Florida Blue
Your local Blue Cross Blue Shield | MEDICARE

2024 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

BlueMedicare Group PPO (Employer PPO)

01 01 2024 – 12 31 2024

Elite PPO w DHV + Elite Rx

The 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.**" To get a complete list of the drugs we cover, call us and ask for the List of Covered Drugs ("Formulary"). You may also view the "Evidence of Coverage" and "Formulary" 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 is nationwide. It includes all fifty states, the District of Columbia and the United States territories.

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 on 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 are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
- If you are not a member of this plan, call us at 844-BLUE-MED (844-258-3633), 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

Our plans group each medication into a tier. The number of tiers may vary based on the plan you choose. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. 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	**$245.55** You must continue to pay your Medicare Part B premium.
Deductible	▪ **$0** per year for In-Network health care services ▪ **$1,000** per year for Out-of-Network health care services ▪ **$0** per year for Part D prescription drugs. There is no deductible for insulins.
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.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Coverage ◊ (Authorization applies to in-network services only.)	▪ **$200** copay per day, for 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 Coverage	▪ **$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 (ASC) Services	▪ **$150** copay for surgery services provided at an Ambulatory Surgical Center ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Doctor Visits	▪ **$10** copay per provider of choice 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 • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C Screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse	▪ **20%** of the Medicare-allowed amount

	In-Network	Out-of-Network
	• Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • "Welcome to Medicare" preventive visit	
Emergency Care	**Medicare-Covered Emergency Care** ▪ **$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 ◊ (Authorization applies to in-network services only.)	**Diagnostic Procedures and Tests** ▪ **$10** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$30** copay at an outpatient hospital facility ▪ **$0** copay for allergy testing **Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$15** copay at an outpatient hospital facility **X-Rays** ▪ **$25** copay at a physician's office or at an 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 specialist 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

	In-Network	Out-of-Network
	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 our participating provider to receive in-network benefits. ▪ Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.	**Additional Hearing Services** ▪ **Member must submit receipts for reimbursement at 50% of maximum allowed** for a 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.**
Dental Services	**Medicare-Covered Dental Services ◊** ▪ **$25** copay for specialist 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.

	In-Network	Out-of-Network
Vision Services	**Medicare-Covered Vision Services** ▪ **$25** copay for specialist 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 for glaucoma screening ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for Medicare-covered specialist services to diagnose and treat diseases and conditions of the eye and diabetic retinal exams ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for eyeglasses or contact lenses after cataract surgery
	Additional Vision Services In-Network ▪ **$0** copay for an annual routine eye examination 1 every 12 months. ▪ **$0** copay for lenses, frames or contacts. Member responsible for any amount in excess of annual maximum plan benefit allowance. ▪ **$250** maximum allowance per year towards the purchase of lenses, frames or contacts.	**Additional Vision Services** Out-of-Network ▪ **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 1 every 12 months. ▪ **Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount for lenses, frames, or contacts. Member is responsible for all amounts in excess of the 50% of the 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.

	In-Network	Out-of-Network
Mental Health Services ◊ (Authorization applies to in-network services only)	**Inpatient Mental Health Services** ▪ **$200** copay per day for days 1-7 ▪ **$0** copay per day for days 8-90 190-day lifetime benefit maximum in a psychiatric hospital.	**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 ▪ **$30** copay	**Outpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊ (Authorization applies to in-network services only.)	▪ **$0** copay per day for days 1-20 ▪ **$100** copay per day for 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** for each Medicare- covered trip (one-way)
Transportation	▪ Not Covered	▪ Not Covered
Medicare Part B Drugs	▪ **$5** copay for allergy injections ▪ Up to **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ ▪ **20% up to $35 per month** for Insulin Drugs via DME ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies	▪ **$0** copay at a Florida Blue Medicare contracted network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips • Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies. ◊ **Important Note:** • **Insulin, insulin syringes and needles for self-administration in the home are obtained from an in-network retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply. • Lifescan (OneTouch®) as well as other brands of glucose meters and test strips can also be obtained through our participating DME network. • The initial fill of a CGM when being used with an insulin pump can be obtained through our participating DME provider.	▪ **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

	In-Network	Out-of-Network
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 service	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medical Equipment and Supplies ◊ (Authorization applies to in-network services only.)	▪ **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
Telehealth ◊ (Authorization applies to in-network services only)	▪ **$25** copay for Urgently Needed Services ▪ **$10** copay for Primary Care Services ▪ **$25** copay for Occupational Therapy/Physical Therapy/Speech Therapy at all locations ▪ **$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	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
	▪ **$30** copay for individual sessions for outpatient Substance Abuse Specialty Services in an office setting ▪ **$0** copay for Diabetes Self-Management Training ▪ **$0** copay for Dietician Services	
Blue Dollars Benefits MasterCard® Prepaid Card *NOTE: See Healthy Blue Rewards*	▪ **Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.** ▪ Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan. ▪ Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply. ▪ The Blue Dollars card will be mailed directly to you and replenished at the beginning of each month. Any unused monthly allowance will not be rolled over into the following month.	▪ Not Available
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.	▪ Not Available

	In-Network	Out-of-Network
HealthyBlue Rewards	▪ Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars card for completing and/or reporting preventive care and screenings. ▪ Rewards are available after opting in to the program.	▪ Not Available

Part D Prescription Drug Benefits

Deductible Stage

This plan does not have a prescription drug deductible.

Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. 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 costs (your payments plus any Part D plan's payments) reach **$8,000**.

You may get your drugs at network retail pharmacies and mail order pharmacies. Our plan gives you preferred pharmacy options. You can fill your prescription drugs at one of our preferred pharmacies to save even more on most prescriptions.

See Evidence of Coverage for details.	**Preferred/Mail Order/LTC (31-day supply)**	**Standard Retail (31-day supply)**	**Preferred/Mail Order (90 to 100-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 **$35** copay for insulin	**$40** copay **$35** copay for insulin	**$90** copay **$105** copay for insulin
Tier 4 - Non-Preferred Drug	**$60** copay **$35** copay for insulin	**$70** copay **$35** copay for insulin	**$120** copay **$105** copay for insulin
Tier 5 - Specialty Tier	**33%** of the cost	**33%** of the cost	**N/A**

Coverage Gap Stage

Because there is no coverage gap for this plan, this payment stage does not apply to you.

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8,000**, you pay:

- **$0.00** copay for all Part D drugs in all tiers.

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.
- Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.