2024 Medicare Program Overview

Retirees Eligible for Medicare

Florida Blue
In the pursuit of health®

2023.10.20

What We Will Cover Today

- What is Medicare?
  - Parts A, B, C and D
- Enrolling into the Medicare Program
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- Part C – Medicare Advantage and Employer Group Waiver Plan (EGWP)
  - Eligibility Requirements and when to Enroll in the Employer Group Waiver Plan

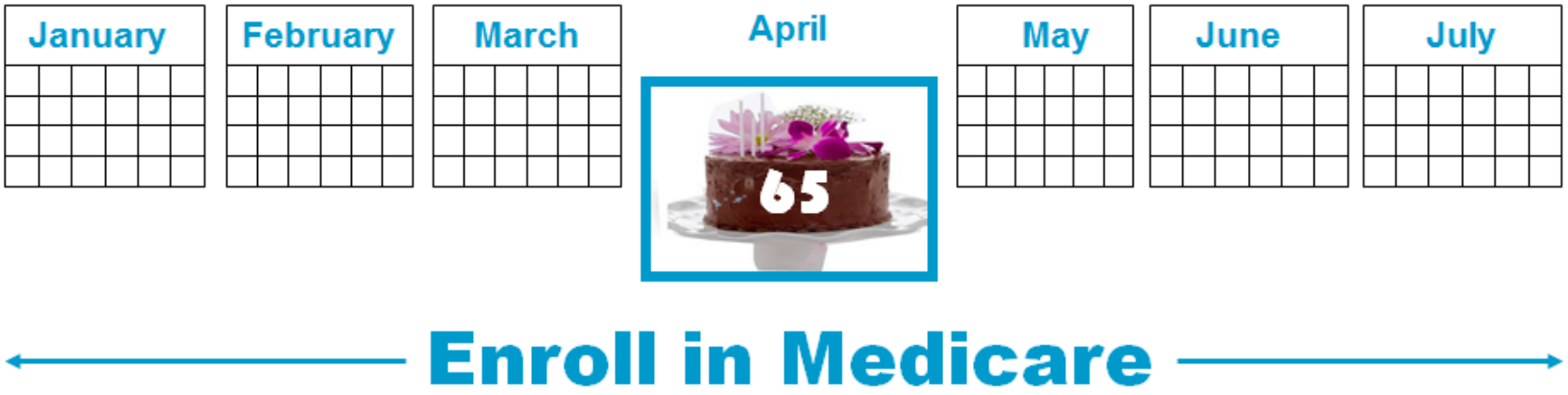
What is Medicare?

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

When do I enroll in the Medicare program?

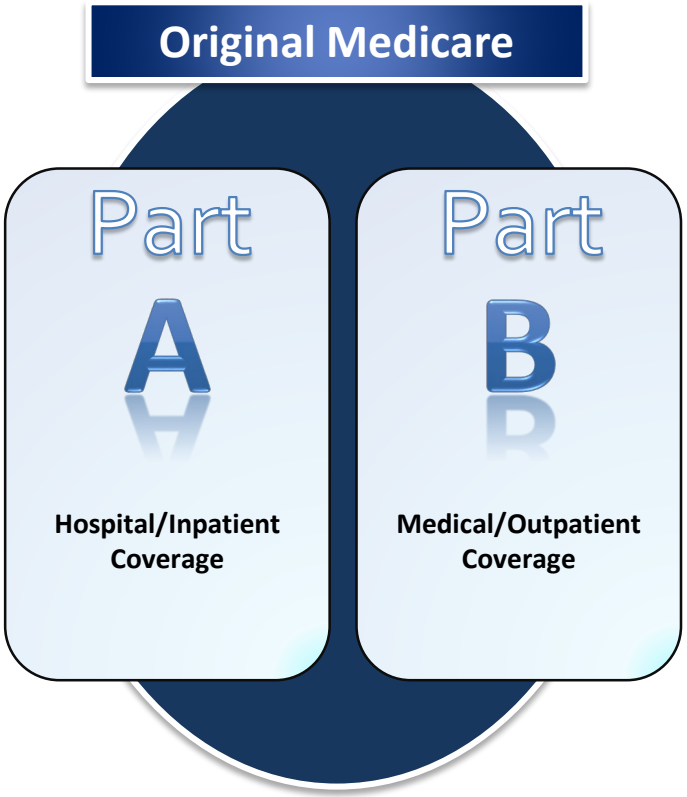
- Enrollment in Part A and Part B is *automatic* if you are already receiving Social Security benefits prior to your 65th birthday.
- Part A can act as a secondary payer even if you are still actively working with group benefits.
- Part B is *optional* if you are still actively working and have coverage through your employer.
- If you are *not automatically* enrolled in Part A and Part B prior to your 65th birthday – you can enroll during the 7-month window around your 65th birthday. This is known as the *Initial Coverage Election Period (ICEP)*.
- Enrollment in Part A and Part B is done through the Social Security Administration. This is known as "Original Medicare." This enrollment MUST be done before you can enroll in any Medicare plan, including Part C and D Medicare Advantage plan.

