Choosing **Blue** means so much more.

2018

**Enrollment Kit**

BlueMedicare Choice (Regional PPO) R3332-001

State of Florida

BlueMedicare means more.
# Table of Contents

4......Welcome

7......Benefits at a Glance

12......Preferred Pharmacies

13......Doctors You Can Trust

15......Summary of Benefits

26......Visitor/Traveler Program

27......Understanding Enrollment Periods

29......Ready to Sign Up?

31......Enrollment Forms

39......Protected Health Information Authorization

41......Scope of Sales Appointment Confirmation Form

45......What to Expect After You Enroll

47......Non-Discrimination Notice
Hello, Future Member!

Hello!

Your journey to better health starts here!

We have put together this booklet to help make your enrollment in a Florida Blue BlueMedicare plan as easy as possible.

Here is what you will learn inside this book:

Health plan benefits: This booklet includes a “Summary of Benefits”, an in-depth guide to all this plan's benefits. You also will find a “Benefits at a Glance”, which gives you a quick look at some of the plan’s main benefits.

Doctors and providers: You will get an explanation about this plan's network of doctors and providers and what steps to take to find a doctor.

Prescription drug benefits: You will get all the information you need to understand Medicare prescription drug benefits and how to save money by using preferred pharmacies, when applicable.

Enrollment steps: We will walk you through all the steps needed to enroll and what will happen in the first 90 days after you become a member. This booklet also includes all the forms you need to enroll in this plan.

Answers to your questions: You will find answers to questions we are asked frequently about Medicare Advantage plans. If you have more questions, you can ask your agent for help or call us. Our contact information and hours of operation are listed throughout this book.

We have worked to make the language in this booklet as simple as possible. But you will see repeated explanations on some of the pages. Many of the documents in this booklet are required by Medicare to include certain information. We are here for you. If you have any questions, ask your agent or give us a call!

Thank you!

Florida Blue
At Florida Blue, we try really hard to avoid words that are complicated or technical. However, there are technical terms we need to use when explaining your benefits under this plan.

Here’s a guide to some of the more complicated terms you might see throughout this book.

| Words to know |
|----------------|-------------------------------------------------|
| **Annual Election Period (AEP)** | This is the time each year when you can sign up for or change your Medicare plan. AEP occurs October 15th to December 7th. |
| **Beneficiary** | A beneficiary is someone who is eligible for Medicare. |
| **Coinsurance** | The percentage of costs of a covered health care service or prescription drug you pay (20%, for example) after you’ve paid your deductible. |
| **Copayment (copay)** | A fixed amount ($20, for example) you pay for a covered health care service or prescription drug after you’ve paid your deductible (if applicable). |
| **Deductible** | The amount you pay for a covered health care service or prescription drug before your insurance plan starts to pay. With a $500 deductible, for example, you pay the first $500 of covered health care services or prescription drugs yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care services or prescription drugs. Your insurance company pays the rest. |
| **Formulary** | A list of prescription drugs covered by a prescription drug plan or a health plan that includes prescription drug benefits. Also called a drug list. |
| **Network** | The facilities, providers, pharmacies and suppliers your Medicare health plan has contracted with to provide health care and prescription drug services. |
| **Provider** | Anyone who provides health care for you is a provider. Doctors, nurses and pharmacists are all providers. A place where you receive care, like a hospital, is a provider, too. |
| **Service Area** | This is the geographical area where your plan covers your health care. |
| **Tier** | A tier is a category. Medicare Advantage Plans that include prescription drug coverage put covered drugs into different categories, called tiers, often based on how much they cost. For example, generic drugs are in one tier, while brand-name drugs are in another tier. |
FREQUENTLY ASKED QUESTIONS

Q: Does Original Medicare cover all my health care needs?  
A: Very few things are covered 100 percent by Original Medicare. Your out-of-pocket costs, like deductibles, coinsurance and copays, can add up. Medicare Advantage plans help you pay fewer out-of-pocket costs and may provide the coverage and protection you want.

Q: If I enroll in a Medicare Advantage plan, will I lose my Original Medicare coverage?  
A: No. Medicare Advantage plans offer an alternate way to receive Part A and Part B coverage. Whether you choose Medicare Advantage or Original Medicare, you’ll always be covered. Each year you can decide what is best for you.

Q: What is included in a Medicare Advantage plan?  
A: All Medicare Advantage plans combine the benefits of Original Medicare Part A (inpatient hospital and skilled nursing facility care) and Part B, (outpatient services and physician care) and usually include prescription drug coverage. Many plans include additional benefits like dental, hearing and vision. All Florida Blue Medicare Advantage plans cover prescription drugs.

Q: What is the difference between Medicare Advantage and Medicare supplement — sometimes called Medigap — plans/policies?  
A: Medicare Advantage plans offer an alternate way to receive Medicare Part A and Part B coverage, while Medicare Supplement (Medigap plans) pay some of the out-of-pocket costs Original Medicare doesn’t pay.

Q: What is a star rating, and why is it important?  
A: Medicare evaluates the quality of every Medicare Advantage and Part D plan based on a 5-star rating system. A star rating, along with cost and coverage information, is designed to help you find the plan that’s best for you. Star ratings are updated each year based on performance in multiple quality categories. For more information on star ratings, you can visit Medicare.gov.

Q: What happens if I join a BlueMedicare HMO plan and then I move? Can I take my plan with me?  
A: That depends on where you’re moving. If you’re moving within the service area (geographical area) of your current plan, you can keep the plan. If you’re moving outside of your plan’s service area, you have two options. You may choose a new Medicare Advantage plan that serves the area where you are moving. Or you may return to Original Medicare Part A and Part B (with an optional Medicare prescription drug plan and/or Medicare supplement policy). If you move or are planning to move, call Member Services to find out if your new home is in your plan’s service area.
# 2018 Benefits at a Glance

**BLUEMEDICARE CHOICE (REGIONAL PPO)**

## Plan Costs

<table>
<thead>
<tr>
<th>Monthly plan premium</th>
<th>$41 (You must continue to pay your Medicare Part B premium.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year (January 1 to December 31) medical deductible (separate from Part D prescription drug deductible)</td>
<td>$0 In-network $950 Out-of-network amount you have to pay before we pay our share of your medical claims.</td>
</tr>
</tbody>
</table>

## Copays and coinsurance

| Varies by benefit. | A copay is a fixed amount ($20, for example) you pay for a covered health care service. | Coinsurance is the percentage you pay for a service, such as 33% for the cost of a specialty prescription drug. |

## Annual out-of-pocket maximum (the most you have to pay for Medicare-covered services in a plan year)

| $6,700 In-Network | $10,000 Combined In and Out-of-Network Maximum Out-of-Pocket |
| (After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of Medicare-covered benefits for the rest of the year.) |

## Doctor Office Visits

<table>
<thead>
<tr>
<th>What You Pay When You Stay In-Network</th>
<th>What You Pay When You Go Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (also called a PCP or your primary doctor)</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$45 copay</td>
</tr>
</tbody>
</table>

## Preventive Care (Medicare-covered screenings)

<table>
<thead>
<tr>
<th>Preventive Care (Medicare-covered screenings)</th>
<th>What You Pay When You Stay In-Network</th>
<th>What You Pay When You Go Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings</td>
<td>$0 copay</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

## Emergency/Urgent Services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>$225 copay</td>
<td>$250 copay</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$80 copay; waived if admitted to the hospital</td>
<td>$80 copay; waived if admitted to the hospital</td>
</tr>
</tbody>
</table>
# 2018 Benefits at a Glance

