2022 Medicare Program Overview

Bay County School District #45791

Retirees Eligible for Medicare

Florida Blue
In the pursuit of health®

Y0011_FBM0531 1021 EGWP C: 10/2021

What we'll cover today

- What is Medicare?
- Enrolling into the Medicare Program
  - Part B Late Enrollment Penalty and IRMAA
- Exploring Original Medicare
  - Part A and Part B Services and Costs
- Other Medicare Coverage Choices
  - Part D Prescription Drug Plans
    - Part D Late Enrollment Penalty and IRMAA
  - Medicare Supplement
  - Part C - Medicare Advantage and EGWP

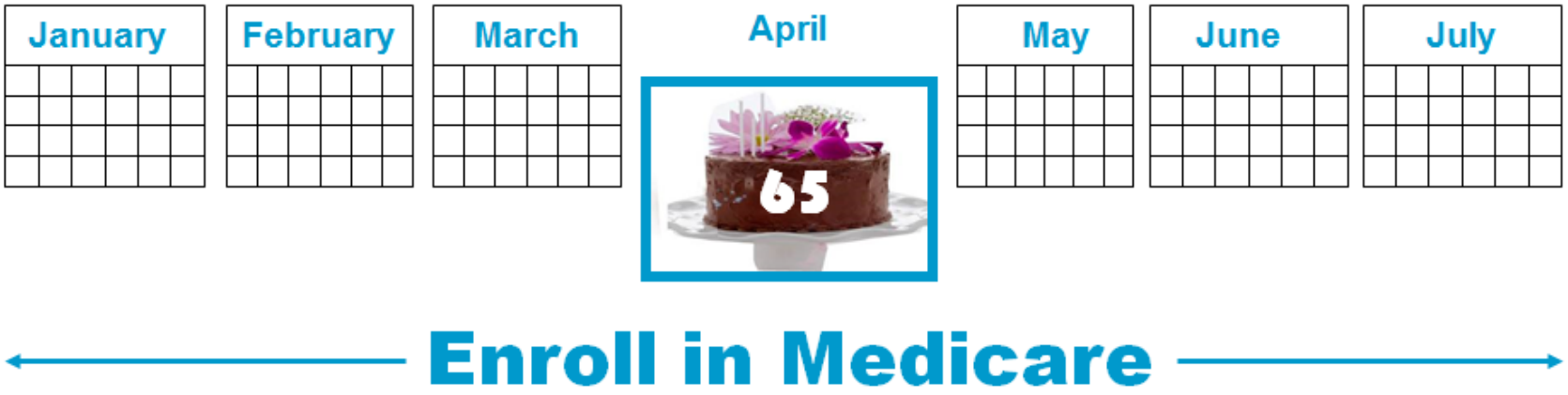
What is Medicare?

- Medicare is a Federal program that is part of the Social Security Act.
- Medicare provides health care coverage to individuals who are age 65 and above; or under age 65 with certain disabilities, or individuals of any age who have End Stage Renal Disease (ESRD).
- It is made up of Parts A, B, C and D.
- Parts A and B make up what is known as “Original Medicare.” You are responsible for Part A and/or Part B cost sharing, which includes premiums, deductibles, coinsurances and prescription drug costs.

How and when do I enroll in the Medicare program?

- Enrollment in Part A and Part B is automatic if you are already receiving Social Security benefits prior to your 65th birthday.
- If you are not automatically enrolled in Part A and Part B prior to your 65th birthday – you can enroll during the 7-month window around your 65th birthday. This is known as the Initial Coverage Election Period (ICEP).
- Enrollment in Part A and Part B is done through the Social Security Administration. This is known as "Original Medicare." This enrollment must be done before you can enroll in any Medicare Supplement plan, Part D Prescription Drug plan, or Part C Medicare Advantage plan.
- Generally, you should also enroll in a Part D prescription drug plan during the 7-month window around your 65th birthday. This is known as the Initial Enrollment Period (IEP) for Part D. Enrollment in Part D is done through a private insurance company that is contracted with the government.