Initial Coverage Election Period (ICEP)



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

Original Medicare



Part A helps cover:

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

Part B helps cover:

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

Original Medicare Coverage

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

Medicare Part A Enrollment

- **Everyone should enroll in Medicare Part A as soon as you are eligible.**
  - Part A can act as a secondary payer even if you are still actively employed with commercial group benefits.
  - If you worked 40 quarters (10 years) of Medicare-credited employment, you are automatically entitled to Part A. Most people are entitled to Part A without any monthly premium.
  - In many cases, beneficiaries with less than 40 quarters of Medicare-credited employment may purchase Part A for a monthly premium. This premium amount will vary depending on the number of quarters of Medicare-credited employment you have. Contact the Social Security Administration for details.

Medicare Part B Enrollment and Penalty

- **You should enroll in Medicare Part B as soon as you are eligible if you are not actively working, have no other coverage, or are enrolled in COBRA.**
  - These types of coverage do not count as current employer coverage and you may be charged a 10% Part B late-enrollment penalty if you do not enroll when you are first eligible. If a penalty is imposed by Medicare, you must continue to pay this penalty if you have Medicare Part B.
  - If you are still actively working, you may delay enrolling in Part B without penalty, until you leave the active-employee commercial group health plan.
  - Part B has a monthly premium that is paid to the government. Many Medicare beneficiaries elect to have the Part B premium deducted directly from their monthly Social Security check. The 2024 monthly standard Part B premium is $174.70 High-Income earners may pay more.

Medicare Part B Premiums for High-Income Earners for Calendar Year 2024* Income-Related Medicare Adjustment Amounts (IRMAA)

Based on 2022 yearly income filed to IRS		
If You Filed Individual Tax Return and your income was:	If You Filed Joint Tax Return and your income was:	You Pay*
Less than or equal to $103,000	Less than or equal to $206,000	$174.70
Greater than $103,000 and less than or equal to $129,000	Greater than $206,000 and less than or equal to $258,000	$244.60
Greater than $129,000 and less than or equal to $161,000	Greater than $258,000 and less than or equal to $322,000	$349.40
Greater than $161,000 and less than or equal to $193,000	Greater than $322,000 and less than or equal to $386,000	$454.20
Greater than $193,000 and less than or equal to 500,000	Greater than $386,000 and less than or equal to $750,000	$559.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$594.00

Medicare Assignment

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

What you pay for Original Medicare services in 2024

Medicare Part A	Medicare Part B
Hospital (Inpatient) ▪ **No monthly premium for most people** ▪ $1,632 deductible each benefit period for admissions of 1 – 60 days ▪ $408 per day for days 61-90 each benefit period ▪ $816 per day for days 91-150 each benefit period (lifetime reserve days)	**General** ▪ **Monthly Premium:** $174.70 ▪ Deductible: $240 per calendar year ▪ Cost sharing: 20% of the Medicare-approved amount for most services
Medicare-Certified Skilled Nursing Facility ▪ Covers up to 100 days each benefit period after at least a 3-day covered hospital stay ▪ $0 copay for first 20 days ▪ $204 per day for days 21-100	**Outpatient Mental Health** ▪ 20% of the Medicare-approved amount for most outpatient mental health services
Home health care ▪ $0 copayment for Medicare-approved home health care services	**Preventive Services** ▪ $0 copay for the Medicare-approved list of preventive services
Blood ▪ Entire cost for first three pints of blood	**Blood** ▪ Entire cost for first three pints of blood as an outpatient, then 20% of the Medicare-approved amount for additional pints

