CONTRACT, LEASE, AGREEMENT CONTROL FORM

Date: 07/09/2021

Contract/Lease Control #: C20-2976-RM

Procurement#: RFP RM 28-20

Contract/Lease Type: AGREEMENT

Award To/Lessee: BLUE MEDICARE

Owner/Lessor: OKALOOSA COUNTY

Effective Date: 10/01/2020

Expiration Date: 09/30/2022 W/3 1 YR RENEWALS

Description of: MEDICARE FOR RETIREES

Department: RM

Department Monitor: BIRD

Monitor's Telephone #: 850-689-5978

Monitor's FAX # or E-mail: KBIRD@MYOKALOOSA.COM

Closed:

Cc: BCC RECORDS

CONTRACT#: C20-2976-RM
BLUE MEDICARE
MEDICATE FOR RETIREES
EXPIRES: 09/30/2022 W/3 1 YR RENEWALS

Florida Blue
In the pursuit of health

BLUEMEDICARE GROUP MASTER AGREEMENT

SECTION 1: INTRODUCTION

This BlueMedicare Group Master Agreement (this "Agreement") describes the rights and obligations which you and Blue Cross and Blue Shield of Florida, Inc. ("Florida Blue") have with respect to the group Medicare Advantage, Medicare Advantage Prescription Drug Plan, and/or standalone Medicare Prescription Drug Plan (hereinafter, "Medicare Plan(s)") coverage to be provided by us to your Covered Retirees and Covered Dependents.

References to "we", "us", "our," and Florida Blue throughout this Agreement refer to Blue Cross and Blue Shield of Florida, Inc. In exchange for your payment of the Premium, we agree to provide the coverage and/or benefits specified in the Evidence of Coverage for the Medicare Plan(s) ("Evidence of Coverage"), a copy of which is attached to this Agreement. The coverage to be provided by us under the Group Plan which you have established is described in the Evidence of Coverage.

SECTION 2: DEFINITIONS

Certain terms defined in the Agreement are also used and defined (for the convenience of Covered Persons) in the Evidence of Coverage. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. The following defined terms apply to this Agreement:

Anniversary Date means the date one year after the Effective Date of coverage and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties.

Appeal means a request submitted by or on behalf of a Covered Person for a review of our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs.

CMS means the Centers for Medicare and Medicaid Services.

CMS Requirements means the provisions of Parts C and D of Title XVIII of the Social Security Act, CMS Medicare Part C and D regulations at 42 C.F.R. Parts 422 and 423, the CMS Managed Care and Prescription Drug Benefit Manuals, other CMS instructions and guidance and the provisions of Florida Blue's contracts with CMS to offer the Medicare Plans.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements described in the Evidence of Coverage and who is enrolled, and actually covered, under the Agreement other than as a Covered Retiree.

Covered Person means a Covered Retiree or a Covered Dependent.

Covered Retiree means an Eligible Retiree, who continues to meet all applicable eligibility requirements described in the Evidence of Coverage and who is enrolled, and actually covered, under the Agreement other than as a Covered Dependent.

Effective Date for the Group means 12:01 a.m. on the date specified on the last page of this Agreement and for Covered Persons means 12:01 a.m. on the date coverage will begin as specified in the Evidence of Coverage.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Evidence of Coverage.

Eligible Retiree means an individual who meets and continues to meet all of the eligibility requirements set forth in the Evidence of Coverage and is eligible to enroll as a Covered Retiree. An Eligible Retiree is not a Covered Retiree until actually enrolled and accepted for coverage as a Covered Retiree by us.

Enrollment Forms means those forms, electronic or paper, which are approved by us and used to maintain accurate enrollment files under the Agreement.

Grace Period means the sixty (60) calendar day period beginning on the date the Premium is due.

Grievance means a type of complaint submitted by a Covered Person (or other person eligible under CMS Requirements to submit a Grievance) about us or one of our network providers or pharmacies, including a complaint concerning the quality of care. This type of complaint does not involve coverage or payment disputes.

