Dear Valued Member,

We’re happy you’ve chosen a BlueMedicare Regional PPO plan for your health care needs.

We’ve enclosed your BlueMedicare Regional PPO Owner’s Manual. This helpful guide explains how your health and prescription drug coverage works—including information about health and wellness screenings and online tools.

Keep this booklet handy so you can refer to it whenever you have a question. For details about your plan and how to use it, visit flblue.com/med/ppoplan1 to download your member kit, 2017 benefits at a glance, and check out your new member video.

Continually improving your BlueMedicare Regional PPO plan—and the benefits that come with it—is our top priority. To ensure we’re meeting your needs, in the next few weeks you may receive an independent survey called the Consumer Assessment of Healthcare Providers and Systems in the mail. Make your voice heard! Fill out each question completely and honestly, and know that we value your feedback in helping us develop better products and services for you.

Call 1-800-926-6565
TTY users should call 1-800-955-8770.
Hours: 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 to September 30, we are open Monday - Friday, 8 a.m. - 8 p.m. local time except for Federal holidays.

Click BlueMedicareFL.com

Visit a Florida Blue Center.
Call 1-877-352-5830 or go to floridablue.com/centers for locations.

Contact your local agent.

Remember, whenever you need us, we’re here for you.

Sincerely,

Luisa Charbonneau
Vice President, Government Markets (Medicare)

P.S. With the start of a new year, don’t forget to get your annual wellness visit—at no extra cost to you.
Florida Blue is a RPPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

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

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BlueMedicare Regional PPO Owner’s Manual

Your guide to using your plan
Let’s get started

When you have questions, we’ve got you covered.

📞 Your Member Services team is just a phone call away.

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✉️ Register online at bluemedicarefl.com.

Once your coverage is in effect, go to bluemedicarefl.com, click on the blue Member Login button, and select Sign Up Now under New Users. Once you register, you can:

+ Find doctors, hospitals and pharmacies
+ Look up claims quickly
+ Get your prescription drug coverage information
+ Use member tools to help you save time and money
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</tbody>
</table>

**Questions?** Call Member Services at **1-800-926-6565** (TTY users please call **1-800-955-8770**)
Use your Member Resources

As a Florida Blue member, your satisfaction and health are important to us. Here’s a list of important resources to keep on hand in case you need us.

Our Member Services team is ready to help with:
+ Benefits, claims and how to make the most of your plan
+ Finding doctors, hospitals and pharmacies near you
+ Health information and more!

Our Care Consultants can help you understand your condition, plus help you explore treatment options, so you’re able to make the choices that are best for you.

Diabetic supplies, such as glucose meters and test strips, are provided by a durable medical equipment supplier. Have your doctor call our partner, CareCentrix.

Our care coordinators can help you manage your health conditions to ensure your treatment and recovery are on the right path.

Save time by using our PrimeMail by Walgreens mail service option for your prescription drug needs. For more information on how to sign up for the home delivery service, see page 13.
Take advantage of online member tools

To sign in to your member account, go to bluemedicarefl.com, and click the blue Member Login button under Already a Member. The features of your online account allow you to find a doctor, look up prescription drug costs and a complete menu of interactive tools, like:

+ **Know Before You Go** You’ll find Know Before You Go under the Tools tab. You can compare quality and cost for medical services before you go, and then decide what’s best for your care.

+ **Virtual Assistant** You can locate the Virtual Assistant by clicking Need Help?. You can get answers to questions and quick links that you are looking for.

+ **And much more!**

Get help finding a doctor or hospital

Finding a doctor or other provider is easy and right at your fingertips. Log in to bluemedicarefl.com and select Tools and then Find a Doctor & More.

Look up prescription drugs and check costs

Check if your prescription is covered, compare costs at nearby pharmacies, and find out if there’s a generic drug substitute for a brand name drug. Just log in to bluemedicarefl.com and select Compare Drug Prices under Tools.

+ **Step 1:** You can search by medicine name or condition. Type the medicine name or condition in the search field and click “medicines” or “condition”.

+ **Step 2:** Select from the list of suggestions.

+ **Step 3:** Enter the drug specifics requested.

+ **Step 4:** Click Compare Pharmacy Pricing and enter zip code to compare prices at different locations.

+ **Step 5:** Click on the Medicine Name to compare lower cost options, when available. Plus, you can find out when other special restrictions for a particular drug might apply.
## Keep your plan documents

Below is a list of the materials that you should have received in the mail. This information is important so be sure to keep it in a safe place.

