-of-network care.

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
	D2150	Silver filling for two parts of a tooth		D2393, D2394		
	D2160	Silver filling for three parts of a tooth				
	D2161	Silver filling for most or all of a tooth				
	D2330	Tooth-colored filling for one part of a tooth				
	D2331	Tooth-colored filling for two parts of a tooth				
	D2332	Tooth-colored filling for three parts of a tooth				
	D2335	Tooth-colored filling covering most of the tooth or including the biting edge				
	D2391	Tooth-colored filling for one part of a back tooth				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
	D2392	Tooth-colored filling for two parts of a back tooth				
	D2393	Tooth-colored filling for three parts of a back tooth				
	D2394	Tooth-colored filling for most or all of a back tooth				
Periodontics	D4910	Ongoing cleaning to keep gums healthy and remove buildup above and below the gums	2 per calendar year	Combined limit with D1110, D4910	\$0 copay	You'll pay the full cost upfront and will be reimbursed 50% of the allowed amount for out-of-network care.
Prosthodontics, removeable	D5110	Full upper denture to replace all top teeth	1 upper and 1 lower denture per 60 months	Combined limit with D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214	\$0 copay	You'll pay the full cost upfront and will be reimbursed 50% of the allowed amount for out-of-network care.
	D5120	Full lower denture to replace all bottom teeth				
	D5130	Temporary full upper denture				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
		placed right after tooth removal				
	D5140	Temporary full lower denture placed right after tooth removal				
	D5211	Partial upper denture with a plastic base to replace some missing teeth				
	D5212	Partial lower denture with a plastic base to replace some missing teeth				
	D5213	Partial upper denture with a metal base and plastic top to replace some teeth				
	D5214	Partial lower denture with a metal base and plastic top to replace some teeth				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
Prosthodontics, removeable	D5410	Adjustment to improve the fit of upper full denture	1 per calendar year	Combined limit with D5410, D5421, D5710, D5730, D5750	\$0 copay	
	D5421	Adjustment to improve the fit of upper partial denture				
	D5710	Rebuilding the base of upper full denture				
	D5730	Refitting upper full denture in the dental office				
	D5750	Refitting upper full denture in a lab for a better fit				
	D5411	Adjustment to improve the fit of lower full denture	1 per calendar year	Combined limit with D5411, D5422, D5711, D5731, D5751	\$0 copay	
	D5422	Adjustment to improve the fit of lower partial denture				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
	D5711	Rebuilding the base of lower full denture				
	D5731	Refitting lower full denture in the dental office				
	D5751	Refitting lower full denture in a lab for a better fit				
	D5511	Repairing a broken lower full denture base	1 per calendar year with up to 5 total in 5 calendar years	Combined limit with D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660	\$0 copay	
	D5512	Repairing a broken upper full denture base				
	D5520	Adding or fixing a tooth on a full denture				
	D5611	Fixing a broken lower partial denture base				
	D5612	Fixing a broken upper partial denture base				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
	D5621	Fixing the metal structure of an upper partial denture				
	D5622	Fixing the metal structure of a lower partial denture				
	D5630	Fixing or replacing a broken clasp on a denture				
	D5640	Replacing or fixing a tooth on a partial denture				
	D5650	Adding a tooth to current partial denture				
	D5660	Adding a clasp to current partial denture				
	D5740	Refitting upper partial denture in the dental office	1 per calendar year	Combined limit with D5740, D5760	\$0 copay	
	D5760	Refitting upper partial denture				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
		in a lab for better comfort	1 per calendar year	Combined limit with D5741, D5761	\$0 copay	
	D5741	Refitting lower partial denture in the dental office				
	D5761	Refitting lower partial denture in a lab for better comfort				
Oral and Maxillofacial Surgery	D7140	Removing a tooth that has come through the gums or an exposed root	1 per calendar year	Combined limit with D7140, D7210, D7220, D7230, D7241, D7250	\$0 copay	You'll pay the full cost upfront and will be reimbursed 50% of the allowed amount for out-of-network care.
	D7210	Surgically removing a tooth that has already come through the gums				
	D7220	Removing a tooth stuck under the gums, covered only by soft tissue				
	D7230	Removing a tooth stuck under the				

Category	Code	Description	Frequency	Limit	Cost Share	
					In-Network	Out-of-Network
Comprehensive Dental (continued)						
		gums and partially covered by bone				
	D7240	Removing a tooth stuck completely under the bone				
	D7241	Removing a deeply stuck tooth with added complications				
	D7250	Removing remaining tooth roots left under the gumline				