<table>
<thead>
<tr>
<th>Inpatient Care</th>
<th>What You Pay When You Stay In Network</th>
<th>What You Pay When You Go Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital facility services</td>
<td>$295 copay per day, days 1-5</td>
<td>Calendar Year Deductible then $495 copay per day, days 1-27</td>
</tr>
<tr>
<td></td>
<td>$0 copay after day 5</td>
<td>$0 copay after day 27</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>$0 copay per day, days 1-20</td>
<td>Calendar Year Deductible then $250 copay per day, days 1-58</td>
</tr>
<tr>
<td></td>
<td>$160 copay per day, days 21-100</td>
<td>$0 copay per day, days 59-100</td>
</tr>
</tbody>
</table>

## Outpatient Care

<table>
<thead>
<tr>
<th>Outpatient surgery at a Hospital facility</th>
<th>20% coinsurance</th>
<th>Calendar Year Deductible then 50% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery at ambulatory surgical center (ASC)</td>
<td>$120 copay</td>
<td>Calendar Year Deductible then 50% coinsurance</td>
</tr>
<tr>
<td>Physical therapy, speech and language pathology and occupational therapy</td>
<td>$40 copay</td>
<td>Calendar Year Deductible then 50% coinsurance</td>
</tr>
</tbody>
</table>

## Lab Services

<table>
<thead>
<tr>
<th>Independent clinical lab (blood work)</th>
<th>$0</th>
<th>Calendar Year Deductible then 50% coinsurance</th>
</tr>
</thead>
</table>
## 2018 Benefits at a Glance

**PART D PRESCRIPTION DRUG BENEFIT**  
The cost-sharing shown is for 1 month (31-day supply).

<table>
<thead>
<tr>
<th>Part D Prescription Drugs</th>
<th>What You Pay at a Preferred Pharmacy</th>
<th>What You Pay at a Standard Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (applies to all drug tiers)</td>
<td>$260 annually</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The amount you have to pay before we pay our share of your drug costs.</td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Preferred Generics</td>
<td>$3 copay</td>
<td>$13 copay</td>
</tr>
<tr>
<td>Tier 2 - Generics</td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Tier 3 – Preferred Brand</td>
<td>$47 copay</td>
<td>$47 copay</td>
</tr>
<tr>
<td>Tier 4 – Non-Preferred Brand</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Tier 5 – Specialty Drugs</td>
<td>28% coinsurance (you pay 28% of the cost of the drug)</td>
<td></td>
</tr>
<tr>
<td>Tier 6 – Select Care Drugs</td>
<td></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Mail order (have your drugs delivered to you at home)</td>
<td>Same copays/coinsurance as Preferred Pharmacy listed above for one-month supply.</td>
<td></td>
</tr>
</tbody>
</table>
Medication: Know What Your Plan Covers
Before you begin using your Medicare Prescription drug coverage, it’s important to:
· Know what drug tiers are; and
· Understand the coverage gap (nicknamed the donut hole); and
· Know which pharmacies are preferred. Your costs may be lower at a preferred pharmacy than at a standard pharmacy (See the Preferred Pharmacy section on page 12)

Know What a Drug Tier Is
BlueMedicare Choice (Regional PPO) places drugs in six different categories, called tiers. You may save money by choosing the lowest tier of drug that will work for you. If you currently use higher-tier drugs, talk to your doctor to see if any lower-tier options might be available.
Tier 1: Preferred Generics
Tier 2: Generics
Tier 3: Preferred Brand
Tier 4: Non-Preferred Brand
Tier 5: Specialty Drugs
Tier 6: Select Care Drugs

Know Your Coverage Gap
Your prescription drug coverage includes four coverage stages. In each of these stages, you pay a different amount for your medications.

1. Deductible stage: At the start of your plan year, you will pay the full cost of your prescription drugs until your prescription drug deductible has been met.

2. Initial coverage stage: After you have met your prescription drug deductible, you move to the initial coverage stage. During this stage you will pay a flat fee (copay) or a percentage of a drug’s total cost (coinsurance) for each medication you need until total drug costs reach $3,750 for the year. Important: The amounts both you and BlueMedicare Choice pay for your covered drugs count toward the $3,750 initial coverage limit.

3. Coverage gap stage: After you reach the initial coverage limit, you move into the coverage gap stage. During the coverage gap stage your drug costs will still vary based on tier. In some cases you may continue to pay the same cost sharing you paid during the initial coverage stage or your cost sharing may change. Please refer to the Summary of Benefits that begins on page 15 for detailed information on what you will pay during the coverage gap stage. You stay in the coverage gap until your out-of-pocket costs for the year reach $5,000. Important: The amount you paid during the deductible stage and initial coverage stage count toward meeting your out-of-pocket limit for the year.

4. Catastrophic coverage stage: Once your out-of-pocket costs reach the coverage gap limit in a plan year, you will move to the catastrophic coverage stage. For the remainder of the calendar year, you will pay a small copay or small coinsurance for covered drugs.
Q: What if I have trouble paying for prescriptions?
A: If your yearly income and resources are below certain limits, you may qualify for Medicare’s Extra Help program, also called the low-income subsidy (LIS). To see if you qualify for Extra Help, you can call:
• 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week; or
• Social Security 1-800-772-1213, TTY 1-800-325-0778, 7 a.m.-7 p.m., Monday through Friday; or
• Your State Medicaid Office.

Q: What is a formulary, and where can I see one?
A: A formulary is a list of drugs that a plan covers. It’s also called a drug list or medication guide. To see our formulary, visit www.bluemedicarefl.com:
1. Click on Resources and tools
2. Select Medicare Forms
3. Find the formulary for your plan in the list.

Q: What happens if coverage changes for a drug I am taking?
A: If there is a change to coverage for a drug you are taking, we will tell you. Normally, we will let you know at least 60 days ahead of time.

Please contact us at 1-855-601-9465 for additional information. (TTY users, call 1-800-955-8770.) We are open from 8 a.m. - 8 p.m. local time, seven days a week from October 1 - February 14, except for Thanksgiving and Christmas. From February 15 - September 30, we are open Monday - Friday, 8 a.m. - 8 p.m. local time, except for Federal holidays.

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

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 on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.
You may save money by using a preferred pharmacy!

Our pharmacy network includes both preferred and standard pharmacy choices. When you fill a prescription at a preferred pharmacy, your cost-sharing amount may be lower than at a standard network pharmacy. This means you may keep more money in your wallet.

Our preferred pharmacy network includes:

- Elevate Provider Network
- Pill Pack
- Publix
- Walgreens
- Winn-Dixie

We want you to get the medications you need at an affordable price. Using our BlueMedicare preferred network pharmacies may offer you greater value.

For a complete list of all our in-network pharmacies, visit BlueMedicareFL.com or call our Customer Service number at 1-855-601-9465. (TTY: 1-800-955-8770). We are open from 8 a.m. - 8 p.m. local time, seven days a week from October 1 - February 14, except for Thanksgiving and Christmas. From February 15th to September 30th, we are open Monday - Friday, 8 a.m. - 8 p.m. local time, except for Federal holidays.

The pharmacy network may change at any time. You will receive notice when necessary.

Florida Blue is a PPO, RPPO and Rx (PDP) Plan with a Medicare contract. Florida Blue HMO is an HMO plan with a Medicare contract. Enrollment in Florida Blue or Florida Blue HMO depends on contract renewal.
Doctors You Can Trust

Having a doctor you depend on is important. At Florida Blue, we make sure only the best doctors and hospitals are in our network, so you get the care you need from providers you can trust.

Get the most out of your coverage when you stay in-network

With our PPO plans, you may choose to receive services from doctors who are in your plan’s network or out of it. However, except when you need emergency or urgent care or dialysis services, you will normally pay lower out-of-pocket costs by seeing a doctor who is in your plan’s network. You’ll also have access to in-network providers when traveling in many areas outside of Florida.

You have the option to select any doctor you choose. We encourage you to select and develop a relationship with a primary doctor. Your primary doctor is the main doctor you go to for routine and basic medical care. The doctor you choose can be – a general practitioner, family physician, internal medicine doctor, or geriatrician – or a specialist, such as a cardiologist or endocrinologist.