<table>
<thead>
<tr>
<th>Material</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Notice of Changes (ANOC)</strong></td>
<td>The ANOC is mailed every September to plan members. You’ll learn about upcoming plan changes that take place on January 1 of the next year.</td>
</tr>
<tr>
<td><strong>Evidence of Coverage (EOC)</strong></td>
<td>The EOC is the main part of your member contract and includes a full description of your plan benefits, processes and requirements.</td>
</tr>
<tr>
<td><strong>Blue365® brochure</strong></td>
<td>Describes exclusive member discounts and other programs and services available.</td>
</tr>
<tr>
<td><strong>BluePrint for Health Schedule</strong></td>
<td>A wellness and support program providing personalized access to a number of health-related resources.</td>
</tr>
<tr>
<td><strong>Diabetic Supplies Information</strong></td>
<td>Complete details on the supplies that can be obtained through our partner, CareCentrix, versus your local pharmacy.</td>
</tr>
<tr>
<td><strong>Formulary</strong></td>
<td>A formulary is your plan’s list of covered drugs.</td>
</tr>
<tr>
<td><strong>Section 1557</strong></td>
<td>This insert details communication services available to help those with disabilities or who need information in another format or language, and also advises you what to do if you should feel there is an issue with discrimination.</td>
</tr>
<tr>
<td><strong>Preventive Care Guidelines</strong></td>
<td>Information on Medicare-covered preventive services.</td>
</tr>
<tr>
<td><strong>Prime Mail by Walgreens Mail Service</strong></td>
<td>Order form to obtain mail-order prescription medications</td>
</tr>
<tr>
<td><strong>Pharmacy Directory</strong></td>
<td>Listing of network pharmacies.</td>
</tr>
</tbody>
</table>
Take control of your health and wellness

Talk to your doctor to see which of these preventive screenings and immunizations you may need to stay healthy in the coming year.

<table>
<thead>
<tr>
<th>General Screenings/Immunizations</th>
<th>Age</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm screening</td>
<td>Varies</td>
<td>One-time screening; see doctor for details.</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Any</td>
<td>At least once a year</td>
</tr>
<tr>
<td>Cholesterol levels</td>
<td>Any</td>
<td>Every 5 years (more frequently if at risk)</td>
</tr>
<tr>
<td>Height and weight (Body Mass Index)</td>
<td>Any</td>
<td>Annually</td>
</tr>
<tr>
<td>Glaucoma screening</td>
<td>Any</td>
<td>Annually, if high risk</td>
</tr>
<tr>
<td>Osteoporosis bone density screening</td>
<td>Any</td>
<td>Once every 2 years</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>40+</td>
<td>Annually</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Varies</td>
<td>Once every 2 years; annually, if high risk</td>
</tr>
<tr>
<td>Flu vaccine</td>
<td>Any</td>
<td>Once a year during flu season</td>
</tr>
<tr>
<td>Pneumonia vaccine</td>
<td>Any</td>
<td>One-time and then as needed</td>
</tr>
<tr>
<td>Colon cancer screening—Fecal Occult blood test</td>
<td>50+</td>
<td>Annually</td>
</tr>
<tr>
<td>Colon cancer screening—Colonoscopy OR Sigmoidoscopy</td>
<td>50+</td>
<td>Every 10 years; every 2 years if high risk</td>
</tr>
<tr>
<td></td>
<td>50+</td>
<td>Every 4 years</td>
</tr>
</tbody>
</table>

For a complete list of covered preventive services and related details such as frequency of coverage, please refer to your EOC. To schedule a preventive care appointment, just call your primary care doctor.

Questions? Call Member Services at 1-800-926-6565 (TTY users please call 1-800-955-8770)
Don’t forget your Annual Wellness Visit

When you first sign up for Medicare, you qualify for a "Welcome to Medicare" preventive visit during the first 12 months of your Medicare Part B enrollment.

Your Annual Wellness Visit is available to you after you’ve been enrolled in Medicare Part B for 12 months. There’s no cost to you if you use a network doctor. This routine visit helps you and your doctor work together to create a personalized plan for keeping you healthy in the coming year, including:

+ A review of your family medical history
+ A review of your prescription medications and current health care providers
+ Routine measurements including height, weight, BMI and blood pressure
+ A schedule of the preventive screenings and tests you need
+ Checking your joints and going over a safety checklist to help keep you from falling
+ Talking about your overall emotional and physical health

Contact your primary care doctor to make an appointment. If you need help finding a new doctor, please call our Member Services team.

Questions? Call Member Services at 1-800-926-6565 (TTY users please call 1-800-955-8770)
Urgent and Convenient Care Centers

For colds, flu, allergies, sprains, minor injuries and more, urgent care centers are open when your doctor’s office is not. With walk-in service and quality care, urgent care centers are a great alternative to the emergency room (ER) or doctor’s office.

Many pharmacy chains have convenient care centers that treat common illnesses, write prescriptions and administer vaccinations.