Initial Coverage Election Period (ICEP)



Your initial **Medicare Effective Date** will be the first of the month in which your 65th birthday occurs, as long as you enroll prior to that date. If your birthday occurs on the first day of a month, your Medicare effective date will be the first of the month **prior to** the month in which your 65th birthday occurs. If you enroll during or after the month in which your 65th birthday occurs, your Medicare effective date will be the first of the month following the month in which you apply. You can have different effective dates for Part A, Part B and Part D.

When should I enroll in Medicare Part A?

- **Everyone should enroll in Medicare Part A as soon as you are eligible.**
  - Part A can act as a secondary payer even if you are still actively employed with commercial group benefits.
  - If you worked 40 quarters of Medicare-credited employment, you are automatically entitled to Part A. Most people are entitled to Part A without any monthly premium.
  - In many cases, beneficiaries with less than 40 quarters of Medicare-credited employment may purchase Part A for a monthly premium. This premium amount will vary depending on the number of quarters of Medicare-credited employment you have. Contact the Social Security Administration for details.

When should I enroll in Medicare Part B?

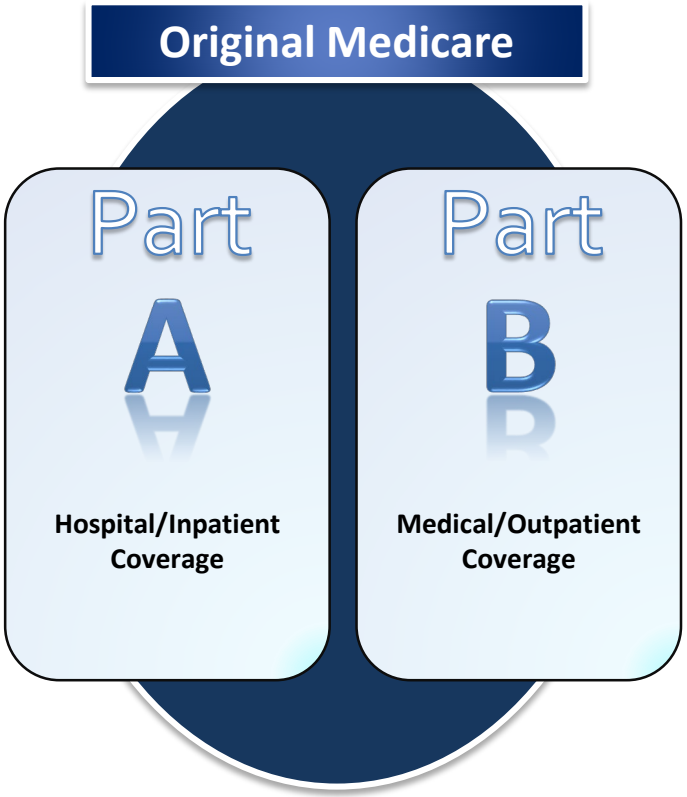
- **You should enroll in Medicare Part B as soon as you are eligible if you are not actively working, have no other coverage, or are enrolled in a *Retiree* health plan or COBRA.**
  - These types of coverage do not count as current employer coverage and you may be charged a Part B late-enrollment penalty if you do not enroll when you are first eligible. If a penalty is imposed by Medicare, you must continue to pay this penalty as long as you have Medicare Part B.
  - If you are still actively working, you may delay enrolling in Part B without penalty, until you leave the active-employee commercial group health plan.
  - Part B has a monthly premium that is paid to the government. Many Medicare beneficiaries elect to have the Part B premium deducted directly from their monthly Social Security check. The 2021 monthly standard Part B premium is $148.50. High-Income earners may pay more.