Group means the employer, labor union, association, partnership, corporation, department, other organization or entity through which coverage and benefits are issued by us.

Note: References to "you" or "your" throughout the first part of this Agreement also refer to the Group. References to "you" or "your" in the Evidence of Coverage refer to Eligible Retirees, Eligible Dependents, Covered Retirees and/or Covered Dependents depending on the context and intent of the specific provision.

Group Master Agreement or Agreement means the written document which is evidence of the entire agreement between the Group and Florida Blue whereby coverage and benefits are provided to Covered Persons.

Late Enrollment Penalty ("LEP") means an amount added to the Part D Premium of an individual who did not have Part D coverage or other creditable prescription drug plan when the individual first became eligible for Part D or who had a break in Part D or other creditable prescription drug coverage for at least 63 days.

Low Income Subsidy ("LIS") means the premium subsidy amount paid to us by CMS for qualifying Covered Persons with Medicare Part D coverage.

Medicare Plan means the group Medicare Advantage Plan, Medicare Advantage Prescription Drug Plan, and/or standalone Medicare Prescription Drug Plan that you select.

Premium means the amount required to be paid by the Group to us for coverage under this Agreement.

Service Area means a geographic area where a Medicare Plan accepts members.

SECTION 3: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

A. Eligibility Determination

Determination of whether an individual is an Eligible Retiree or Eligible Dependent will be a two-step process:

1. You will determine whether the individual is eligible to participate in the retiree group health benefit plan that you sponsor. For individuals meeting your eligibility criteria, you will promptly forward completed applications to us. You are responsible for complying with all applicable laws and regulations, including but not limited to the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, in making this eligibility determination. You must also comply with all eligibility guidelines included in the benefit administrative guide and Evidence of Coverage.

2. After receiving a complete application, we will process the application in accordance with CMS Requirements. An application must be approved by us and accepted by CMS for an individual to be enrolled in a Medicare Plan.

B. Distribution of Enrollment Materials

You may only distribute materials describing the Medicare Plan that we have provided to you or that we have approved in writing. You will distribute any pre-enrollment materials that we provide to you to each potential enrollee before collecting enrollment applications. Nothing in this Section will preclude you from making additional disclosures about your group health benefit plan as applicable to comply with ERISA, such as a wrap-around summary plan description or other plan document. If applicable, you are solely responsible for compliance with ERISA disclosure requirements in connection with the Medicare Plan(s).

C. Group Disenrollment

If you decide to disenroll all Covered Persons from a Medicare Plan, you must:

1. Notify all beneficiaries that you intend to disenroll them from the Medicare Plan. You will provide this notice at least twenty one (21) calendar days before the disenrollment. This notice will explain how to contact Medicare for information about other plan options that may be available. You will include language provided by Florida Blue in this notice to meet specific CMS Requirements for notice contents.

2. Provide us with all information necessary to submit a complete disenrollment request transaction to CMS in accordance with CMS Requirements.

3. In the event of termination of this Agreement, provide advanced notice in accordance with Section 4 of this Agreement.

D. Individual Covered Person Disenrollment

Covered Persons may be disenrolled from a Medicare Plan by Florida Blue if they become ineligible for continued enrollment. Covered Persons may also be disenrolled if this Agreement terminates or if you

inform us that they are no longer eligible to participate in your retiree group health plan. If Florida Blue determines that a Covered Person is ineligible for continued enrollment or if you instruct us to disenroll an individual, you must:

1. Provide us with at least thirty (30) calendar days advanced notice of the ineligibility or disenrollment election of an individual; and

2. Provide the Covered Person(s) who will be disenrolled with at least twenty one (21) calendar days advanced notice of the termination and of other insurance options that are available to them. You will include language provided by Florida Blue in this notice to meet specific CMS Requirements for notice contents.

The Covered Person will have the opportunity to elect another plan offered by us or by you, join Original Medicare, or join another carrier's Medicare Plan (by submitting an enrollment request to that organization).