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 Get care using our plan's optional visitor/traveler benefit

If you don't permanently move, but you continuously away from our plan's service area for more than 6 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 stay enrolled when you're outside of our service area for less than 12 months. Under our visitor/traveler program you can get all plan covered services at in-network cost-sharing. Contact our plan for help 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 at 1-800-926-6565 (TTY users call 1-800-955-8770). The Member Service number is also on the back of your ID card. It's 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 don't return 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 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 9, 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 doesn't 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

Services not covered by Medicare	Covered only under specific conditions
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
Homemaker services including basic household assistance, such as 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 Benefits 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.

Services not covered by Medicare	Covered only under specific conditions
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> See the "Dental services* (additional benefits)" section of the Benefits 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> Routine eye examination 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 benefits)" Section of the Benefit Chart in this chapter for additional information about this coverage.

Services not covered by Medicare	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare	Not covered under any condition

CHAPTER 5:

Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Our plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term “covered drugs” means all of the Part D drugs that are on our plan’s Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website <https://providersearch.floridablue.com/> or call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan’s network, you’ll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or use the *Pharmacy Directory*. You can also find information on our website at <https://providersearch.floridablue.com/>.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your Pharmacy Directory <https://providersearch.floridablue.com/> or call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

Section 2.2 Our plan's mail-order service

Our plan's mail-order services require you to order **at least a 31-day supply of the drug and no more than a 90-day supply for Tiers 3 and 4 and up to a 100-day supply for Tiers 1, 2 and 6.**

To get order forms and information about filling your prescriptions by mail: please call one of our mail-order service pharmacies.

- Walgreens Mail Service Pharmacy, 24 hours a day, 7 days a week, at 1-888-849-7845, or at their website, www.WalgreensMailService.com
- Express Scripts Pharmacy, 24 hours a day, 7 days a week, at 1-877-277-7914, or at their website, www.express-scripts.com
- Amazon Home Delivery, call customer care 24 hours a day, 7 days a week. You can also speak to a pharmacist 24 hours a day, 7 days a week, at 1-855-745-5725, or at their website pharmacy.amazon.com.

If you use a mail-order pharmacy not in our plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will be delivered to you in no more than 14 days. Prescriptions for controlled substances may take longer because our mail-order pharmacy has to take additional steps to review the prescription. This may include contacting your doctor prior to filling.

If you experience a delay in receiving your order and you're in danger of running out of your medication, you can request an override to have your prescription filled at a local retail pharmacy by calling the number on the back of your ID card. Once approval is obtained, our mail-order pharmacy can transfer your prescription to the pharmacy of your choice or have your doctor telephone a short-term supply prescription directly to your pharmacy. If you use a mail-order pharmacy not in our plan's network, your prescriptions will not be covered.

Consistent with State and Federal laws, some prescriptions for drugs classified as controlled substances require detailed review before they can be filled. This review may take 7-10 days, in addition to shipping time. Sending a prescription to a network mail-order pharmacy or transferring to a local network pharmacy doesn't guarantee the prescription will be filled; pharmacists fill prescriptions subject to the exercise of their professional discretion.

Please note: There may be some instances when a mail-order pharmacy in our network is unable to fill your prescription. In those cases, you'll be alerted after the review is completed.

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It's important that you respond each time

you're contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, please contact your pharmacy *15 days* before your current prescription will run out to make sure your next order is shipped to you in time.

Section 2.3 How to get a long-term supply of drugs

Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Your *Pharmacy Directory* <https://providersearch.floridablue.com/> tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Check first with Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstance:

- If you're traveling within the United States and its territories and become ill, lose or run out of your prescription drugs, we'll cover prescriptions that are filled at an out-of-network pharmacy. Coverage in this situation will be for a **temporary 31-day supply** of medication, or less if your prescription is for fewer days.
- We'll cover prescriptions filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care.
- We'll cover prescriptions at an out-of-network pharmacy if at least one of the following applies:
 - If you're unable to obtain a covered drug in a timely manner within our service area because there's no network pharmacy within a reasonable driving distance that provides 24-hour service.

- If you're trying to fill a prescription drug that's not regularly stocked at an accessible network retail or mail-order pharmacy (including high-cost and unique drugs).
- If you're getting a vaccine that's medically necessary but not covered by Medicare Part B, as well as some covered drugs administered in your doctor's office.