Medicare Part B Premiums for High-Income Earners for Calendar Year 2021* Income-Related Medicare Adjustment Amounts (IRMAA)

Based on 2019 yearly income filed to IRS		
If You Filed Individual Tax Return and your income was:	If You Filed Joint Tax Return and your income was:	You Pay
above $88,000 up to $111,000	above $176,000 up to $222,000	$207.90
above $111,000 up to $138,000	above $222,000 up to $276,000	$297.00
above $138,000 up to $165,000	above $276,000 up to $330,000	$386.10
above $166,000 up to $500,000	above $330,000 and less than $750,000	$475.20
above $500,000	$750,000 and above	$504.90

*2022 amounts not yet released by CMS.

Exploring Original Medicare



Part A helps cover:

- Inpatient hospital admissions
- Skilled nursing facility admissions
- Home health agency care
- Hospice care
- Inpatient blood services

Part B helps cover:

- Physician's office services
- Ancillary medical and other services
- Clinical laboratory services
- Outpatient hospital services
- Outpatient blood services
- Many preventive services covered at 100% with no deductible

Exploring Original Medicare

- For most services, you are required to pay a portion of the costs when services are rendered
  - Part A beneficiaries usually do not pay a monthly premium for coverage.
  - Part A generally pays 100% of the Medicare allowed amount for covered services after any deductibles and cost sharing are applied.
  - Part B beneficiaries pay a monthly premium to the government.
  - Part B generally pays 80% of the Medicare allowed amount for covered services after an annual deductible is met. Many preventive services are covered at no cost to the beneficiary.
- Original Medicare does not provide coverage for most prescription drugs.
- Original Medicare is widely accepted by providers nationwide.
- Most providers that accept Original Medicare also accept “Medicare assignment.” Beneficiaries pay more for doctors or providers who don’t accept Medicare assignment. In Florida, most physicians accept Medicare assignment.

Medicare Assignment

- Providers that accept “Medicare assignment” have agreed to accept Medicare’s allowance as payment in full.
- Medicare Limiting Amount – Providers that do not accept Medicare assignment may not collect more that 15% over the Medicare allowance.
- Providers that do not accept Medicare assignment may require payment in full at the time services are rendered. Reimbursement will then go directly to the beneficiary from Medicare.
- Claim filing to Medicare is the provider’s responsibility whether or not they accept Medicare assignment.
- The vast majority of providers who accept Medicare, also accept Medicare assignment.