SECTION 4: TERM AND TERMINATION

A. Term of Agreement and Renewal Process

This Agreement shall become effective as of the Effective Date provided: (1) that we accept your Group Application; and (2) that you pay the required initial Premium specified by us.

This Agreement shall continue in effect until the first Anniversary Date following the Effective Date unless terminated earlier as permitted by its terms. After the initial term, this Agreement shall automatically renew each succeeding year on the Anniversary Date for an additional one-year period unless:

1. At least sixty (60) calendar days prior to such Anniversary Date, you notify us that you do not want the Agreement to automatically renew; or

2. It is terminated as permitted by its terms.

At least ninety (90) calendar days before each Anniversary Date, we will provide you with notice of changes in Premium and benefits under the Medicare Plan for the upcoming year (the "Renewal Notice").

If this Agreement renews as specified above, all of its terms and provisions (including the Premium due) shall be amended to include the terms of the Renewal Notice, and the amended Agreement shall govern coverage as of the Anniversary Date. Payment of the new charges shall constitute acceptance of the change in Premium rates. This Agreement is conditionally renewable. This means that it automatically renews each year on your Anniversary Date unless terminated earlier in accordance with its terms.

B. Termination by Group

The Group may cancel this Agreement on its Anniversary Date by giving written notice to us at least sixty (60) calendar days in advance, unless we have initiated a termination for any of the reasons stated below.

C. Termination by Florida Blue

We may terminate this Agreement or refuse to renew for the following reasons:

1. **Failure to Pay Premiums**. You do not pay Premiums in accordance with its terms or we have not received timely Premium payments prior to the end of the Grace Period. Termination of this Agreement for failure to pay premiums shall be effective as of the end of the Grace Period. In the event of such termination, you are obligated to pay the following:

    a. Any portion of the Premium due for coverage provided by us prior to termination; and

    b. Any amounts otherwise due us.

2. **Fraud or Intentional Misrepresentation of Material Fact.** You perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact.

3. **Group Contribution and Participation and CMS Rules.** You do not comply with: (1) a material provision which relates to rules for Group contributions or Covered Person participation; or (2) any provision in this Agreement which relates to LIS or other CMS Requirements.

4. **Service Area**. There is no longer any Covered Person who lives, resides, or works in the Service Area.

5. **Termination or Non-renewal of the CMS Contract**. We will provide you with at least ninety (90) calendar days' notice upon termination or non-renewal of our contract with CMS.

Except as specifically provided in this Subsection 4.C, if we decide to terminate or not renew the Agreement based on one or more of the circumstances mentioned above, we will give you at least forty-five (45) calendar days advance written notice.

D. Notification of Termination to Covered Retirees

It is your obligation to immediately notify each Covered Person of any such termination of this Agreement for any reason, consistent with the requirements of Section 3 of this Agreement.

E. Representations Made By, and Obligations of, the Group

In agreeing to provide coverage in accordance with the terms of this Agreement, we rely on the representations you made when you applied for coverage with us and your representation that you have authority to act on behalf of all Covered Persons with respect to this Agreement. Consequently, every act by, agreement with, or notice given to, you will be binding on all Covered Persons. You agree that you shall offer to all Eligible Retirees the opportunity to become a Covered Person under this Agreement. You agree that, if requested by us, you will distribute the Evidence of Coverage and other coverage materials to Covered Persons.

SECTION 5: PAYMENT PROVISIONS

A. Monthly Invoice

We will prepare a monthly invoice of the Premium due on or before the due date. This monthly invoice will also reflect any prorated charges and credits resulting from changes in the number of Covered Persons and changes in the types of coverage that took place in the previous or current month.

If you become aware that a Covered Person will become ineligible, you must provide us with written notice of such ineligibility as described in Section 3 of this Agreement. You shall be liable to us for the Premium due for each individual enrolled in a Medicare Plan under this Agreement until the effective date of disenrollment, which is set by CMS Requirements.