Please Note: If you purchase a drug at an out-of-network pharmacy, and one of the situations explained above applies to you, you may be reimbursed at our plan's standard in-network pharmacy rate, not the full price that you paid for the drug. Additionally, the difference in our plan's reimbursement amount and the total amount you paid for the drug will be included in your total out-of-pocket costs.

When none of the situations explained above apply and you voluntarily pay out-of-pocket for a drug, you'll be responsible for paying the total cash price of the drug, and you'll not be reimbursed by our plan. The amount you pay will not apply toward your total out-of-pocket costs.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs (formulary)*. In this *Evidence of Coverage*, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug is for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the FDA for the diagnosis or condition for which it's being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that's sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of the types of drugs that may be on the Drug List.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Six cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of six cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Tier 1, our lowest cost-sharing tier, includes Preferred Generic Drugs.
- Tier 2, our next tier, includes Generic Drugs. The cost-sharing amount is greater than for Tier 1 drugs.
- Tier 3, our next tier, includes Preferred Brand Drugs and some Generic Drugs. The cost-sharing amount for drugs in this tier is greater than for Tier 2 drugs.

- Tier 4, our next tier, includes Non-Preferred Drugs and some Generic Drugs. The cost-sharing amount for drugs in this tier is greater than for Tier 3 drugs.
- Tier 5, our next tier, includes Generic and Brand Specialty Drugs. Specialty Drugs are very high-cost drugs. The cost-sharing amount is greatest for Tier 5 drugs.
- Tier 6, our last tier, includes Select Care Drugs. Select Care Drugs are certain Generic drugs used to treat diabetes, hypertension and high cholesterol. There is no cost-share for drugs in this tier in the Initial Coverage Stage.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

1. Check the most recent Drug List we provided electronically.
2. Visit our plan's website (<https://www.floridablue.com/medicare/forms>). The Drug List on the website is always the most current.
3. Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
4. Use our plan's "Real-Time Benefit Tool" (<https://www.myprime.com>) to search for drugs on the Drug List to get an estimate of what you'll pay and if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why do some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to learn what you or your provider would need to do to get coverage for the drug. **If you want us to waive the restriction for you, you'll need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9).

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or on our website <https://www.myprime.com/en/forms/coverage-determination/prior-authorization.html>.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but it's in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way.**

- **If you're a new member**, we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 31 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 31 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For members who have changes in care settings:**

During a level of care change, drugs that aren't covered by our plan may be prescribed. If this happens, you and your doctor must use our plan's coverage determination request process.

To prevent a gap in care when you're discharged, you may get a full outpatient supply that will allow therapy to continue once the limited discharge supply is gone. This outpatient supply is available before discharge from a Medicare Part A-covered stay. When you're admitted to or discharged from a long-term care (LTC) setting, you may not have access to the drugs you were previously given. However, you may get a refill upon admission or discharge.

For questions about a temporary supply, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan that may work just as well for you. You can call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you're a current member and a drug you're taking will be removed from the formulary or restricted in some way for next year, we'll tell you about any change prior to the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we'll authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1	What to do if your drug is in a cost-sharing tier you think is too high
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Tier) aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during the plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower

cost-sharing tier and on the same or lower cost-sharing tier and with the same or fewer restrictions.

- We'll make these immediate changes only if we are adding a new generic version of a brand name or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We may make these changes immediately and tell you later, even if you're taking the drug that we are removing or making changes to. If you're taking the like drug at the time we make the change, we'll tell you about any specific change we made.

- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List**

- When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and on the same or lower cost-sharing tier and with the same or fewer restrictions.
- We'll make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We'll tell you at least 30 days before we make the change, or tell you about the change and cover a 31-day fill of the version of the drug you're taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**

- Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.

- **Making other changes to drugs on the Drug List.**

- We may make other changes once the year has started that affect drugs you're taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- We'll tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 31-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you're taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or

requesting a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, Go to Chapter 9.

Changes to the Drug List that don't affect you during the plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you get Extra Help Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6).

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it's part of our network.

Check your *Pharmacy Directory* <https://providersearch.floridablue.com/> to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). If you're in an LTC facility, we must ensure that you're able to routinely receive your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep any notices about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it's unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews for our members to help make sure that they're getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you're taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you're taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you may get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you have had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to 9 for information about how to ask for an appeal.