What you pay for Original Medicare services in 2021*

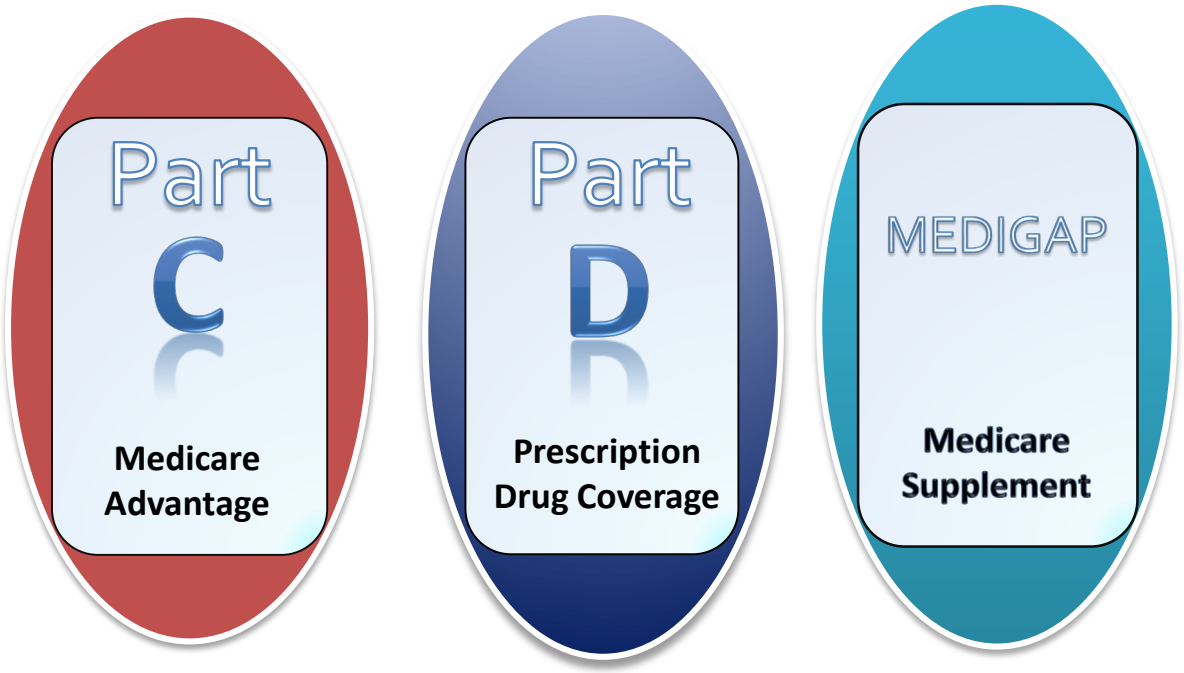
Medicare Part A	Medicare Part B
Hospital (Inpatient) ▪ **No monthly premium for most people** ▪ $1,484 deductible each benefit period for admissions of 1 – 60 days ▪ $371 per day for days 61-90 each benefit period ▪ $742 per day for days 91-150 each benefit period (lifetime reserve days)	**General** ▪ **Monthly Premium:** $148.50 ▪ Deductible: $203 per calendar year ▪ Cost sharing: 20% of the Medicare-approved amount for most services
Medicare-Certified Skilled Nursing Facility ▪ Covers up to 100 days each benefit period after at least a 3-day covered hospital stay ▪ $0 copay for first 20 days ▪ $185.50 per day for days 21-100	**Outpatient Mental Health** ▪ 20% of the Medicare-approved amount for most outpatient mental health services
Home health care ▪ $0 copayment for Medicare-approved home health care services	**Preventive Services** ▪ $0 copay for the Medicare-approved list of preventive services
Blood ▪ Entire cost for first three pints of blood	**Blood** ▪ Entire cost for first three pints of blood as an outpatient, then 20% of the Medicare-approved amount for additional pints

*2021 amounts not yet released by CMS.

What Original Medicare does not cover

- Most Outpatient Prescription Drugs (must purchase a Part D plan from a private carrier)
- Insulin/Syringes only covered under Part D
- Shingles Vaccine (Zostavax) only covered under Part D
  - An office visit copay or administration fee is usually charged to administer the vaccine, as well as the applicable prescription drug copay for the vaccine
- Routine Eye Exams and Eyewear
- Routine Hearing Exams and Hearing Aids
- Long-Term Nursing Home Care/Custodial Care
- Routine Dental Care
- Care Received Outside the United States

Other Medicare coverage choices



Purchasing a Medicare Advantage, Medicare Supplement (Medigap) policy, and/or a Part D Prescription Drug Plan can help you reduce the out-of-pocket costs associated with Original Medicare.

When should I enroll in Medicare Part D?

- **You should enroll in Medicare Part D as soon as you are eligible if you do not have creditable prescription drug coverage, such as coverage through an employer-sponsored Rx plan.**
  - If you do not have creditable prescription drug coverage, you may be subject to a Part D late-enrollment penalty if you do not enroll when you are first eligible. If a penalty is imposed by Medicare, you must continue to pay this penalty as long as you have Medicare Part D.
  - You may delay enrolling in Part D without penalty if you have other creditable prescription drug coverage, such as an Rx plan through active employment, VA benefits, or other prescription drug coverage that is as good as or better than coverage provided under the Medicare Part D defined-standard coverage.
  - Your prescription drug plan is required to send you an annual notice to let you know whether your coverage is creditable or not.