If the doctor you choose to manage all your health care is a specialist, you may pay a higher specialist cost-sharing amount. In addition, if this doctor is not in your plan’s network, you will usually pay a higher out-of-network cost-sharing amount. There are several advantages to selecting a primary doctor:

• This doctor is your health partner and will help you coordinate all your health care needs.

• Having a relationship with a primary doctor means having someone who knows all about your current and past health information.

Finding doctors

There are a few ways to find out which doctors are in your plan’s network:

1. Go online to www.bluemedicarefl.com and follow these steps:
   • Click on “Resources and Tools.”
   • Then select “Find a Doctor.”
   • Click “I Agree.”
   • Under “Just Browsing? Select a Plan”, select your plan and click “Continue”.
   • Enter your search criteria.

2. Ask your agent for help.

3. Call Customer Service at the number provided below.

Please contact us at 1-855-601-9465 for additional information (TTY users, call 1-800-955-8770.) We are open from 8 a.m. - 8 p.m. local time, seven days a week from October 1 - February 14, except for Thanksgiving and Christmas. From February 15 - September 30, we are open Monday - Friday, 8 a.m. - 8 p.m. local time, except for Federal holidays.

The provider network may change at any time. You will receive notice when necessary. Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

Florida Blue is a PPO and RPPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.
Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.
BlueMedicare Choice (Regional PPO)

Summary of Benefits

January 1, 2018 - December 31, 2018

This booklet provides a summary of what BlueMedicare Choice (Regional PPO) covers. It also explains what you pay for covered services and supplies. To get a complete list of services we cover, contact your local agent or call our Customer Service Department. You may also view the “Evidence of Coverage” for this plan on our website, www.BlueMedicareFL.com. The Evidence of Coverage includes a complete list of services we cover.

Things to Know About BlueMedicare Choice (Regional PPO)

Eligibility requirements

To join, you must:

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

Our service area is the entire State of Florida.

Which doctors, hospitals and pharmacies can I use?

We have a network of doctors, hospitals and other providers. With a Regional PPO plan you can use both in-network and out-of-network providers. You will usually pay less money for your covered services if you use providers in our network. And you can rest easy knowing that we’ve got you covered at home and when you’re away. If you need emergency care, urgent care or dialysis, you will pay in-network cost sharing for services you receive from out-of-network providers.

In most situations, you must use our network pharmacies to fill your prescriptions for covered Part D drugs. You may save money by using a preferred retail pharmacy instead of a standard one. You can also use our mail order pharmacy to have your prescription delivered to your home.

Find doctors, pharmacies and our comprehensive formulary (list of covered Part D drugs) on our website, www.BlueMedicareFL.com.

What do we cover?

Our plan includes all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Medicare Part D drugs. In addition, we cover drugs covered under Medicare Part B, such as chemotherapy drugs and certain other drugs your doctor gives you.

Hours of Operation

From October 1 to February 14 we’re open 8 a.m. - 8 p.m. local time, 7 days a week.
From February 15 to September 30, we’re open 8 a.m. - 8 p.m. local time, Monday through Friday.
Phone Numbers and Website
If you are a current member of this plan, call 1-800-926-6565
If you are not currently a member of this plan, call 1-855-601-9465
TTY users: Call 1-800-955-8770
Our website: www.BlueMedicareFL.com

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.

This document is available in other formats such as Braille and large print.

This information is available for free in other languages. Please call our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 to February 14, except for Thanksgiving and Christmas. From February 15 to September 30, we are open Monday - Friday, 8:00 a.m. – 8:00 p.m., local time.

Esta información está disponible de manera gratuita en otros idiomas. Comuníquese con Atención al cliente al 1-800-926-6565. (Usuarios de equipo telescriptor TTY llamen al 1-877-955-8773.) Estamos abiertos de 8:00 a.m.a 8:00 p.m. hora local los siete días de la semana, desde el 1 de octubre hasta el 14 de febrero, excepto el día de Acción de Gracias (Thanksgiving) y el día de Navidad. Desde el 15 de febrero al 30 de septiembre, estamos abiertos de lunes a viernes de 8:00 a.m. a 8:00 p.m. hora local.

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

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 on January 1 of 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.

Out-of-network/non-contracted providers are under no obligation to treat BlueMedicare Regional PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.
<table>
<thead>
<tr>
<th>Premiums and Benefits</th>
<th>BlueMedicare Choice (Regional PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Plan Premium</td>
<td>You pay $41.00. You must continue to pay your Medicare Part B premium.</td>
</tr>
<tr>
<td>Deductible</td>
<td>$950 per year for out-of-network medical services. $260 per year for Part D prescription drugs.</td>
</tr>
</tbody>
</table>
| Maximum Out-of-Pocket Responsibility  | Your yearly limit(s) in this plan:  
  - $6,700 for services from in-network providers.  
  - $10,000 for services from in and out-of-network providers combined.  
  If you reach the limit on out-of-pocket costs, we will pay the full cost of covered medical services and supplies for the rest of the year. You will still need to pay your monthly plan premium.  
  **Note:** (Amounts you pay for Part D drugs and hearing and vision services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.) |
| Inpatient Hospital Coverage           | **Prior Authorization is required for non-emergency Inpatient Hospital stays.**  
  **In-Network**  
  - Days 1-5: $295 copay per day  
  - After day 5: You pay nothing.  
  **Out-of-Network**  
  - Days 1-27: $495 copay per day after the $950 yearly out-of-network deductible  
| Outpatient Hospital Coverage          | **In-Network**  
  - 20% coinsurance for surgeries  
  - Up to a $150 copayment for all other. Please call us or see the plan’s Evidence of Coverage for specific cost-sharing for services received in an outpatient hospital setting  
  **Out-of-Network**  
  - OON Deductible then 50% coinsurance.                                                                                                                                                                                      |
| Doctor Visits                         | **In-Network**  
  - $10 copay per primary care visit  
  - $45 copay per specialist visit  
  **Out-of-Network**  
  50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible                                                                                                                                         |
<table>
<thead>
<tr>
<th>Premiums and Benefits</th>
<th>BlueMedicare Choice (Regional PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>You pay nothing.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td></td>
<td>Covered preventive services include:</td>
</tr>
<tr>
<td></td>
<td>• Alcohol misuse screening and counseling</td>
</tr>
<tr>
<td></td>
<td>• Annual “Wellness” visit</td>
</tr>
<tr>
<td></td>
<td>• Bone mass measurements</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease screening tests</td>
</tr>
<tr>
<td></td>
<td>• Colorectal cancer screening</td>
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<tr>
<td></td>
<td>• Counseling to prevent Tobacco use</td>
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<tr>
<td></td>
<td>• Depression screening</td>
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<tr>
<td></td>
<td>• Diabetes screening</td>
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<tr>
<td></td>
<td>• Diabetes self-management training</td>
</tr>
<tr>
<td></td>
<td>• Glaucoma screening</td>
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<td></td>
<td>• Hepatitis B Virus screening</td>
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<tr>
<td></td>
<td>• Hepatitis B Virus vaccine and administration</td>
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<tr>
<td></td>
<td>• Hepatitis C Virus screening</td>
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<tr>
<td></td>
<td>• Human Immunodeficiency Virus screening</td>
</tr>
<tr>
<td></td>
<td>• Influenza virus vaccine and administration</td>
</tr>
<tr>
<td></td>
<td>• Initial preventive physical examination</td>
</tr>
<tr>
<td></td>
<td>• Intensive behavioral therapy for cardiovascular disease</td>
</tr>
<tr>
<td></td>
<td>• Intensive behavioral therapy for obesity</td>
</tr>
<tr>
<td></td>
<td>• Lung cancer screening</td>
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<tr>
<td></td>
<td>• Medical nutrition therapy</td>
</tr>
<tr>
<td></td>
<td>• Pneumococcal vaccine and administration</td>
</tr>
<tr>
<td></td>
<td>• Prostate cancer screening</td>
</tr>
<tr>
<td></td>
<td>• Screening for Cervical Cancer with human Papillomavirus tests</td>
</tr>
<tr>
<td></td>
<td>• Screening for sexually transmitted infections (STIs) and HIBC to prevent STIs</td>
</tr>
<tr>
<td></td>
<td>• Screening mammography</td>
</tr>
<tr>
<td></td>
<td>• Screening pap tests</td>
</tr>
<tr>
<td></td>
<td>• Screening pelvic examinations</td>
</tr>
<tr>
<td></td>
<td>• Ultrasound screening abdominal aortic aneurysm</td>
</tr>
</tbody>
</table>