You must pay the total amount of the invoice. Do not add names to an invoice, change coverage or pay for a retiree or dependent whose name does not appear on the invoice. No changes can be made to a Group invoice unless a signed application form is on file and submitted to Florida Blue. Payment shall be for the total amount of the Group invoice.

B. Payment Due Date

The first Premium payment is due before the Effective Date of the Agreement. Each following payment is due monthly unless you agree with us in writing on some other method and/or frequency of payment. The Premium is due and payable on or before the first day of each succeeding calendar month to which such payments apply.

C. Grace Period

This Agreement has a sixty (60) calendar day Premium payment Grace Period, which begins on the date the Premium payment is due. If we do not receive the required Premium payment on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If Premium payments are not received by the end of the Grace Period, we will terminate this Agreement and proceed with the disenrollment of Covered Persons as described in Section 3 of this Agreement.

D. Changes in Premium

Premium rates may be changed on your Anniversary Date as described in Section 4.A above regarding renewal.

E. Other Rules Regarding the Payment of Premiums

1. CMS rules govern the effective date of any disenrollment of a Covered Person under this Agreement, and we are not required to retroactively terminate this Agreement or coverage for any Covered Person.

2. If full payment of the Premium is not paid when due, this Agreement may be terminated as described in Section 4 of this Agreement.

F. Premium Subsidization

You may subsidize Premium amounts charged to Eligible Retirees. You are responsible for compliance with all applicable laws and regulations relating to your subsidy of Premiums, including ERISA and CMS Requirements, as applicable. You acknowledge and agree that Premium subsidization may vary for different classes of Eligible Retirees only if such classes are reasonable and based on objective business criteria. You represent and warrant that you will not vary Premium subsidization based on any Covered Person's eligibility for LIS. Further, you will not vary Premium subsidization for individuals within a given class of Eligible Retirees. In no case will you charge an Eligible Retiree more than the sum of the monthly Premium that we charge you for the Medicare Plan benefits.

G. Low Income Subsidy

You will comply with the following requirements in connection with LIS:

1. You are required to pass through any LIS payments received from CMS to reduce the Premium amount that the Covered Retiree pays. You will first apply any LIS amounts to a Covered Person's share of Premium. You may not benefit from any LIS amount until the Premium for a Covered Person (including amounts for the non-drug benefits in a combined Medicare Advantage Prescription Drug Plan) paid by a Covered Retiree is reduced to zero ($0.00).

2. You are responsible for reducing up-front Premium contributions that you collect from Covered Retirees for any Covered Persons eligible for LIS. In limited situations where you are unable to reduce the up-front Premium contribution (*e.g.* if LIS is awarded retroactively), you will directly refund the LIS amount to the Eligible Retiree within fifteen (15) calendar days of the date you receive the LIS amount from Florida Blue.

H. Late Enrollment Penalty (LEP)

The Premium for an individual Covered Person may be higher if the Covered Person is assessed an LEP for not enrolling in Part B in a timely manner. This higher Premium will be reflected on the bill you receive from us.

I. Premium Billing

You will be responsible for the payment of the "Total Monthly Premium per Covered Retiree" of all Group members. The Total Monthly Premium may be less for Covered Persons who qualify for LIS as defined by CMS. You will also be responsible for any LEP charges that Group members have been assessed by CMS. The first Premium charge is payable before the Effective Date of this Agreement. Monthly charges are payable on the first day of each following month during the time this Agreement is in effect.

J. Retroactive Premium Adjustment

The monthly charge will be determined from our records by the number of Covered Retirees who have been confirmed through the CMS enrollment transaction process. Retroactive adjustments will be made for additions and terminations of Covered Retirees and for Covered Retirees who have been confirmed through the CMS enrollment transaction process after the initial billing statement. Any refund that is owed to a Covered Retiree must come from the Group, unless the Covered Retiree is billed directly by us. Florida Blue will only adjust the amount due of a Group and will not refund Premium(s) paid to a Covered Retiree, unless we mutually agree that a Covered Retiree is to be directly billed by Florida Blue. You must refund to Covered Retirees any amounts received from us that are due to Covered Retirees in a timely manner.