Medicare Part D premiums for high-income earners for calendar year 2021
Income-Related Medicare Adjustment Amounts (IRMAA)

Based on 2018 yearly income filed to IRS		
If You Filed Individual Tax Return and your income was:	If You Filed Joint Tax Return and your income was:	You Pay*
above $88,000 up to $111,000	above $176,000 up to $222,000	$12.30
above $111,000 up to $138,000	above $222,000 up to $276,000	$31.80
above $138,000 up to $165,000	above $276,000 up to $330,000	$51.20
above $165,000 up to $500,000	above $330,000 up to $750,000	$70.70
above $500,000	above $750,000	$77.10

Medicare Part D – Standard Benefit

The basic plan (defined by Medicare). All Part D plans are required by law to offer benefits equal to or better than:

2022 Medicare Prescription Drug Program - Basic Coverage

	2022 Basic Benefits	You Pay
Deductible	$480	100% of the first $480
Initial Coverage Limit	$4,430	25% of the next $480 to $4,430
Coverage Gap	$4,431+	25% of brand name and 25% of generic drugs until total out-of-pockets costs reach $7,050
Annual Out-Of-Pocket Amount (TrOOP)		$7,050
Catastrophic Coverage		$3.95 for generic/multiple-source drug and $9.85 for all other drugs; or 5% coinsurance, whichever is greater

Extra Help – Low-Income Subsidy (LIS)

- The Federal government has set aside money to help people with their prescription drug expenses. Call to see if you qualify:
  - 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048, 24 hours a day, seven days a week
  - The Social Security Administration at 1-800-772-1213 or TTY 1-800-325-0778 from 7 a.m. to 7 p.m., Monday – Friday
  - The Florida Medicaid office

Medicare Supplement plans

- For people with Original Medicare, also known as “Medigap”
- Supplemental insurance sold by private insurance companies like Florida Blue
- Does not include prescription drug coverage and is usually purchased with a Part D plan
- Covers costs that Original Medicare doesn’t pay
- Beneficiaries pay monthly premiums in addition to the Part B premium
- A beneficiary may not be sold a Medicare Supplement plan while enrolled in a Medicare Advantage plan
- Regulated by the Florida Office of Insurance Regulation (OIR)
- Standardized benefit packages

Medicare Supplement plans

- Florida Blue offers 11 different plan designs
  - 4 Standard plans – A, B, D, G
  - 4 Standard “lower-premium” plans – K, L, M, N
  - 3 SELECT plans – B, D, M – these plans have a hospital network requirement
- Acts as “secondary” coverage for Original Medicare Part A and Part B cost sharing

How does a Medicare Supplement work?

- Original Medicare must first approve and pay for services
- Once Original Medicare has approved and paid for services, then the supplement plan pays its part
- Based on the benefits of the policy selected, your out-of-pocket expenses will be reduced or covered in full by your Medicare Supplement policy. This reduces or eliminates your out-of-pocket costs under Original Medicare.