What Original Medicare Does Not Cover

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

Medicare Part D Enrollment and Penalty

- **You should also enroll in Medicare Part D as soon as you are eligible if you do not have creditable prescription drug coverage, such as coverage through an employer-sponsored Rx plan.**
  - If you do not have creditable prescription drug coverage, you may be subject to a 1% Part D late-enrollment penalty if you do not enroll when you are first eligible. If a penalty is imposed by Medicare, you must continue to pay this penalty if you have Medicare Part D.
  - You may delay enrolling in Part D without penalty if you have other creditable prescription drug coverage, such as an Rx plan through active employment, VA benefits, or other prescription drug coverage that is as good as or better than coverage provided under the Medicare Part D defined-standard coverage.
  - Your prescription drug plan is required to send you an annual notice to let you know whether your coverage is creditable or not.

Medicare Part D premiums for high-income earners for calendar year 2024*
Income-Related Medicare Adjustment Amounts (IRMAA)

Based on 2022 yearly income filed to IRS		
If You Filed Individual Tax Return and your income was:	If You Filed Joint Tax Return and your income was:	You Pay*
Less than or equal to $103,000	Less than or equal to $206,000	$0.00
Greater than $103,000 and less than or equal to $129,000	Greater than $206,000 and less than or equal to $258,000	$12.90
Greater than $129,000 and less than or equal to $161,000	Greater than $258,000 and less than or equal to $322,000	$33.30
Greater than $161,000 and less than or equal to $193,000	Greater than $322,000 and less than or equal to $386,000	$53.80
Greater than $193,000 and less than or equal to 500,000	Greater than $386,000 and less than or equal to $750,000	$74.20
Greater than or equal to $500,000	Greater than or equal to $750,000	$81.00

Part C – Medicare Advantage plans – 3 Things You Should Know

What is it?	• It's a Medicare program that replaces Original Medicare and/or the need for a supplemental insurance policy (you get coverage from a private, Medicare-contracted insurer instead of Original Medicare). **Medicare Advantage is NOT a Medicare Supplement.**
What if I don't like it - when can I change to another plan or go back to Original Medicare?	• During your Group Annual Enrollment Period.
Am I no longer in Medicare if I join a Medicare Advantage Plan?	• You are still in the Medicare program; however, if you stay in the Medicare Advantage plan you are no longer enrolled in Original Medicare • While enrolled in the Medicare Advantage plan, you will not show your red, white and blue Medicare ID card to a provider because you will receive a new ID card from Florida Blue

Part C – Medicare Advantage plans

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

Medicare Advantage Employer Group Waiver Plan – Eligibility and When to Enroll

In order to enroll in a BlueMedicare Employer Group Waiver Plan;

You must be:

- Retired
- Enrolled in Medicare Part A and Medicare Part B.
- For BlueMedicare Group Rx plans, you must also be enrolled in Medicare Part A and Medicare Part B.

Additionally:

- BlueMedicare Employer Group Waiver Plans (EGWP) are available to retiree dependent(s) that are Medicare-eligible.
- Retiree can enroll during their Initial Coverage Election Period (ICEP) or during the group annual open enrollment.

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BlueMedicare Group Elite PPO/Elite Rx

Bay County School District #45791

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

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BlueMedicare Group Elite PPO

Monthly Premium, Deductible and Limits

Monthly Plan Premium **$241.44**
You must continue to pay your Medicare Part B premium.

Deductible

- **$0** per year for In-Network health care services
- **$1,000** per year for Out-of-Network health care services
- **$0** per year for Part D prescription drugs. There is no deductible for insulins.

Maximum Out-of-Pocket Responsibility

- **$1,000** is the most you pay for copays, coinsurance, and other costs for Medicare-covered medical services from in-network providers for the year.
- **$3,000** is the most you pay for copays, coinsurance, and other costs for Medicare-covered medical services you receive from in- andout-of-network providers.

BlueMedicare Group Elite PPO

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Coverage ◊ (Authorization applies to in-network services only.)	• **$200** copay per day, for days 1-5 • **$0** copay per day, after day 5	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Outpatient Hospital Coverage	• **$75** copay per visit for Medicare-covered observation services • ▪**$200** copay for all other services ◊	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulatory Surgical Center (ASC) Services	• **$150** copay for surgery services provided at an Ambulatory Surgical Center ◊	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Doctor Visits	• **$10** copay per provider of choice visit • **$25** copay per specialist visit	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