If you need help finding an urgent care or convenient care center, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) or go to bluemedicarefl.com and click the blue Member Login button under Already a Member to log in to Member website.
Know your prescription drug coverage

If you take prescription drugs, we can help you follow your doctor’s orders by:

+ Reminding you to get your prescriptions refilled
+ Helping you take your medication the way your doctor instructed
+ Helping you know when a medication can put you at risk of harm

You may also want to make a list of all your prescription and over-the-counter medicines including vitamins and herbal supplements. Then, share your list with your doctor. Ask him/her to discuss the risks and benefits of each medicine or identify any possible harmful drug interactions.

Have questions? We’ve got you covered.

📞 Your Member Services team is just a phone call away.

Just call 1-800-926-6565 (select the option for prescription and pharmacy related questions). TTY users call 1-800-955-8770.

🌐 Register online at bluemedicarefl.com.

Go to bluemedicarefl.com and click the blue Member Login button under Already a Member. Then select Sign Up Now under New User to register for your member account. Then click My Plan and select Pharmacy. Once you register, you can:

+ View and print a list of covered medications (formulary)
+ Find a pharmacy
+ Compare medication prices and print forms
+ Get answers to commonly asked questions
Review your formulary (list of covered drugs)

The list of prescription drugs covered by your Florida Blue plan is called a formulary. You can find the BlueMedicare formulary online anytime at bluemedicarefl.com. Share it with your doctor. You can also find a copy in your plan documents that are listed on page 6 of this booklet.

Understanding your drug list

Each drug on your plan’s drug list falls into one of five tiers, or cost-sharing levels. The copay/coinsurance increases with each tier level. Drugs are usually placed into tiers based on how many other drugs are available that can be used to treat the same medical condition, as well as how much the drugs cost. By organizing covered drugs this way, we help you save money.

<table>
<thead>
<tr>
<th>TIER</th>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preferred generic drugs</td>
<td>Lowest copay generic drugs</td>
</tr>
<tr>
<td>2</td>
<td>Generic drugs</td>
<td>Higher copay generic drugs</td>
</tr>
<tr>
<td>3</td>
<td>Preferred brand name drugs</td>
<td>Lower copay brand drugs and some generic drugs</td>
</tr>
<tr>
<td>4</td>
<td>Non-preferred brand name drugs</td>
<td>Higher copay brand drugs or some generic drugs considered as high-risk medications</td>
</tr>
<tr>
<td>5</td>
<td>Specialty drugs</td>
<td>High-cost generic and brand drugs</td>
</tr>
</tbody>
</table>
Your Medicare Part D prescription drug coverage consists of four stages:

**+ Deductible Stage**—An annual deductible is the amount you pay out of pocket for your covered prescription drugs before we pay our part. You pay 100% of covered prescription costs until you meet your deductible.

**+ Initial Coverage Stage**—Initial coverage begins after you meet your deductible. During this stage, we pay our share of the cost of your drugs and you pay your share (copay or coinsurance*). You stay in this stage until your total drug costs, paid by you and us (or any other Part D plan in which you are enrolled in 2017), reach $3,700 in 2017.

*The coinsurance for each specialty drug is always based on a percentage of the negotiated drug cost.

**+ Coverage Gap Stage**—In the coverage gap, also known as the donut hole, we pay a limited amount for covered medications. For 2017, you’ll pay 40% for covered brand name medicines and 51% for covered generic medicines.

Once you’ve paid out-of-pocket costs of $4,950 in 2017 (this includes payments made by you or certain individuals or organizations on your behalf and the 50% manufacturer’s coverage gap discount), you are no longer in the coverage gap.

**+ Catastrophic Coverage Stage**—Catastrophic coverage starts after your paid out-of-pocket costs for your covered Part D drugs reach $4,950 and lasts until the end of the year. During the catastrophic stage, you pay the greater of $3.30 or 5% for generic drugs and $8.25 or 5% for brand name drugs.

Questions? Call Member Services at 1-800-926-6565 (TTY users please call 1-800-955-8770)
Order your prescription drugs through our PrimeMail by Walgreens mail service. PrimeMail by Walgreens will deliver up to a 90-day supply of your long-term prescription drugs right to your door.

Sign-up is easy

📞 Call 1-866-525-1590, 24 hours a day, seven days a week (TTY users dial 1-800-955-8770).

💻 Or, go to bluemedicarefl.com, log in, click My Plan, then Pharmacy; select Home Delivery Services, then scroll down to the Prime Mail Order Form, print and follow the instructions on the form.

For new prescriptions, your doctor can use ePrescribe, or fax the original prescription to PrimeMail by Walgreens. You can also mail it to PrimeMail by Walgreens directly.

Tip

You can save more money by using generic drugs. Be sure to ask your doctor if there is a generic substitute for your brand-name prescription drug. Before making the change, review your formulary to ensure the generic is covered.
Your BlueMedicare Regional PPO formulary was designed to include a wide range of drugs to cover various conditions. Talk to your doctor to see if there is a covered formulary alternative that may be better for you.