Medicare Supplement plans – Coverage Summary

Medicare Supplement Coverage Summary

MEDICARE DOES NOT PAY:	What BlueMedicare Supplement Insurance policies pay:							
Medicare Part A: Hospital Services (Core Benefits)	**A**	**B and Select B**	**D and Select D**	**G**	**K***	**L***	**M and Select M**	**N**
$1,484 Part A Deductible each benefit period		√	√	√	50%	75%	50%	√
$371 per day copayment for days 61-90 in a hospital	√	√	√	√	√	√	√	√
$742 per day copayment for days 91-150 in a hospital	√	√	√	√	√	√	√	√
$185.50 per day copayment for day 21-100 in a Skilled Nursing Facility	√	√	√	√	√	√	√	√
100% of Medicare-allowable expenses for an additional 365 days after Medicare hospital benefits stop completely			√	√	50%	75%	√	√
Blood Services - Calendar year deductible, first 3 pints (also includes any Part B charges)	√	√	√	√	50%	75%	√	√
100% coverage of Hospice Care (also includes any Part B charges)	√	√	√	√	50%	75%	√	√
Medicare Part B: Physician Care and Medical Services (Core Benefits)								
$203 Part B Deductible, per year								
Part B Coinsurance - generally, 20% of the Medicare-approved amount, or the applicable cost sharing under any prospective payment system.	100%	100%	100%	100%	50%	75%	100%	100%‡
Excess Charges (100% of excess charges for Medicare-approved Part B charges)				√				
Additional Benefits Not Covered by Medicare								
Benefits for medically-necessary care received in a foreign country (after a $250 deductible is met)			√	√			√	√
*Out-of-Pocket Limit - Member is responsible for cost sharing of covered services until the annual out-of-pocket limit is met. Once reached, policy pays 100% of Medicare cost sharing for the rest of the calendar year.					$6,220	$3,110		
‡Plan N has $20 copayment for office visits, $50 copayment for ER.								$20/$50

Note: As of 2020, plans C and F are no longer sold. Existing members are grandfathered to keep those plans.

Part C – Medicare Advantage plans

What is it?	• It's a Medicare program that replaces Original Medicare and/or the need for a supplemental insurance policy (you get coverage from a private, Medicare-contracted insurer instead of Original Medicare). **Medicare Advantage is NOT a Medicare Supplement.**
Who can enroll?	• You must be retired, entitled to Medicare Part A and enrolled in Medicare Part B to join • You must be eligible with your employer group and live in the plan's service area • Individuals with End-Stage Renal Disease may not be eligible (exceptions exist)
When can I enroll?	• The Initial Coverage Election Period (ICEP/IEP) (3 months prior to month of Medicare eligibility, the month of eligibility, and 3 months after) • Group Annual Enrollment Period
What if I don't like it - when can I change to another plan or go back to Original Medicare?	• Medicare Advantage Open Enrollment Period (OEP) Jan. 1 – Mar. 31 each calendar year (may only be used to return to Original Medicare and if desired buy a Part D plan, or move to another Medicare Advantage plan.) • Annual Election Period (AEP) Oct. 15 – Dec. 7 each year • Group Annual Enrollment Period
Am I no longer in Medicare if I join a Medicare Advantage Plan?	• You are still in the Medicare program; however, as long as you stay in the Medicare Advantage plan you are no longer enrolled in Original Medicare • While enrolled in the Medicare Advantage plan, you will not show your red, white and blue Medicare ID card to a provider because you will receive a new ID card from Florida Blue
Why is it different?	• Medicare Advantage plans cover everything that Original Medicare does, plus they may offer extra benefits (like Rx coverage), may require you to use a provider network and may charge a monthly plan premium (in addition to your Medicare Part B premium)
You may be able to get Extra Help to pay for your drug premiums and costs. To see if you qualify, call:	• 1-800-MEDICARE (1-800-633-4227), TTY/TDD 1-877-486-2048, 24 hours a day, 7 days a week • Social Security at 1-800-772-1213, M – F, 7 a.m. to 7 p.m. ET, TTY/TDD 1-800-325-0778 • Your state Medical Assistance (Medicaid) Office
More info?	• Visit www.Medicare.gov, or call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048

Part C – Medicare Advantage plans

- Part C Medicare Advantage plans are offered by private insurance companies
- Regulated by the Federal government – Centers for Medicare & Medicaid Services (CMS) – companies contract on an annual basis with CMS
- Can combine Part A, Part B and Part D benefits under a single plan
- Replaces Original Medicare but must cover the same benefits
- May also include “extra” benefits such as routine dental and routine vision coverage, or additional prescription drug coverage in the “coverage gap”
- Usually requires a copay or coinsurance when services are rendered
- Usually requires adherence to a network of providers
- Is NOT a Medicare Supplement plan – acts as “primary” coverage in place of Original Medicare
- May be individual coverage or offered as an Employer Group Waiver Plan (EGWP)
- Medicare Advantage plans usually feature plan designs similar to an HMO or PPO – Florida Blue offers EGWP PPO plan designs

Typical coverage combinations and the premiums you pay

Original Medicare

If you only have Original Medicare, you will have to pay all Original Medicare cost-sharing out-of-pocket. You also would not have coverage for most outpatient prescription drugs. You must pay the monthly Part B premium to the government.