Any additional preventive services approved by Medicare during the contract year will be covered by our plan or Original Medicare.
<table>
<thead>
<tr>
<th>Premiums and Benefits</th>
<th>BlueMedicare Choice (Regional PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Care</strong></td>
<td><strong>Medicare Covered Emergency Care</strong></td>
</tr>
<tr>
<td></td>
<td><strong>In- and Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>$80 copay per visit</td>
</tr>
<tr>
<td></td>
<td>If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.</td>
</tr>
<tr>
<td></td>
<td><strong>Additional Emergency Care Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Worldwide Emergency Care</strong></td>
</tr>
<tr>
<td></td>
<td>$125 copay</td>
</tr>
<tr>
<td></td>
<td>Emergency coverage is provided worldwide. <strong>Worldwide emergency coverage does not include emergency transportation.</strong> If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.</td>
</tr>
<tr>
<td><strong>Urgently Needed Services</strong></td>
<td><strong>Medicare Covered Urgently Needed Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>In- and Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>• $10 copay at a Convenient Care Center</td>
</tr>
<tr>
<td></td>
<td>• $50 copay at an Urgent Care Center</td>
</tr>
<tr>
<td></td>
<td><strong>Additional Urgently Needed Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Worldwide Urgently Needed Services</strong></td>
</tr>
<tr>
<td></td>
<td>$125 copay</td>
</tr>
<tr>
<td></td>
<td>Emergency coverage is provided worldwide. <strong>Worldwide emergency coverage does not include emergency transportation.</strong></td>
</tr>
<tr>
<td><strong>Diagnostic Services/Labs/Imaging</strong></td>
<td><strong>Prior Authorization is required for certain services. Call Member Services for additional information.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Laboratory Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>• You pay nothing at an Independent Clinical Laboratory.</td>
</tr>
<tr>
<td></td>
<td>• $40 copay at an outpatient hospital facility</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td><strong>X-Rays</strong></td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>• $50 copay at an Independent Diagnostic Testing Facility (IDTF)</td>
</tr>
<tr>
<td></td>
<td>• $150 copay at an outpatient hospital facility</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td>Premiums and Benefits</td>
<td>BlueMedicare Choice (Regional PPO)</td>
</tr>
<tr>
<td>---------------------------------------</td>
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</tr>
<tr>
<td>Diagnostic Services/Labs/Imaging</td>
<td><strong>Advanced Imaging Services</strong> (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan)</td>
</tr>
<tr>
<td>(continued)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>In-Network</em></td>
</tr>
<tr>
<td></td>
<td>• $40 copay at a specialist’s office</td>
</tr>
<tr>
<td></td>
<td>• $40 copay at an IDTF</td>
</tr>
<tr>
<td></td>
<td>• $150 copay at an outpatient hospital facility</td>
</tr>
<tr>
<td></td>
<td><em>Out-of-Network</em></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td>Hearing Services</td>
<td><strong>Medicare-Covered Hearing Services</strong> (a referral will be required from your Primary Care Provider (PCP) for a Medicare-Covered hearing exam)</td>
</tr>
<tr>
<td></td>
<td>Exams to diagnose and treat hearing and balance issues:</td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>$45 copay</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Routine Hearing Services In- and out-of-network.</strong></td>
</tr>
<tr>
<td></td>
<td>• Routine hearing exam: $45 copay.</td>
</tr>
<tr>
<td></td>
<td>• Up to 2 hearing aids per year for either a $699 or $999 copay per aid.</td>
</tr>
<tr>
<td></td>
<td>• $0 copay for evaluation/fitting of hearing aids.</td>
</tr>
<tr>
<td>Dental Services</td>
<td><strong>Prior authorization is required for Medicare-covered comprehensive dental services.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Medicare-Covered Dental Services</strong> (non-routine dental care such as setting fractures of the jaw or facial bones, jaw surgery, extraction of teeth to prepare for radiation therapy, services covered when provided by a physician)</td>
</tr>
<tr>
<td></td>
<td><strong>In-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>$45 copay</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td>Premiums and Benefits</td>
<td>BlueMedicare Choice (Regional PPO)</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td><strong>Medicare-Covered Vision Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>• $45 copay for physician services to diagnose and treat eye diseases and conditions</td>
</tr>
<tr>
<td></td>
<td>• You pay nothing for glaucoma screening (once per year for members at high risk of glaucoma).</td>
</tr>
<tr>
<td></td>
<td>• You pay nothing for diabetic retinal exams.</td>
</tr>
<tr>
<td></td>
<td>• You pay nothing for one pair of eyeglasses or contact lenses after each cataract surgery.</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Routine Vision Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>Annual routine eye examination: $0 copay</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>Annual routine eye examination: Up to $25 reimbursement per year</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td><strong>Prior authorization is required for non-emergency services.</strong></td>
</tr>
<tr>
<td><strong>Inpatient Mental Health Services</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental services provided in a general hospital.</td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>• Days 1-5: $318 copay per day</td>
</tr>
<tr>
<td></td>
<td>• Days 6-90: You pay nothing.</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-network</strong></td>
</tr>
<tr>
<td></td>
<td>• Days 1-27: $495 copay per day after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td>• Days 28-90: You pay nothing.</td>
</tr>
<tr>
<td></td>
<td><strong>Prior authorization is required for non-emergency services.</strong></td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Services</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>$40 copay</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td></td>
<td>$40 copay after the $950 yearly out-of-network deductible</td>
</tr>
<tr>
<td>Premiums and Benefits</td>
<td>BlueMedicare Choice (Regional PPO)</td>
</tr>
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<td>-------------------------------------------</td>
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</tr>
</tbody>
</table>
| Skilled Nursing Facility (SNF)            | **Prior authorization is required for SNF stays.**  
Our plan covers up to 100 days in a SNF per benefit period. |  
**In-Network**  
• Days 1-20: You pay nothing.  
• Days 21-100: $160 copay per day  
**Out-of-Network**  
• Days 1-58: $250 copay per day after the $950 yearly out-of-network deductible  
• Days 59-100: You pay nothing. |
| Physical Therapy                          | **Prior authorization is required for all therapy services.**  
Occupational, physical therapy and speech and language therapy visits  
**In-Network**  
$40 copay  
**Out-of-Network**  
50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible  
A $1,980 yearly Medicare limit applies to outpatient physical and speech therapy services. This limit is for 2017 and may change in 2018.  
A separate $1,980 yearly Medicare limit applies to outpatient occupational therapy services. This limit is for 2017 and may change in 2018. |
| Ambulance                                 | **Prior authorization is required for non-emergency ambulance services.**  
**In-Network**  
$225 copay for each Medicare-covered trip (one-way)  
**Out-of-Network**  
$250 copay for each Medicare-covered trip (one-way) |
| Transportation (Routine)                  | Not covered                         |
| Medicare Part B Drugs                     | **Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.**  
**In-Network**  
• $5 copay for allergy injections  
• 20% coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs  
**Out-of-Network**  
50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible |
<table>
<thead>
<tr>
<th>Premiums and Benefits</th>
<th>BlueMedicare Choice (Regional PPO)</th>
</tr>
</thead>
</table>
| **Foot Care** *(podiatry services)* | Diagnosis and treatment of injuries and diseases of the feet. Routine care for members with certain conditions affecting the lower limbs.  
In-Network  
$40 copay  
Out-of-Network  
50% of the cost after the $950 yearly out-of-network deductible |
| **Medical Equipment/Supplies** | *Prior authorization is required for certain equipment/supplies. Call Member Services for additional information.*  
**Durable Medical Equipment**  
In-Network  
- You pay nothing for equipment except motorized wheelchairs and electric scooters.  
- 20% coinsurance for motorized wheelchairs and electric scooters  
Out-of-Network  
50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible  
**Prosthetics**  
In-Network  
20% coinsurance  
Out-of-Network  
50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible  
**Diabetic Supplies**  
In-Network  
You pay nothing.  
Out-of-Network  
50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible |
| **Wellness Programs** | • SilverSneakers® fitness program by Tivity Health.  
• Diabetes Prevention Program - An evidence-based program designed to delay or prevent participants’ progression to type 2 diabetes.  
  In- and Out-Of-Network  
  You pay nothing to participate in a fitness program or a Diabetes Prevention Program. |
| **Outpatient Surgery** | *Prior authorization is required for non-emergency services.*  
In-Network  
$120 copay at an Ambulatory Surgical Center  
20% coinsurance at an outpatient hospital facility  
Out-of-Network  
50% of the Medicare-allowed amount after the $950 yearly out-of-network deductible |
### Premiums and Benefits

