Florida Blue | MEDICARE

2021 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

BlueMedicare Group PPO (Employer PPO)

1/1/2021-12/31/2021

BlueMedicare Elite PPO with Dental, Hearing and Vision

City of Tallahassee #45380

The plan's service area includes:

Nationwide

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

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

Who Can Join?

You and your dependent(s) can join this plan if you are a retired employee of the group and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and enrolled in Medicare Part B
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer.

Neither you nor your dependent(s) are eligible for this plan if:

- You are an active employee of the group, or
- You are a retired employee of the group with a dependent who is an active employee of the group and has coverage through the group's plan for active employees.

Our service area includes all 50 states and the District of Columbia

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Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network to receive medical services, you may pay more for these services. If you use pharmacies that are not in our network to fill your covered Part D drugs, the plan will generally not cover your drugs.

- You can see our plan's provider and pharmacy directory at our website (**www.floridablue.com/medicare**). Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- If you have questions about this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
  - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
  - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at **www.floridablue.com/medicare.**

Important Information

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

Monthly Premium, Deductible and Limits

Monthly Plan Premium	▪ **$206.39 for Elite PPO with D/H/V** You must continue to pay your Medicare Part B premium.
Deductible	▪ In-Network: **$0** ▪ Out-of-Network: **$1,000** ▪ **$0** per year for Part D prescription drugs
Maximum Out-of-Pocket Responsibility	▪ **$1,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$3,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers combined.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Care ◊	▪ **$200** copay per day, days 1-5 ▪ **$0** copay per day, after day 5	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Outpatient Hospital Care	▪ **$75** copay per visit for Medicare-covered observation services ▪ **$200** copay for all other services ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulatory Surgical Center	▪ **$150** copay in an ambulatory surgical center	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Doctor's Office Visits	▪ **$10** copay per primary care visit ▪ **$25** copay per specialist visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Preventive Care	▪ **$0** copay ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse screening and counseling ▪ Annual Wellness Visit ▪ Bone mass measurements ▪ Breast cancer screening (mammograms) ▪ Cardiovascular disease screening and intensive behavioral therapy ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening ▪ Depression screening ▪ Diabetes screening and self-management training ▪ Glaucoma screening ▪ Hepatitis B and C screening ▪ HIV screening ▪ Intensive Behavioral Therapy for Obesity	▪ **20%** of the Medicare-allowed amount

	In-Network	Out-of-Network
	▪ Lung cancer screening ▪ Medical nutrition therapy ▪ Prostate cancer screening ▪ Sexually transmitted infections - screening and high-intensity behavioral counseling to prevent them ▪ Smoking and tobacco use cessation counseling ▪ Vaccines for influenza, pneumonia and Hepatitis B ▪ Welcome to Medicare preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	**Medicare Covered Emergency Care** ▪ **$75** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$75** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	
Urgently Needed Services	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$25** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$25** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$75** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	

	In-Network	Out-of-Network
Diagnostic Services/ Labs/Imaging◊	**Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$15** copay at an outpatient hospital facility **X-Rays** ▪ **$25** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$100** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a physician's office ▪ **$75** copay at an IDTF ▪ **$100** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Hearing Services 	**Medicare-Covered Hearing Services** ▪ **$25** copay for exams to diagnose and treat hearing and balance issues **Additional Hearing Services** ▪ **$0** copay for one routine hearing exam per year ▪ **$0** copay for evaluation and fitting of hearing aids ▪ **$350 per ear.** You pay a $0 copay for up to 2 hearing aids every year with a maximum benefit allowance of $350 per ear. **NOTE:** Hearing aids must be purchased through NationsHearing to receive in-network benefits. ▪ Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.	**Medicare-Covered Hearing Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible **Additional Hearing Services** ▪ Member must submit receipts for reimbursement at 50% of maximum allowed for one routine hearing exam per year. ▪ Member must submit receipts for reimbursement at 50% of maximum allowed for evaluation and fitting of hearing aids. ▪ Member must submit receipts for reimbursement at 50% of maximum allowed for up to 2 hearing aids every year. Subject to benefit maximum. ▪ Member is responsible for any amount after the benefit allowance has been applied.