If a drug is not covered as you believe it should be, ask your doctor about alternative formulary drugs or to request an exception by completing a coverage determination form.

Types of Exceptions

+ **Formulary Exception**—If your doctor prescribes a drug that is not on our formulary, you may ask your doctor to submit a formulary exception request so that your drug that is not on the formulary may be covered. If your exception request is approved, the non-formulary drug will be covered at the tier 4 copay.

+ **Tiering Exception**—You may obtain a tiering exception to lower the copay of a drug. Tiering exceptions may be requested to change the copay from tier 2 generic to tier 1 preferred generic; or from tier 4 non-preferred brand to tier 3 preferred brand. Drugs on tier 5 are not eligible for a tiering exception.

+ **Utilization Management**—In some cases, you may be required to use a drug that works the same but costs less, before a higher-priced drug can be approved. This is called Step Therapy. You may request an exception to waive the Step Therapy requirement. The quantity limits of some drugs are based on maximum doses. If your therapy requires more than the monthly limit allows, talk with your doctor about requesting a quantity limit exception. In some cases, you may need approval before your doctor can prescribe certain medications. This safeguard ensures the medicines are safe and work well.
Transition supply (temporary supply)

You may be eligible for a temporary supply of prescription drugs. This may give you and your doctor time to change your prescription to a medicine that is on the formulary, or to request an exception for a medication that is restricted in some way. A temporary supply may be available through your pharmacy if:

+ You are in the first 90 days of your plan membership or the first 90 days of the calendar year
+ You have been taking a medicine that is no longer on the formulary
+ The drug you’ve been taking is subject to new restrictions

A temporary supply is limited to a 30-day supply. If you live in a long-term care facility, the temporary supply may be up to 98 days. Copays and coinsurance may apply.

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The BlueMedicare Regional PPO Medication Therapy Management (MTM) program is included in your plan coverage—at no additional cost. MTM is a patient-centered comprehensive program designed to improve medication use, minimize the risk of harmful effects and ensure that medications are taken correctly. We’ll review your prescription drugs, and if you meet certain criteria, you’ll automatically be enrolled in the MTM program. Please let us know if you decide not to participate.

As an MTM participant, you’ll receive a medication review to help ensure safe and effective medication use. A pharmacist or other health care professional may call you to review your list of medications, explain how your medications work and their possible side effects, and address questions or concerns about your medications.

By understanding your health and medication needs, we may be able to help you maintain your overall health and wellness, help you improve your condition with the medications you take, or identify and/or prevent problems that can occur when taking several medicines.

**Drug manufacturer assistance programs:**

**Through drug manufacturers:** Many drug companies will offset prescription costs for people who meet certain requirements. To learn more about Pharmaceutical Assistance Programs, visit medicare.gov/pharmaceutical-assistance-program/index.aspx.
Medicare Part D covers all medically necessary vaccines that are not covered under Part B such as shingles and tetanus vaccines. Flu and pneumonia vaccines are covered under Part B at no additional cost when you use an in-network doctor or pharmacy. Hepatitis B vaccine may be covered under the medical or pharmacy benefit based on your medical condition.

Call Member Services at 1-800-926-6565 before you get a vaccination. TTY users call 1-800-955-8770. We’ll review your coverage, what you’ll pay, and how to save money by using providers and pharmacies in your plan’s network.

If you can’t use a provider or pharmacy in the network, we’ll explain what you need to do for us to pay our part of the cost.

Through Extra Help: This federal program covers part of the cost of your medication if your yearly income and resources are below certain limits.

To get more information or to see if you qualify, call:

+ 1-800 Medicare (1-800-633-4227). TTY users call 1-877-486-2048, 24 hours a day, 7 days a week; or
+ the Social Security office at 1-800-772-1213, 7 a.m. - 7 p.m., Monday - Friday. TTY users call 1-800-325-0778; or
+ your State Medicaid Office by calling the Agency for Healthcare Administration at 1-888-419-3456. TTY users call 1-800-955-8770.

Vaccination coverage

Medicare Part D covers all medically necessary vaccines that are not covered under Part B such as shingles and tetanus vaccines.

Flu and pneumonia vaccines are covered under Part B at no additional cost when you use an in-network doctor or pharmacy. Hepatitis B vaccine may be covered under the medical or pharmacy benefit based on your medical condition.

Call Member Services at 1-800-926-6565 before you get a vaccination. TTY users call 1-800-955-8770. We’ll review your coverage, what you’ll pay, and how to save money by using providers and pharmacies in your plan’s network.

If you can’t use a provider or pharmacy in the network, we’ll explain what you need to do for us to pay our part of the cost.
This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium 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.

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