**BlueMedicare Choice (Regional PPO)**

#### Part D Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Deductible Stage</th>
<th>Cost-Sharing for a one-month supply (up to 31 days) of a covered Part D prescription drug</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You begin in this payment stage when you fill your first prescription of the year.</strong></td>
<td>Tier</td>
</tr>
<tr>
<td><strong>During this stage, you pay the full cost of your drugs.</strong></td>
<td>Tier 1 (Preferred Generic)</td>
</tr>
<tr>
<td><strong>You stay in this stage until you have paid $260 for your drugs ($260 is the amount of your deductible).</strong></td>
<td>Tier 2 (Generic)</td>
</tr>
<tr>
<td><strong>Initial Coverage Stage</strong></td>
<td>Tier 3 (Preferred Brand)</td>
</tr>
<tr>
<td><strong>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</strong></td>
<td>Tier 4 (Non-Preferred Brand)</td>
</tr>
<tr>
<td><strong>You remain in this stage until your total yearly drug costs (total drug costs paid by you and any Part D plan) reach $3,750.</strong></td>
<td>Tier 5 (Specialty Tier)</td>
</tr>
<tr>
<td><strong>You may get your drugs at network retail pharmacies and mail order pharmacies.</strong></td>
<td>Tier 6 (Select Care Drugs)</td>
</tr>
</tbody>
</table>

The cost-sharing information shown above is for a one-month supply of a covered Part D prescription drug purchased at a retail pharmacy (standard and preferred) and through our mail order pharmacy. 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. Please call us or see the plan’s “Evidence of Coverage” on our website (www.BlueMedicareFL.com) for complete information about your costs for covered drugs.

<table>
<thead>
<tr>
<th>Coverage Gap Stage</th>
<th>The Coverage Gap Stage begins after total yearly drug costs (what any Part D plan has paid and what you have paid) reach $3,750.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the Coverage Gap Stage:</strong></td>
<td><strong>You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 6 (Select Care Drugs) or 44% of the cost, whichever is lower; and</strong></td>
</tr>
<tr>
<td><strong>For all other drugs, you pay 35% of the cost for covered brand name drugs (plus a portion of the dispensing fee) and 44% of the plan's cost for covered generic drugs.</strong></td>
<td><strong>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of $5,000.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Catastrophic Coverage Stage</th>
<th>After your yearly out-of-pocket drug costs reach $5,000, you pay the greater of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% of the cost, or</td>
<td>$3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copay for all other drugs</td>
</tr>
</tbody>
</table>

25
Visitor/Traveler Program

34 STATES AND 1 TERRITORY


When you receive services from a PPO provider in any area where the Visitor/Traveler Program is offered, you will pay the same cost-sharing amounts you pay when you receive covered benefits from network providers in your home service area.

The provider network may change at any time. You will receive notice when necessary.

For some of the states listed, Medicare Advantage PPO networks are available only in portions of the state.

Your enrollment materials will also tell you in which states the Visitor/Traveler Program is available. In addition, you may:

- Call 1-800-810-BLUE (1-800-810-2583), 24 hours a day, 7 days a week, to find a BlueMedicare Advantage PPO provider (TTY: 1-800-955-8770);
- Visit “Find a Doctor” at www.bcbs.com to find a Blue Medicare Advantage PPO provider; or call our Customer Service Department toll-free at 1-855-601-9465. You will be able to speak to someone from 8:00 a.m. – 8:00 p.m. local time, seven days a week. From February 15th to September 30th, we are open Monday - Friday 8 a.m. - 8 p.m. local time (TTY: 1-800-955-8770).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Benefits and/or copayments/co-insurance may change on January 1 of each year.

Under the Medicare Advantage rules, if you are absent from the service area for more than six (6) months, you must be disenrolled. However, in areas where we offer the Visitor/Traveler Program you may remain in the plan while out of our service area for 12 months.

Florida Blue is a PPO and RPPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.
Understanding Enrollment Periods

If you choose to purchase a Medicare Advantage Plan or Medicare Prescription Drug Plan, there are specific times when you can sign up for these plans or make changes to coverage you already have.

ANNUAL ENROLLMENT PERIOD (AEP)

Every year from October 15 to December 7, you can switch, drop or join a Medicare Advantage or Medicare Prescription Drug Plan of your choosing. Your plan selection becomes effective January 1 of the following year.

✓ **Enrollment:** October 15 through December 7, 2017
✓ **Coverage:** Begins January 1, 2018

**Note:** You cannot enroll in our plan after December 7 unless you qualify for a Special Election Period (SEP).

INITIAL ENROLLMENT PERIOD (IEP)

The initial enrollment period is when you first become eligible for Medicare.

✓ You can enroll in a Medicare health or prescription plan three months before the month you turn 65, the month of your birthday, and the three months after the month of your birthday.

**Note:** You may be automatically enrolled if you are under age 65, disabled and have been receiving Social Security disability benefits or certain disability benefits from the Railroad Retirement Board for 24 months.

If you miss the initial enrollment period, you may have to wait until AEP to enroll. And if you don’t sign up for Part D coverage through a Medicare Advantage Plan or Medicare Prescription Drug Plan during the IEP, you may also have to pay a late enrollment penalty once you enroll, and every year going forward.
Understanding Enrollment Periods

SPECIAL ELECTION PERIOD (SEP)
If you answer yes to any of the following questions, you may be eligible for a Special Election Period. If you think you qualify, talk to your local sales agent.

- Do you have a chronic or disabling condition?
- Have you recently moved?
- Are you currently receiving Extra Help from Medicare to help with your prescription drug costs?
- Do you no longer qualify for Extra Help with your prescription drug costs?
- Have you recently left a PACE program (Program of All-Inclusive Care for the Elderly)?
- Do you live in a long-term care facility?
- Have you recently lost your employer or union coverage?
- Will you be moving into a long-term care facility?
- Have you recently moved out of a long-term care facility?
- Are you currently receiving any level of Medicaid from your state?
- Have you recently stopped receiving Medicaid?

MEDICARE ADVANTAGE DISENROLLMENT PERIOD (MADP)
If you are a Medicare Advantage Plan member, you can leave your plan and switch to Original Medicare during the MADP.

If you switch to Original Medicare, you have until February 14, 2018 to sign up for a Medicare Prescription Drug Plan.