	In-Network	Out-of-Network
Dental Services 	**Medicare-Covered Dental Services ◊** ▪ **$25** copay for non-routine dental care **Additional Dental Services** ▪ **$0** copay for covered preventive dental services ▪ **$0** copay for covered comprehensive dental services	**Medicare-Covered Dental Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental **Additional Dental Services** ▪ Member pays up front and is reimbursed 50% of non-participating rates for covered preventive dental services. ▪ Member pays up front and is reimbursed 50% of non-participating rates for covered comprehensive dental services.
Vision Services 	**Medicare-Covered Vision Services** ▪ **$25** copay for physician services to diagnose and treat eye diseases and conditions ▪ **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) ▪ **$0** copay for one diabetic retinal exam per year ▪ **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery **Additional Vision Services** ▪ **$0** copay for an annual routine eye examination ▪ **$0** copay for lenses, frames or contacts. Subject to the annual maximum plan benefit allowance. Member responsible for any amounts in excess of the annual maximum plan benefit allowance. ▪ **$100** maximum allowance per year towards the purchase of lenses, frames or contacts.	**Medicare-Covered Vision Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible **Additional Vision Services** ▪ Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount for an annual routine eye examination. ▪ Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance for lenses, frames or contacts. ▪ Total reimbursement is subject to the annual maximum plan benefit allowance.
Mental Health Care ◊	**Inpatient Mental Health Services** ▪ **$200** copay per day, days 1-7 ▪ **$0** copay per day, days 8-90 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **$30** copay	**Inpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Skilled Nursing Facility (SNF) ◊	▪ **$0** copay per day, days 1-20 ▪ **$100** copay per day, days 21-100 Our plan covers up to 100 days in a SNF per benefit period.	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Physical Therapy ◊	▪ **$25** copay per visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulance ◊	▪ **$150** copay for each Medicare-covered trip (one-way)	▪ **$150** copay for each Medicare-covered trip (one-way)
Transportation	▪ Not covered	▪ Not covered
Medicare Part B Drugs ◊	▪ **$5** copay for allergy injections ▪ **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

Part D Prescription Drug Benefits

Deductible Stage

This plan does not have a prescription drug deductible.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

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

	Preferred Retail	Standard Retail	Mail Order
Tier 1 - Preferred Generic	**$0** copay	**$8** copay	**$0** copay
Tier 2 - Generic	**$3** copay	**$15** copay	**$3** copay
Tier 3 - Preferred Brand	**$30** copay	**$40** copay	**$30** copay
Tier 4 - Non- Preferred Drug	**$60** copay	**$70** copay	**$60** copay
Tier 5 - Specialty Tier	**33%** of the cost	**33%** of the cost	**33%** of the cost

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what any Part D plan has paid and what you have paid) reaches **$4,130**.

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

<u>During the Coverage Gap Stage:</u>

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs, throughout the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the *greater* of:

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

Additional Drug Coverage

- Please call us or see the plan’s “Evidence of Coverage” on our website (**<u>www.floridablue.com/medicare</u>**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 cost sharing.
- Your cost-sharing may be different if you use a Long-Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies ◊	▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medicare Diabetes Prevention Program	▪ **$0** copay for Medicare-covered services	▪ **20%** of the Medicare-allowed amount
Podiatry	▪ **$25** copay for each Medicare-covered podiatry visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Chiropractic	▪ **$20** copay for each Medicare-covered chiropractic visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medical Equipment and Supplies ◊	▪ **20%** of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Occupational and Speech Therapy ◊	▪ **$25** copay per visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Telehealth	▪ $25 copay for Urgently Needed Services ▪ $10 copay for Primary Care Services ▪ $25 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location ▪ $25 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital ▪ $25 copay for Dermatology Services ▪ $30 copay for individual sessions for outpatient Mental Health Specialty Services ▪ $30 copay for individual sessions for outpatient Psychiatry Specialty Services ▪ $30 copay for Opioid Treatment Program Services ▪ $30 copay for individual sessions for outpatient Substance Abuse Specialty Services ▪ $0 copay for Diabetes Self-Management Training ▪ $0 copay for Dietician Services	▪ 20% of the Medicare-allowed amount after $1,000 out-of-network deductible

You Get More with BlueMedicare

	In-Network	Out-of-Network
HealthyBlue Rewards 	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.	
SilverSneakers® Fitness Program 	▪ Gym membership and classes available at fitness locations across the country, including national chains and local gyms ▪ Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more	

Disclaimers

Florida Blue is a PPO and Rx (PDP) plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

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

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

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

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

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
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 is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20211
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-008-1.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

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