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Preventive Care

In-Network

- **$0** copay
- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammograms)
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Diabetes self-management training, diabetic services and supplies
- Health and wellness education programs
- Hepatitis C Screening
- HIV screening
- Immunizations
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and therapy to promote sustained weight loss
- Prostate cancer screening exams

Out-of-Network

- **20%** of the Medicare-allowed amount

BlueMedicare Group Elite PPO

Preventive Care

- Screening and counseling to reduce alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Vision care: Glaucoma screening
- "Welcome to Medicare" preventive visit

Emergency Care

Medicare-Covered Emergency Care

- **$75** copay per visit, in- or out-of-network

- This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit.
- **Worldwide Emergency Care Services**
- **$75** copay for Worldwide Emergency Care
- **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services

Does not include emergency transportation

BlueMedicare Group Elite PPO

Urgently Needed Services

Medicare-Covered Urgently Needed Services

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

- **$25** copay at an Urgent Care Center, in- or out-of-network

Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed.

- **$25** copay at a Convenient Care Center, in- or out-of-network

Worldwide Urgently Needed Services

- **$75** copay for Worldwide Urgently Needed Services
- **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
Diagnostic Services/ Labs/Imaging ◊ (Authorization applies to in-network services only.)	**Diagnostic Procedures and Tests** • **$10** copay at an Independent Diagnostic Testing Facility (IDTF) • **$30** copay at an outpatient hospital facility • **$0** copay for allergy testing **Laboratory Services** • **$0** copay at an Independent Clinical Laboratory • **$15** copay at an outpatient hospital facility **X-Rays** • **$25** copay at a physician's office or at an IDTF • **$100** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan • **$50** copay at a physician's office • **$75** copay at an IDTF • **$100** copay at an outpatient hospital facility **Radiation Therapy** **20%** of the Medicare-allowed amount	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
Hearing Services	**Medicare-Covered Hearing Services** • **$25** copay for specialist exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** • **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Dental Services	**Medicare-Covered Dental Services ◊** • **$25** copay for specialist non-routine dental care	**Medicare-Covered Dental Services** • **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental
Vision Services	**Medicare-Covered Vision Services** • **$25** copay for specialist to diagnose and treat eye diseases and conditions • **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) • **$0** copay for one diabetic retinal exam per year • **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery	**Medicare-Covered Vision Services** • **20%** of the Medicare-allowed amount for glaucoma screening • **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for Medicare-covered specialist services to diagnose and treat diseases and conditions of the eye and diabetic retinal exams • **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for eyeglasses or contact lenses after cataract surgery

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	In-Network	Out-of-Network
Mental Health Services ◊ (Authorization applies to in-network services only)	**Inpatient Mental Health Services** • **$200** copay per day for days 1-7 • **$0** copay per day for days 8-90 190-day lifetime benefit maximum in a psychiatric hospital. **Outpatient Mental Health Services** • **$30** copay	**Inpatient Mental Health Services** • **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital. **Outpatient Mental Health Services** • **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊ (Authorization applies to in-network services only.)	• **$0** copay per day for days 1-20 • ▪**$100** copay per day for days 21-100 Our plan covers up to 100 days in a SNF per benefit period.	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

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	In-Network	Out-of-Network
Physical Therapy	• **$25** copay per visit ◊	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulance	• **$150** copay for each Medicare-covered trip (one-way) ◊	• **$150** for each Medicare-covered trip (one-way)
Transportation	• Not Covered	• Not Covered
Medicare Part B Drugs	• **$5** copay for allergy injections • Up to **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ • **20% up to $35 per month** for Insulin Drugs via DME ◊	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

BlueMedicare Group Elite PPO

Additional Benefits

Diabetic Supplies

In-Network

- **$0** copay at a Florida Blue Medicare contracted network retail or mail-order pharmacy for Diabetic Supplies such as:

- Lifescan (One Touch®) Glucose Meters
- Lancets
- Test Strips
- Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies. ◊

Important Note:

- **Insulin, insulin syringes and needles for self-administration in the home are obtained from an in-network retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply.
- Lifescan (OneTouch®) as well as other brands of glucose meters and test strips can also be obtained through our participating DME network.
- The initial fill of a CGM when being used with an insulin pump can be obtained through our participating DME provider.