You'll not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we'll withdraw you. For questions about this program, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider)*, which tells you about your drug coverage. If you don't have this insert, please call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage <https://www.myprime.com> the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they're for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs and most charities.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,100 in out-of-pocket costs within the calendar year, you'll move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that aren't covered by our plan.
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation.)

- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770).

Tracking your out-of-pocket total costs

- The Part D Explanation of Benefits (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for BlueMedicare Value (PPO) members

There are **3 drug payment stages** for your drug coverage under BlueMedicare Value (PPO). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are 2 types of costs we keep track of:

- **Out-of-Pocket Costs:** This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions filled through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we'll not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that's not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
 - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D EOB* look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770). Be sure to keep these reports.

SECTION 4 The 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'll pay a yearly deductible of \$615 on Tier 3, 4, and 5 drugs. **You must pay the full cost of your Tier 3, 4 and 5 drugs** until you reach our plan's deductible. For all other drugs you'll not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay \$615 for your Tier 3, 4, and 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, our plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has six cost-sharing tiers

Every drug on our plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1, our lowest cost-sharing tier, includes Preferred Generic Drugs.

- Tier 2, our next tier, includes Generic Drugs. The cost-sharing amount is greater than for Tier 1 drugs.
- Tier 3, our next tier, includes Preferred Brand Drugs and some Generic Drugs. The cost-sharing amount for drugs in this tier is greater than for Tier 2 drugs. You pay up to \$35 per month supply of each covered insulin product on this tier.
- Tier 4, our next tier, includes Non-Preferred Drugs and some Generic Drugs. The cost-sharing amount for drugs in this tier is greater than for Tier 3 drugs. You pay up to \$35 per month supply of each covered insulin product on this tier.
- Tier 5, our next tier, includes Generic and Brand Specialty Drugs. Specialty Tier Drugs are very high-cost drugs. The cost-sharing amount is greatest for Tier 5 drugs. You pay up to \$35 per month supply of each covered insulin product on this tier.
- Tier 6, our last tier, includes Select Care Drugs. Select Care Drugs are certain Generic drugs used to treat diabetes, hypertension and high cholesterol. There's no cost-share for drugs in this tier in the Initial Coverage Stage.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please Go to 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* <https://providersearch.floridablue.com/>.

Section 5.2 Your costs for a one-month supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a one-month supply of a covered Part D drug

Tier	Standard retail cost-sharing (in-network) (up to a 31-day supply)	Mail-order cost-sharing (up to a 31-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Cost-Sharing Tier 2 (Generic)	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Cost-Sharing Tier 3 (Preferred Brand)	21% coinsurance	21% coinsurance	21% coinsurance	21% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Drug)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Cost-Sharing Tier 5 (Specialty Tier)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay	\$0 copay	\$0 copay

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

Go to Section 8 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3

If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your

pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you'll only pay for the number of days of the drug that you receive instead of a whole month. We'll calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

Section 5.4	Your costs for a <i>long-term</i> up to a 90-day supply or up to a 100-day supply of a covered Part D drug
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For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply for Tiers 3 and 4 and up to a 100-day supply for Tiers 1, 2 and 6.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a long-term up to a 90-day supply or up to 100-day supply of a covered Part D drug:

Tier	Standard retail cost-sharing (in-network) (up to a 90-day supply Tier 3 & 4, and up to a 100-day supply Tiers 1, 2, and 6)	Mail-order cost-sharing (up to a 90-day supply Tier 3 & 4, and up to a 100-day supply Tiers 1, 2, and 6)
Cost-Sharing Tier 1 (Preferred Generic)	\$0 copay	\$0 copay
Cost-Sharing Tier 2 (Generic)	\$0 copay	\$0 copay
Cost-Sharing Tier 3 (Preferred Brand)	21% coinsurance	21% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Drug)	30% coinsurance	30% coinsurance
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply isn't available for drugs in Tier 5.	A long-term supply isn't available for drugs in Tier 5.
Cost-Sharing Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay

You won't pay more than \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Section 5.5

You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,100. You then move on to the Catastrophic Coverage Stage.

The *Part D EOB* that you receive will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the \$2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 What you pay for Part D Vaccines

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to your plan's Drug List or contact Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on 3 things:

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccinations are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you'll pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you'll pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you'll pay nothing.
- For other Part D vaccines, you'll pay the pharmacy your coinsurance OR copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance OR copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we'll reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
- For other Part D vaccines, you'll pay the pharmacy your coinsurance OR copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.

- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we'll reimburse you for this difference.)

CHAPTER 7:

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

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

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of our plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called reimbursing you). It's your right to be paid back by our plan whenever you have paid more than your share of the cost for medical services or drugs that are 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's not in our plan's network

When you received 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 got 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 isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

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 that 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 have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have 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 or drugs 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.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you'll have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

7. When you pay the full cost for a vaccine covered under your Part D benefit

If you go to your doctor's office to get a vaccine covered under your pharmacy benefit, you may have to pay the full cost of the vaccine as well as the fee charged by your doctor to give you the vaccine.

You can ask us to pay you back for our share of the cost.

Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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 the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 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. 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 these addresses:

For requests related to medical care:

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

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

For requests related to Part D prescription drugs:

Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18002-0970

You must submit your claim to us within 36 months of the date you received the service, item, or drug.

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 or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug isn't 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 rights to appeal that decision.

Section 3.1	If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal
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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 the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:

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 proporcionarle información de una manera que funcione para usted y que sea coherente con sus sensibilidades culturales (en idiomas que no sean ingles, braille, letra grande u otros formatos alternativos, etc.)

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 protect the privacy of your personal health information

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. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, tells what you can do.

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.
 - Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D drugs. 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 at 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's 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 web site 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's 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, receive, 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 clearing houses, 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's 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 receive 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 receiving 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's 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's 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's 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 receive 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 doesn't 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 receive 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 receive 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 receive, 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 receive 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 receive a paper copy of this notice, upon request, even if you have previously agreed to receive 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 1.3	We must give you information about our plan, its network of providers, and your covered services
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As a member of BlueMedicare Value (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, 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 and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies 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. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.4 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 of your choices.** You have the right to be told about all of the treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **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. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, 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 in 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, from 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 the right people.** You should 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 you 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 1.5 You have the right to make complaints and 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 9 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 1.6 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you have 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 have 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 1.7 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 is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give details about your medical services.
 - Chapters 5 and 6 give details about your Part D prescription drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, 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 or Part D drugs.
- **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 that you and your doctors agree on.
 - Make sure your doctors know all of the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any 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 premiums to stay a member of our plan.
 - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
 - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
 - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of our plan.

- **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 9:

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 is not 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 to get 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 10, 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 prescription 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 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 your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either 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.
- Part D appeals are discussed further in Section 6 of this chapter.

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 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'll 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 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.
 - For Part D drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can request a Level 2 appeal.
- **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 other 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 www.floridablue.com/medicare/forms.) This 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 receive 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 can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Which section of this chapter gives the details for your situation?

There are 4 different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each of these situations in this chapter:

- **Section 5** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8** 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 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 a request 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 this 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 not 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 told that coverage for certain medical care you have 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 7 and 8. 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 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 10 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 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*. (Go to Section 10 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.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. 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 are 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 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 Medicare Part B prescription 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 10 of this chapter for 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's 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 the information about 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 review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- However, 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 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 drug within **72 hours** after we receive 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 that:
 - 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 9 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

Chapter 7 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 decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed all 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 all the rules, we'll send you the payment for our share of 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 didn't 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 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 got 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

Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1

What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a coverage determination .

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2

Asking for an exception

Legal Terms
Asking for coverage of a drug that’s not on the Drug List is a formulary exception .
Asking for removal of a restriction on coverage for a drug is a formulary exception .
Asking to pay a lower price for a covered non-preferred drug is a tiering exception .

If a drug isn’t covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

- Covering a Part D drug for you that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to Tier 4 - (Non-Preferred Drug). You can't ask for an exception to the cost sharing amount we require you to pay for the drug.
- Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
- Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you'll pay as your share of the cost of the drug.

If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

You can't ask us to change the cost-sharing tier for any drug in Tier 5 – (Specialty Tier).

If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can’t take, you'll usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're requesting and would not cause more side effects or other health problems, we'll generally not approve your request for an exception. If you ask us for a tiering exception, we'll generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception**Legal Term**

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

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber'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 or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Tells you how 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. We'll answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website www.floridablue.com/medicare/forms. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
 - For exceptions, we'll give you our answer within 24 hours after we receive your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **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. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we receive your request.
 - For exceptions, we'll give you our answer within 72 hours after we receive your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **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. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **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. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal**Legal Terms**

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination**.