SECTION 6: HOST BLUE PLANS

A. Out-of-Area Services – Medicare Advantage

We have relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") referred to generally as the "Inter-Plan Medicare Advantage Program." This Program operates under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). When members access

healthcare services outside the geographic area we serve, the claim for those services will be processed through the Inter-Plan Medicare Advantage Program. The Inter-Plan Medicare Advantage Program available to members under this agreement is described generally below.

B. Member Liability Calculation

When you receive Covered Services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services; or
- The amount either we negotiate with the provider or the Host Blue negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

C. Nonparticipating Healthcare Providers Outside Our Service Area

When Covered Services are provided outside of our service area by nonparticipating healthcare providers, the amount(s) a member pays for such services will be based on either the payment arrangements, described above, for Medicare Advantage PPO network providers, Medicare's limiting charge where applicable or the provider's billed charge. In these situations, the member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

SECTION 7: GENERAL PROVISIONS

A. Administration and Record Retention

You must provide us with any information we need to administer the coverage and/or benefits to be provided or needed to compute the Premium due. While this coverage is in force, we have the right, at any reasonable time, to examine your records on any issues necessary to verify information provided by you. You must retain all records relating to this Agreement, including but not limited to those relating to LIS administration, for the current calendar year plus an additional ten (10) years.

B. Assignment and Delegation

You may not assign, delegate or otherwise transfer this Agreement and the obligations hereunder without our written consent. Any assignment, delegation, or transfer made in violation of this provision shall be void. We may assign, delegate, or otherwise transfer this Agreement to our successor in interest or an affiliated entity without your consent at any time.

C. Authorization

Where this Agreement requires that an act involving the administration of coverage and/or benefits be authorized or approved by us, such authorization or approval shall be considered given when provided in writing by a duly authorized officer of Florida Blue or his or her designee.

D. Evidence of Coverage

We will provide an Evidence of Coverage and ID Card for each Covered Retiree. The Evidence of Coverage will describe the coverage and benefits to be provided to Covered Persons by us.

You agree that, if requested by us, you will distribute the Evidence of Coverage (and any Endorsements to it) and other coverage materials to Covered Persons.

E. Grievance and Appeals Process

We have established and will maintain a process for hearing and resolving Grievances and Appeals raised by Covered Persons in accordance with CMS requirements. Details regarding this process are provided in the Evidence of Coverage.

F. Changes to the Agreement

Florida Blue may make any changes to this Agreement that are necessary to meet CMS Requirements ("CMS Mandated Amendments") with sixty (60) calendar days advanced written notice to you. Such changes shall become effective as amendments to this Agreement upon expiration of this sixty (60) calendar day notice period.

Except in the case of (a) CMS Mandated Amendments or (b) Renewal Notices as described in Section 4.A., no person may change, modify, or revise the written terms or provisions of this Agreement unless such change is made by a written amendment signed by one of our duly authorized officers. For example, no Eligible Retiree or agent of Florida Blue or the Group can change or waive the written terms or provisions of this Agreement except as stated in the first sentence of this paragraph.

G. Furnishing and Maintaining Enrollment Records

You must provide any information required by us for the purpose of creating and maintaining enrollment records, processing terminations, and recording changes in family status. In addition, you and each Eligible Retiree must submit accurate and complete Enrollment Forms on a timely basis. You are responsible for collecting the Enrollment Forms, reviewing them for accuracy and completeness, and forwarding them to us, along with the applicable Premium payment. All enrollment record information which is relevant to the eligibility or coverage status of any individual must be made available to us for inspection and copying upon request.

H. Errors or Delays

Clerical errors or delays by us in maintaining enrollment records regarding Covered Persons will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise be validly terminated, provided you have furnished us with timely and accurate enrollment information. Errors or delays by you in furnishing accurate enrollment information to us will not affect our right to strictly enforce any and all eligibility requirements.