During this period you cannot:

- Switch from Original Medicare to a Medicare Advantage Plan
- Switch from one Medicare Advantage Plan to another
Have your Medicare ID card handy, and let’s get started!

<table>
<thead>
<tr>
<th>Choose the way to enroll that’s best for you</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paper:</strong> Use the paper enrollment form that is included in this enrollment kit. Once you are done filling it out, you can mail the form to Florida Blue. (One form must be filled out for each person who enrolls.)</td>
</tr>
<tr>
<td><strong>On-Line:</strong> Use the online form at bluemedicarefl.com. You’ll be guided through the process of completing and submitting the enrollment form and the system will prompt you if you left anything missing or incomplete.</td>
</tr>
</tbody>
</table>
| **Licensed Sales Agent:** An agent can help you choose the best plan for YOU and can also offer you help in filling out and submitting the enrollment form. The agent will be employed by or contracted with Florida Blue and may be paid based on your enrollment in a plan.  
  - Visit your local Florida Blue Center or agent; or  
  - Call and speak with one of our agents at 1-800-876-2227. (TTY users should call 1- 800-955-8770.) |

**Helpful tips for filling out your enrollment form**

1. No matter which way you choose to enroll, make sure you don’t skip any sections. If the enrollment form you submit is missing information, it **could delay your start date.**
2. When choosing a plan, select only ONE plan name.
3. Where requested, be sure to fill in the Part A and Part B effective dates from your Medicare ID card.
4. If you choose an HMO plan, write in your choice for a primary care physician (PCP). If you do not write in your choice for a PCP, one will be chosen for you.
5. Are you signing up between October 15 and December 7? If your answer is no, then go to the “Attestation of Eligibility for an Enrollment Period” section, and choose the reason that best describes why you qualify to sign up for coverage outside the regular enrollment period.
Other Important information:

- If you currently have health coverage through an employer or union, joining one of our plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this plan. Read the communications your employer or union sends you. If you have questions, contact their office.
- If you need to give us permission to release your health information to someone else, please complete the “Authorization to Release Protected Health Information” form included in this booklet and send it (the original, not a photocopy) in with your enrollment form. Otherwise, we will protect this information and release it only to you.
- If you are filling out the enrollment form on behalf of the enrollee and are the enrollee’s legal guardian or conservator, or you have been granted a Durable Power of Attorney or Durable Power of Attorney for Health Care, you must attest that you have the authority under state law to fill out the enrollment form. You must also confirm that proof of your authority is available and can be provided to the Centers for Medicare & Medicaid Services if requested.

**FREQUENTLY ASKED QUESTIONS**

Q: What is a scope of appointment (SOA) form, and why am I being asked to complete it?
A: According to Medicare guidelines, when you meet with an agent they can talk only about the products you choose to discuss. Medicare asks you to complete an SOA form that shows which Medicare Advantage and/or Part D products you wish to discuss. The form is intended to protect you. Completing the form does not mean you have enrolled in a plan. Your agent may also complete this form over the phone instead of using a paper copy.

Q: What is an enrollment verification checklist?
A: When you meet with an agent to enroll in a plan, your agent will look up how your plan will cover medications you take (including cost, tier and requirements/limitations). Your agent will also look up providers you use to see if they are in your network. Your agent will fill out this information on an enrollment verification checklist you can take with you.

Q: What is a late enrollment penalty (LEP), and how does it work if I have a $0 premium plan?
A: A late enrollment penalty (LEP) is an amount Medicare may require you to pay in addition to your monthly plan premium if you did not sign up for Medicare Parts A or B or enroll in a Medicare prescription drug plan when you were first eligible. You must also pay a Part D LEP if you had a continuous period of 63 days or more without “creditable” prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare Part D’s standard drug coverage.) An LEP must be paid even if you are enrolled in a $0 monthly premium plan.

Please contact us at 1-855-601-9465 for additional information. (TTY users, call 1-800-955-8770.) We are open from 8 a.m. - 8 p.m. local time, seven days a week from October 1 - February 14, except for Thanksgiving and Christmas. From February 15 - September 30, we are open Monday - Friday, 8 a.m. - 8 p.m. local time, except for Federal holidays.

Florida Blue is a PPO, RPPO and Rx (PDP) Plan with a Medicare contract. Florida Blue HMO and Florida Blue Preferred HMO are HMO plans with a Medicare contract. Enrollment in Florida Blue, Florida Blue HMO or Florida Blue Preferred HMO depends on contract renewal.

Health coverage is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO, and BeHealthy Florida, Inc., Florida Blue Preferred HMO, which are affiliates of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.
Please contact BlueMedicare Select or BlueMedicare Choice if you need information in another language or format (Braille).

To Enroll in BlueMedicare Select or BlueMedicare Choice, please provide the following information:

Please check which plan you want to enroll in:
- BlueMedicare Choice (Regional PPO) (Statewide) $41.00 per month
- BlueMedicare Select (PPO) (Only in select counties) $147.80 per month

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<th>Middle Initial:</th>
<th>Sex:</th>
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Birth Date: M M D Y Y Y Y

Permanent Residence Street Address (P.O. Box is not allowed):

City: County: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

E-mail Address: I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.
- Fill out this information as it appears on your Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To

HOSPITAL (PART A)

MEDICAL (PART B)

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying Your Plan Premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay BlueMedicare Select or BlueMedicare Choice the Part D-IRMAA.
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don’t even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover.

If you don’t select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill monthly.
- Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIED check or provide the following:
  - Account holder name: ________________________________
  - Bank routing number: ________________________________
  - Bank account number: ________________________________
  - Account type:  ○ Checking  ○ Saving
  - Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
  - I get monthly benefits from: ○ Social Security  ○ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ○ Yes ○ No
   
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to BlueMedicare Select or BlueMedicare Choice? ○ Yes ○ No

   If “yes,” please list your other coverage and your identification (ID) number(s) for this coverage:
   
   Name of other coverage: ____________________________  ID # for this coverage: ____________________________  Group # for this coverage: ____________________________

3. Are you a resident in a long-term care facility, such as a nursing home? ○ Yes ○ No

   If “yes,” please provide the following information:
   
   Name of Institution: ___________________________________________________________

   Address & Phone Number of Institution (number and street): __________________________

4. Are you enrolled in your State Medicaid program? ○ Yes ○ No

   If “yes,” please provide your Medicaid number: ______________________________________

5. Do you or your spouse work? ○ Yes ○ No
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:  □ Spanish  □ Braille, audio tape, large print

Please contact BlueMedicare Select or BlueMedicare Choice at 1-800-926-6565 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. - 8 p.m. local time, seven days a week from October 1 through February 14, except for Thanksgiving Day and Christmas Day. However, from February 15 to September 30, you will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day. TTY users should call 1-800-955-8770.

STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining BlueMedicare Select or BlueMedicare Choice could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueMedicare Select or BlueMedicare Choice. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.
☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):  __________
☐ I recently was released from incarceration. I was released on (insert date):  __________
☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):  __________
☐ I recently obtained lawful presence status in the United States. I got this status on (insert date):  __________
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
☐ I get extra help paying for Medicare prescription drug coverage.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date):  __________
☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):  __________
☐ I recently left a PACE program on (insert date):  __________
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):  __________
☐ I am leaving employer or union coverage on (insert date):  __________
☐ I belong to a pharmacy assistance program provided by my state.
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):  __________

If none of these statements applies to you or you’re not sure, please contact BlueMedicare Select or BlueMedicare Choice at 1-800-876-2227 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m. local time, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on Saturdays, Sundays and Federal holidays.
Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

BlueMedicare Select or BlueMedicare Choice are Medicare Advantage plans and have contracts with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances. BlueMedicare Select and BlueMedicare Choice serve specific service areas. If I move out of the area that BlueMedicare Select or BlueMedicare Choice serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BlueMedicare Select or BlueMedicare Choice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueMedicare Select or BlueMedicare Choice when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date BlueMedicare Select or BlueMedicare Choice coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, BlueMedicare Select or BlueMedicare Choice provides refunds for all covered benefits, even if I get services out of network. Services authorized by BlueMedicare Select or BlueMedicare Choice and other services contained in my BlueMedicare Select or BlueMedicare Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUEMEDICARE SELECT OR BLUEMEDICARE CHOICE WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Florida Blue, he/she may be paid based on my enrollment in BlueMedicare Select or BlueMedicare Choice.