Original Medicare

+

Medicare Supplement

+

Part D Rx

By adding a Medicare Supplement plan and a Part D plan, you gain coverage for Original Medicare cost-sharing and outpatient prescription drugs. Plan cost-sharing applies. You must pay the monthly Part B premium to the government. You will also pay a monthly premium for the Medicare Supplement plan and a monthly premium for the Part D plan.

Medicare Advantage

With a Medicare Advantage plan, you typically receive coverage for Part A, Part B and Part D services combined in a single plan. Some plans also include “extra” benefits. Plan cost-sharing applies. You must pay the monthly Part B premium to the government. You may also pay a monthly Part C/Medicare Advantage plan premium.

Florida Blue | MEDICARE

BlueMedicare Group Elite PPO (Employer PPO) Employer Group Waiver Plan (Part C – Medicare Advantage Plan)

This information is not a complete description of benefits. Contact the plan for more information.
Limitations, copayments, and restrictions may apply.
Benefits, premiums and/or copayments/coinsurance may change each year.
You must continue to pay your Medicare Part B premium.
The formulary, pharmacy network and /or provider network may change at any time. You will receive notice when necessary.

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BlueMedicare Group Elite PPO

Monthly Premium, Deductible and Limits

Monthly Plan Premium	▪ **$205.37 for Elite PPO** You must continue to pay your Medicare Part B premium.
Deductible	▪ In-Network: **$0** ▪ Out-of-Network: **$1,000**
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.

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.

BlueMedicare Group Elite PPO

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

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
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 ▪ 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.	▪ **20%** of the Medicare-allowed amount

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
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.	

BlueMedicare Group Elite PPO

	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

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
Hearing Services 	**Medicare-Covered Hearing Services** ▪ **$25** copay for exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Dental Services 	**Medicare-Covered Dental Services ◊** ▪ **$25** copay for non-routine dental care	**Medicare-Covered Dental Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental
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	**Medicare-Covered Vision Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
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
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

BlueMedicare Group Elite PPO

	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

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
Occupational and Speech Therapy ◊	▪ **$25** copay per visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
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