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

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-926-6565 (TTY 1-800-955-8770).** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website www.floridablue.com/medicare/forms. Include your name, contact information, and information about your claim to help us process your request.
- **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 requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** 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 we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

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 we don't give you an answer within 72 hours, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **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 and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **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 and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within **30 calendar days** after we get your request.
- **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. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term
The formal name for the independent review organization is the Independent Review Entity . It's sometimes called the IRE .

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and it is not 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: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- 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.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it's for a drug you have not yet received. If you're requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you its answer.***For fast appeals:***

- **If the independent review organization says yes to part or all of what you requested**, we must **provide the drug coverage** that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no **to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**). In this case, the independent review organization will send you a letter:

- Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you're requesting meets a certain minimum. If the dollar value of the drug coverage you're requesting is too low, you can't make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five 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 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 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 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 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 7.1 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 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 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 that 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 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, you can 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 should call 1-877-486-2048. You can also get this notice online at www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your 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 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 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 should call 1-877-486-2048.) Or you can get a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

Section 7.3 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 that 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 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 on 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 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 the 3 types of care for you, we are 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 8.1 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 request a **fast-track appeal**. Requesting a fast-track appeal is a formal, legal way to request 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 request 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 8.2 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 paid by the Federal government to check on and help 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 want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization using the contact information on the *Notice of Medicare [RB1] 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 provides 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 can 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 will 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 service 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 have 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, **then 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 8.3	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 the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their 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 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'll 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 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 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 as 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's 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 on 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 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.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is 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 answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, 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 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, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, 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 or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- A judge will review all 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 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 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 have received (including care in the hospital)?
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're being encouraged to leave our 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?

Complaint	Example
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 asked 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 decision</i> 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 or drugs 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 10.2 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 also called **using the process for filing a grievance**.
- A **fast complaint** is also 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 weren't 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 prescription drug coverage:

1. Please send your complaint to one of the addresses shown in Chapter 2, Section 1. Look for the section called *How to contact us when you're making a complaint about your Part D prescription drugs*. We have Grievance (Complaint) Form you use when making a formal complaint. You aren't 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 calendar days after we receive 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.

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 aren't 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 receive 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 Part D prescriptions drugs or medical care:

1. Contact Member Services 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 10.3	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 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 10.4 You can also tell Medicare about your complaint

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

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in BlueMedicare Value (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 give 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 prescription drugs 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.
 - - or -Original Medicare *without* a separate Medicare drug plan.

- If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **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 beneficiaries 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 Value (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 you're eligible for Extra Help for paying Medicare drug coverage.
- 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).
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

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.
- - or - Original Medicare *without* a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after we get your request to change our plan.

If you receive Extra Help from Medicare to pay for your drug coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

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

If you have any 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.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 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 Value (PPO) when your new plan's coverage begins.
• Original Medicare <i>with</i> a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You'll automatically be disenrolled from BlueMedicare Value (PPO) when your new plan's coverage begins.
• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	• Send us a written request to disenroll. Contact Member Services 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 Value (PPO) when your coverage in Original Medicare starts.

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

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

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies *or mail order* to get your prescriptions filled**

- **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 Value (PPO) must end your membership in our plan in certain situations

BlueMedicare Value (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 lie or withhold information about other insurance, you have that provides prescription drug coverage.
- 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's 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're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose prescription drug coverage.

If you have questions or would like more information on when we can end your membership, call Member Services at 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 Value (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 that you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 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 11:

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, or 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 isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, BlueMedicare Value (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

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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 12:

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 prescription drugs or payment for services or drugs 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 Value (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 have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to **"Original Biological Product"** and **"Biosimilar"**).

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars substituted for the original biological product at the pharmacy without needing a new prescription (Go to **"Interchangeable Biosimilar"**).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

Chronic-Care Special Needs Plan (C-SNP) - 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 or prescription drugs 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.

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 related 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 drug. 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 or drugs are gotten. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that

isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use in this EOC 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.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

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 the 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.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, 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 have 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.

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage –This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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 Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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 an i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or a 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 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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 Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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 Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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 Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

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 or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

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.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

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 are gotten 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 gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both 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 services and/or certain drugs. 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. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but aren't 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.

Quantity Limits – A management tool that is designed to limit the use of drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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 physical therapy, speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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 plan 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're getting "Extra Help" with your prescription drug costs, 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.

Specialist – A doctor who provides healthcare services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for the bones).

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

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 Value (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 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>

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