Release of Information: By joining this Medicare health plan, I acknowledge that BlueMedicare Select or BlueMedicare Choice will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueMedicare Select or BlueMedicare Choice will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: ___________________________                      Today’s Date: ____________

If you are the authorized representative, you must sign above and provide the following information:

Name: ____________________________________________________________

Address: __________________________________________________________

Phone Number: ___________ ____________________ Relationship to Enrollee: ____________

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ____________________________________________________________

Plan ID #: ________________________________________________________

Effective Date of Coverage: ____________________

ICEP/IEP: _______ AEP: _______ SEP (type): _______ Not Eligible: _______

Entity Name: ______________________________________________________

Five digit Entity ID number (if known): ____________

Date Received by agent: ____________________

Florida Blue Agent ID #: ____________

Agent State License #: ____________

Agent Confirmation #: ____________
To Enroll in BlueMedicare Select or BlueMedicare Choice, please provide the following information:

**Please check which plan you want to enroll in:**
- BlueMedicare Choice (Regional PPO) (Statewide) $41.00 per month
- BlueMedicare Select (PPO) (Only in select counties) $147.80 per month

**Last Name:**

**First Name:**

**Middle Initial:**
- Mr.
- Mrs.
- Ms.

**Birth Date:**

**Sex:**
- M
- F

**Home Phone Number:**

**Alternate Phone Number:**

**Permanent Residence Street Address (P.O. Box is not allowed):**

**City:**

**County:**

**State:**

**ZIP Code:**

**Mailing Address (only if different from your Permanent Residence Address):**

**Street Address:**

**City:**

**State:**

**ZIP Code:**

**E-mail Address:**

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**Please Provide Your Medicare Insurance Information**

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

**Name (as it appears on your Medicare card):**

**Medicare Number:**

**Is Entitled To**

**Effective Date**

- HOSPITAL (PART A)
- MEDICAL (PART B)

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

**Paying Your Plan Premium:**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay BlueMedicare Select or BlueMedicare Choice the Part D-IRMAA.
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don’t even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover.

If you don’t select a payment option, you will get a bill each month.

**Please select a premium payment option:**
- ☐ Get a bill monthly.
- ☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIED check or provide the following:
  - Account holder name: ________________________________
  - Bank routing number: ________________________________
  - Bank account number: ________________________________
  - Account type: ☐ Checking ☐ Saving
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from:
- ☐ Social Security
- ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Please read and answer these important questions:**

1. Do you have End-Stage Renal Disease (ESRD)?
   - ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to BlueMedicare Select or BlueMedicare Choice?
   - ☐ Yes ☐ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
   - Name of other coverage:
   - ID # for this coverage:
   - Group # for this coverage:

3. Are you a resident in a long-term care facility, such as a nursing home?
   - ☐ Yes ☐ No
   If "yes," please provide the following information:
   - Name of Institution:
   - Address & Phone Number of Institution (number and street):

4. Are you enrolled in your State Medicaid program?
   - ☐ Yes ☐ No
   If "yes," please provide your Medicaid number:

5. Do you or your spouse work?
   - ☐ Yes ☐ No
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:  ☐ Spanish  ☐ Braille, audio tape, large print

Please contact BlueMedicare Select or BlueMedicare Choice at 1-800-926-6565 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. – 8 p.m. local time, seven days a week from October 1 through February 14, except for Thanksgiving Day and Christmas Day. However, from February 15 to September 30, you will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day. TTY users should call 1-800-955-8770.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining BlueMedicare Select or BlueMedicare Choice could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueMedicare Select or BlueMedicare Choice. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): ____________

☐ I recently was released from incarceration. I was released on (insert date): ____________

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): ____________

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date): ____________

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date): ____________

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date): ____________

☐ I recently left a PACE program on (insert date): ____________

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (insert date): ____________

☐ I am leaving employer or union coverage on (insert date): ____________

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): ____________

If none of these statements applies to you or you’re not sure, please contact BlueMedicare Select or BlueMedicare Choice at 1-800-976-2227 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m. local time, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on Saturdays, Sundays and Federal holidays.
Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

BlueMedicare Select or BlueMedicare Choice are Medicare Advantage plans and have contracts with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

BlueMedicare Select and BlueMedicare Choice serve specific service areas. If I move out of the area that BlueMedicare Select or BlueMedicare Choice serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BlueMedicare Select or BlueMedicare Choice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueMedicare Select or BlueMedicare Choice when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date BlueMedicare Select or BlueMedicare Choice coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, BlueMedicare Select or BlueMedicare Choice provides refunds for all covered benefits, even if I get services out of network. Services authorized by BlueMedicare Select or BlueMedicare Choice and other services contained in my BlueMedicare Select or BlueMedicare Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUEMEDICARE SELECT OR BLUEMEDICARE CHOICE WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Florida Blue, he/she may be paid based on my enrollment in BlueMedicare Select or BlueMedicare Choice.

Release of Information: By joining this Medicare health plan, I acknowledge that BlueMedicare Select or BlueMedicare Choice will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueMedicare Select or BlueMedicare Choice will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: ________________________________ Today’s Date: _____________

If you are the authorized representative, you must sign above and provide the following information:

Name: ________________________________________________

Address: ______________________________________________

Phone Number: ____________________________ Relationship to Enrollee: ____________________________

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ________________________________

Plan ID #: ________________________________

Effective Date of Coverage: ________________________________

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Entity Name: ________________________________

Five digit Entity ID number (if known): ______________

Date Received by agent: ________________

Florida Blue Agent ID #: 5205-001

Agent State License #: E051889

Agent Confirmation #: ________________________________
Protected Health Information Authorization

PURPOSE

I am the member listed in Section I.
This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc., and BeHealthy Florida, Inc. (together, “Florida Blue”) to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

SECTION I

(Please provide the following information regarding the person whose Protected Health Information is to be released.)

Member Name: ______________________________________________________
Policy or Contract Number: _____________________________________________
Group Number: ______________________Date of Birth: _____________________

SECTION II

I authorize Florida Blue to release, orally and/or in writing, the following Protected Health Information concerning me:

• Identifying information (e.g., name, address, age, gender);
• Health care coverage information (i.e., general & plan-specific benefit information);
• Past, present and future claims information (except for any period of time during which a Confidential Communication address was in effect); and
• Coordination of Benefit Information.

SECTION III

(Please identify the person(s) to whom the member’s Protected Health Information may be released and their relationship (i.e., sales agent, employer health benefit representative, parent, family member, friend, corporation, organization, law firm, vendor.)

My information may be given to the person(s) listed below.

Please Print:
Name: _________________________ Relationship to Member: _______________
Name: _________________________ Relationship to Member: _______________
Name: _________________________ Relationship to Member: _______________

SECTION IV

By law, this authorization must indicate that persons other than Florida Blue receiving member’s Protected Health Information may not have to obey federal health information privacy laws and member’s Protected Health Information may be further released by those persons.
I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, Florida Blue will have no further liability as to the further release of my Protected Health Information by those designated persons.

This authorization is voluntary and is not a condition of enrollment in a health plan, eligibility for benefits or payment of claims.

SECTION V

This authorization will expire:

__________________________ / __________________ / __________
Month Day Year

OR

The date member’s Florida Blue health coverage ends

It is advised that you place a specific expiration date on this authorization if you are designating a sales agent or employer as an authorized representative, or any other person for whom you may have designated to assist you with a specific, short-term task.