BlueMedicare Group Elite PPO

You Get More with BlueMedicare

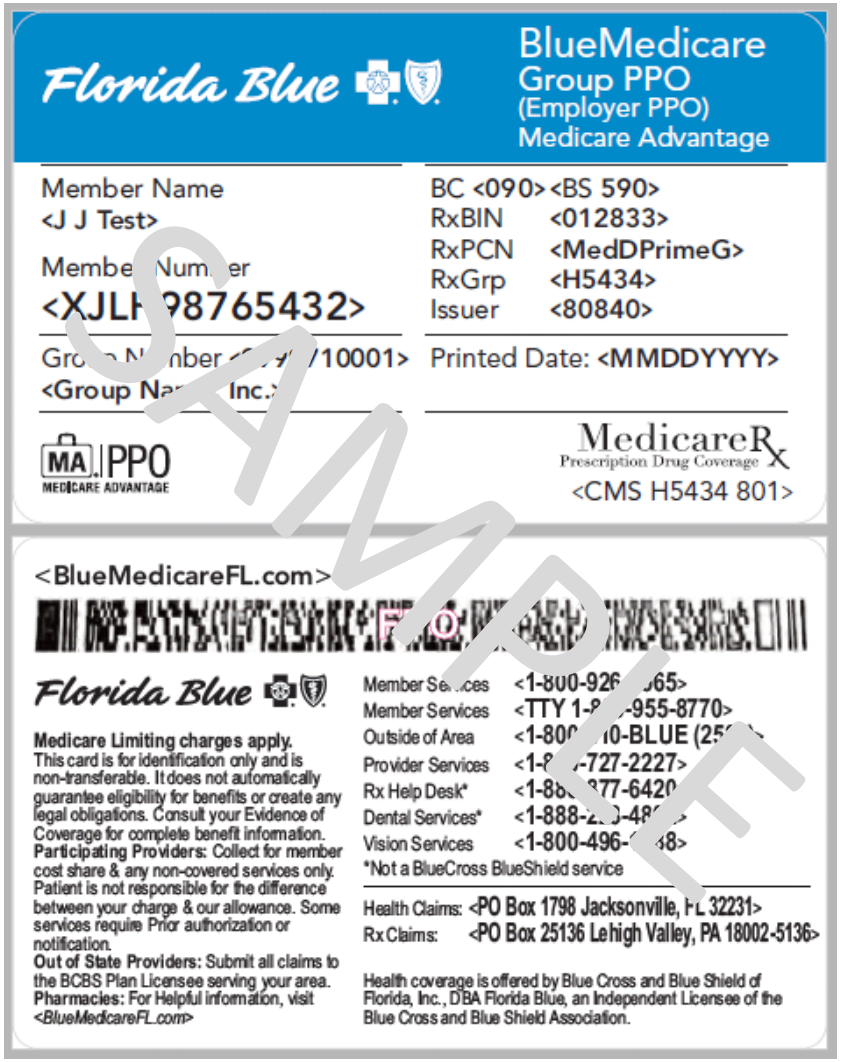
	In-Network	Out-of-Network
HealthyBlue Rewards 	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.	
SilverSneakers® Fitness Program 	▪ Gym membership and classes available at fitness locations across 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	

BlueMedicare Group PPO Supplemental Benefit Contact

To find a participating fitness center, please visit: www.silversneakers.com or call toll-free **1-866-584-7389** or TTY 1-800-955-8770.

BlueMedicare Group PPO Plans' Sample ID Card

(One card for both Medical and Prescription Drug benefits)



Florida Blue | MEDICARE

BlueMedicare Group Elite Rx (Employer PDP) Employer Group Waiver Plan (Part D Prescription Drug Plan)

This information is not a complete description of benefits. Contact the plan for more information.
Limitations, copayments, and restrictions may apply.
Benefits, premiums and/or copayments/coinsurance may change each year.
The formulary, pharmacy network and /or provider network may change at any time. You will receive notice when necessary.

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BlueMedicare Group Elite Rx

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**Included with Elite PPO** You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.

Part D Prescription Drug Benefits

Deductible Stage

$0 per year for Part D prescription drugs.

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 **$4,430**. You may get your drugs at network retail pharmacies and mail-order pharmacies.

BlueMedicare Group Elite Rx

	Preferred Retail/LTC (31-day supply)	Standard Retail (31-day supply)	Mail Order (90-day supply)
Tier 1 - Preferred Generic	$0 copay	$8 copay	$0 copay
Tier 2 - Generic	$3 copay	$15 copay	$9 copay
Tier 3 - Preferred Brand	$30 copay	$40 copay	$90 copay
Tier 4 - Non-Preferred Drug	$60 copay	$70 copay	$120 copay
Tier 5 - Specialty Tier	33% of the cost	33% of the cost	N/A

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 total drug costs paid by you *and* any Part D plan) reaches **$4,430**.

You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **$7,050**.

<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.

BlueMedicare Group Elite Rx

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the *greater* of:

- **$3.95** copay for generic (including brand drugs treated as generic) and **$9.85** 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 (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (Non-Preferred Drug) cost-sharing

- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug

BlueMedicare Group Rx Plans' Sample ID Card