Out-of-Network

- **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
Medicare Diabetes Prevention Program	• **$0** copay for Medicare-covered services	• **20%** of the Medicare-allowed amount
Podiatry	• **$25** copay for each Medicare-covered podiatry visit	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Chiropractic	• **$20** copay for each Medicare-covered chiropractic service	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medical Equipment and Supplies ◊ (Authorization applies to in-network services only.)	• **20%** of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters • **0%** of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

BlueMedicare Group Elite PPO

Occupational and Speech Therapy	• **$25** copay per visit ◊	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Telehealth ◊ (Authorization applies to in-network services only)	• **$25** copay for Urgently Needed Services • ▪**$10** copay for Primary Care Services • ▪**$25** copay for Occupational Therapy/Physical Therapy/Speech Therapy at all locations • ▪**$25** copay for Dermatology Services • ▪**$30** copay for individual sessions for outpatient Mental Health Specialty Services • ▪**$30** copay for individual sessions for outpatient Psychiatry Specialty Services • **$30** copay for Opioid Treatment Program Services • **$30** copay for individual sessions for outpatient Substance Abuse Specialty Services in an office setting • **$0** copay for Diabetes Self-Management Training • **$0** copay for Dietician Services	• **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

BlueMedicare Group Elite PPO

	In-Network	Out-of-Network
Blue Dollars Benefits MasterCard® Prepaid Card *NOTE: See Healthy Blue Rewards*	• **Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.** • Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan. • Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply. • The Blue Dollars card will be mailed directly to you. Unused dollars will not be rolled over.	• Not Available
SilverSneakers® Fitness Program	• Gym membership and classes available at fitness locations across the country, including national chains and local gyms. • ▪Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.	• Not Available

BlueMedicare Group Elite PPO

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

HealthyBlue Rewards

Rewards program for members of Medicare Advantage plans

HealthyBlue is a rewards program focused on keeping **Florida Blue Medicare** Advantage members their healthiest. It's our way of saying "thanks" for being loyal to your health! Participating members must redeem earned rewards no later than 12/31 each year.[4]

Who is it for?

HealthyBlue is a program for BlueMedicare HMO, PPO and Group PPO (Employer PPO) members. This includes BlueMedicare Complete (HMO D-SNP) members.

	All Plans, All Counties
Health Risk Assessment (HRA)	$20.00
Annual Wellness Visit (AWV) or Welcome to Medicare Exam	$50.00
In-Home Health Visit	$30.00
Mammogram *(female only)*	$20.00
Flu Shot	$10.00
Colon Cancer Screening 1. In Home FIT kit 2. FIT-DNA (Cologuard) 3. Colonoscopy	$20.00
Diabetic Retinal Exam (DRE)	$20.00
Diabetic Blood Test (A1c)	$20.00
Diabetic Urine Protein Test	$10.00
Maximum Award	
	$200.00

Earned dollars can be used for items such as healthy foods, OTC products, dental, vision costs

Earn up to $200 per year

Members must be registered with HealthyBlue to be considered eligible to participate in the HealthyBlue Rewards program. Eligible members can earn and redeem rewards for completing certain preventive exams and tests between January 1 and December 31.

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BlueMedicare Group Elite Rx

Part D Prescription Drug Benefits

Deductible Stage

This plan does not have a prescription drug deductible.

Initial Coverage Stage
You begin in this stage after you meet your deductible (if applicable). During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. You remain in this stage until your total yearly costs (your payments plus any Part D plan's payments) reach **$8,000**.

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

BlueMedicare Group Elite Rx

See Evidence of Coverage for details	**Preferred/Mail Order (31-day supply)**	**Standard Retail/LTC (31-day supply)**	**Preferred/Mail Order (90 to 100-day supply)**
Tier 1 - Preferred Generic	$0 copay	$8 copay	$0 copay
Tier 2 - Generic	$3 copay	$15 copay	$9 copay
Tier 3 - Preferred Brand	$30 copay **$35** copay for insulin	$40 copay **$35** copay for insulin	$90 copay **$105** copay for insulin
Tier 4 - Non-Preferred Drug	$60 copay **$35** copay for insulin	$70 copay **$35** copay for insulin	$120 copay **$105** copay for insulin
Tier 5 - Specialty Tier	33% of the cost	33% of the cost	N/A

BlueMedicare Group Elite Rx

Coverage Gap Stage

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

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

- For insulins, you won't pay more than **$35** for a one-month supply of each insulin.

Catastrophic Coverage Stage

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

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

Additional Drug Coverage

- Please call us or see the plan's "*Evidence of Coverage*" on our website (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (Non-Preferred Drug) cost-sharing.