SECTION VI

Copy of Authorization

Please keep a copy of your signed authorization. A photocopy is as valid as the original.

SECTION VII

Right to Withdraw Authorization

I understand that I may withdraw this authorization at any time by giving written notice to the address listed on page 1 of this form. I further understand that withdrawal of this authorization will not affect any action taken by Florida Blue in reliance on this authorization prior to receiving my written notice of withdrawal.

1 A Confidential Communication address is one specified by an adult (age 18 or older) that is different than the address where the subscriber receives his or her mail.

2 Please provide written documentation to support your status as a guardian or other legal representative.

Health insurance is offered by Blue Cross and Blue Shield of Florida Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, and BeHealthy Florida Inc., DBA Florida Blue Preferred HMO. These companies are independent licensees of the Blue Cross and Blue Shield Association.
The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

<table>
<thead>
<tr>
<th><strong>Medicare Prescription Drug Plan (PDP)</strong> — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Health Maintenance Organization (HMO)</strong> — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).</td>
</tr>
<tr>
<td><strong>Medicare Preferred Provider Organization (PPO) Plan</strong> — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.</td>
</tr>
<tr>
<td><strong>Medicare Private Fee-For-Service (PFFS) Plan</strong> — A Medicare Advantage Plan in which you may go to any Medicare approved doctor, hospital and provider that accepts the plan’s payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.</td>
</tr>
<tr>
<td><strong>Medicare Special Needs Plan (SNP)</strong> — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.</td>
</tr>
<tr>
<td><strong>Medicare Medical Savings Account (MSA) Plan</strong> — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.</td>
</tr>
<tr>
<td><strong>Medicare Cost Plan</strong> — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan’s network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.</td>
</tr>
</tbody>
</table>
By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: ________________________________________________________________________________________________

Signature Date: ______________________________________________________________________________________________

If you are the authorized representative, please sign above and print below:

Representative’s Name: _____________________________________________________________________________________________

Your Relationship to the Beneficiary: ________________________________________________________________________________

To be completed by Agent:

<table>
<thead>
<tr>
<th>Beneficiary Name:</th>
<th>Beneficiary Phone (Optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Address (Optional):</td>
<td></td>
</tr>
<tr>
<td>Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)</td>
<td></td>
</tr>
<tr>
<td>Agent’s Signature:</td>
<td></td>
</tr>
<tr>
<td>Plan(s) the agent represented during this meeting:</td>
<td></td>
</tr>
<tr>
<td>Date Appointment Completed:</td>
<td></td>
</tr>
<tr>
<td>Plan Use Only:</td>
<td></td>
</tr>
</tbody>
</table>

*Scope of Appointment documentation is subject to CMS record retention requirements*

Health coverage is offered by Blue Cross and Blue Shield of Florida, DBA Florida Blue. HMO coverage is offered by Health Options Inc., DBA Florida Blue HMO and BeHealthy Florida, Inc., DBA Florida Blue Preferred HMO, which are affiliates of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent licensees of the Blue Cross and Blue Shield Association.
Agent, if the form was signed by the beneficiary at time of appointment, provide written explanation below why SOA was not documented prior to meeting:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Florida Blue is a PPO, RPPO and Rx (PDP) Plan with a Medicare contract. Florida Blue HMO and Florida Blue Preferred HMO are HMO plans with a Medicare contract. Enrollment in Florida Blue, Florida Blue HMO or Florida Blue Preferred HMO depends on contract renewal.
What to Expect After You Enroll

### Your First 90 Days

Once you have joined the Blue Family, our focus is on helping you get the most from your plan.

Over the next three months, we’d like the chance to get to know you and your health care needs.

Here are some key things we will do to make sure you get the maximum value from your plan benefits.

<table>
<thead>
<tr>
<th>WHAT HAPPENS?</th>
<th>HOW</th>
<th>OVERVIEW</th>
</tr>
</thead>
</table>
| Acknowledgement that enrollment form has been received | Mailed | You will receive a letter letting you know we received your enrollment form. Additionally, if you completed a paper enrollment form, a copy of the signed paper enrollment form is included for your records.  
**Timeline: 7-10 days after you enroll** |
| Notice to confirm enrollment           | Mailed| Medicare requires Florida Blue to send you an official letter to let you know your enrollment in our plan has been approved.  
**Timeline: 7-10 days after you enroll** |
| Enrollment Verification                 | Mailed| We contact each new member to make sure the Medicare Advantage plan or Prescription Drug Plan you selected was explained to you clearly and thoroughly. We also reach out to members who change plans. This step gives you a chance to make sure you signed up for the plan you want or to make changes. You may receive a call from a Florida Blue representative if more information is needed to process your enrollment.  
**Timeline: Within 15 days of enrollment** |
| Identification Card (ID)               | Mailed| If you purchased a Medicare Advantage plan, this ID card is what you should use every time you visit your doctor, hospital or pharmacy. If you purchased just a Prescription Drug Plan, this ID card is what you should use every time you visit your pharmacy. Your ID card will be mailed first and is separate from your Enrollment Package.  
**Timeline: Within 10 days after we verify your enrollment** |
| Enrollment Package                     | Mailed| Your Enrollment Package includes:  
**Evidence of Coverage:** This provides detailed plan information  
**Formulary:** A list of the prescriptions that are covered by your plan  
**Other important information** about your plan  
**Timeline: Within 10 days after we verify your enrollment** |
<table>
<thead>
<tr>
<th>WHAT HAPPENS?</th>
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</thead>
<tbody>
<tr>
<td><strong>6</strong> Online Account*</td>
<td>![Online icon] Online</td>
<td>By creating a personal account you can view claims history and status, find claims forms and much more. Go to <a href="http://www.BlueMedicareFl.com">www.BlueMedicareFl.com</a> to create your personal account. <strong>Timeline: You can sign up online after your effective date.</strong></td>
</tr>
<tr>
<td><strong>7</strong> Member Events</td>
<td>![Meeting icon] Meeting</td>
<td>Throughout the year you will receive information from Florida Blue letting you know about seminars, events and health fairs in your area, including new member meetings. We encourage you to take advantage of these opportunities to learn more about the coverage, programs and services that are available to you. <strong>Timeline: Year Round</strong></td>
</tr>
<tr>
<td><strong>8</strong> Annual Health Assessment*</td>
<td>![Exam icon] Exam</td>
<td>Make an appointment with your doctor to get a current checkup within your first 90 days of coverage. Florida Blue has programs to help you and your doctor thoroughly manage your health care needs. Florida Blue works with trusted business partners who may contact you to coordinate a doctor’s office visit or a free checkup in your home. <strong>Timeline: Within the first 90 days after your plan’s effective date. If your new plan is effective on January 1, you should receive a health assessment by March 31.</strong></td>
</tr>
</tbody>
</table>

*This is not applicable to standalone Prescription Drug Plans.*

Please contact us at 1-855-601-9465 for additional information. (TTY users, call 1-800-955-8770.) We are open from 8 a.m. - 8 p.m. local time, seven days a week from October 1 - February 14, except for Thanksgiving and Christmas. From February 15 - September 30, we are open Monday - Friday, 8 a.m. - 8 p.m. local time, except for Federal holidays.

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Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, “Florida Blue”), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) 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.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- 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)
- Provide 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:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (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 discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

**Florida Blue (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

**Florida Combined Life:**
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 https://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. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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


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


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

TOHE: Կայք է զբանավորող Վարդան Գայուզ, Անաթ, Արարատ, Չորս, Տանասար, Երկիր, Երկիր, Արարատ, Ամենա Բարձր Պոչի ծննդյան տոն։

FEP: 1-800-352-2583 (TTY: 1-800-955-8770) համար կարելի է համարակալվել։

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.