I. Entire Agreement

This Agreement sets forth the exclusive and entire understanding and agreement between the parties and shall be binding upon the Covered Persons, the parties, and any of their subsidiaries, affiliates, successors,

heirs, and permitted assigns. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this Agreement, which includes the terms of coverage and/or benefits set forth in the Evidence of Coverage, the Schedule of Benefits, and any other attachments, amendments or riders.

J. Financial Responsibilities of the Group

We reserve the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Our recovery efforts may relate to benefit payments made for health care services rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination is required to be made by you. Your cooperation with and support such recovery efforts is required.

In the event that you do not comply with the notice requirements set forth in Subsection 5.A (Monthly Invoice), you shall be solely liable to us for Premium due until the effective date established by CMS for a Covered Person's disenrollment.

K. Indemnification

You shall hold harmless and indemnify Florida Blue, against all claims, demands, liabilities, or expenses (including reasonable attorney fees and court costs), which are related to, arise out of, or are in connection with any of your acts or omissions, or acts or omissions of any of your employees, retirees or agents, in the performance of your obligations under this Agreement. We are not your agent, nor are you our agent, for any purpose. This paragraph shall only apply to the extent allowed under Florida Statutes § 768.28.

L. Representations on the Group Application and the Enrollment Forms

We rely on the information you and your Eligible Retirees provide to determine whether to issue coverage; the appropriate Premium and financing method; and eligibility for coverage. All such information must be accurate, truthful, and complete. Statements made on the Enrollment Forms are representations and not warranties.

We may cancel, terminate, or void this Agreement if the information which you provide is fraudulent, or if you make an intentional misrepresentation.

M. Reservation of Right to Contract

We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities for assistance with the servicing of coverage and benefits to be provided by us or obligations due, under this Agreement.

N. Service Mark

You, on behalf of the Group and its Covered Retirees, hereby expressly acknowledge your understanding that this Agreement constitutes a contract solely between you and Florida Blue. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting us to use the Blue Cross and Blue Shield Service Mark in the state of Florida and that we are not contracting as the agent of the

Association. You further acknowledge and agree that you have not entered into this contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Agreement.

O. Third Party Beneficiary

This Agreement was entered into solely and specifically for the benefit of Florida Blue and the Group. The terms and provisions of the Agreement shall be binding solely upon, and inure solely to the benefit of, Florida Blue and the Group, and no other person shall have any rights, interest or claims under this Agreement, including the Evidence of Coverage, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Florida Blue and the Group hereby specifically express their intent that health care providers that have not entered into contracts with Florida Blue to participate in Florida Blue's provider networks shall not be third-party beneficiaries under this Agreement, including the Evidence of Coverage.

P. Inspection and Audit

You shall permit CMS, The U.S. Department of Health and Human Services, the Comptroller General, or their designees, to inspect, evaluate, and audit any of your books, contracts, medical records, patient care documentation, documents, papers, and other records pertaining to coverage by providing records to Florida Blue, which will submit the records to CMS. This right to inspect, evaluate, and audit shall extend ten (10) years from the expiration or termination of the Agreement or completion of final audit, whichever is later, unless otherwise required by applicable law.

Q. Benefit Administrator Guide

We will provide you with a Benefit Administrator Guide, which provides details related to how your plan is administered and your responsibilities as a benefit administrator.

R. Member Communications and Campaigns

We may send CMS required or Florida Blue member communications without your consent. Samples of all required materials are available upon request for informational purposes.

We may also contact Covered Persons by telephone regarding any Florida Blue campaign and any campaign approved by the Florida Office of Insurance Regulation and/or CMS, as applicable. We will notify you of the campaign prior to making contact with members.

S. COBRA

You are solely responsible for determining when individuals are eligible for coverage under a Medicare Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). You will notify us promptly of any COBRA elections. For more information on your COBRA responsibilities refer to the Benefit Administrator Guide.

* * * * * * *

In consideration of the payment of Premiums when due and subject to all of the terms of this Agreement, Blue Cross Blue Shield of Florida, Inc. hereby agrees to provide each enrollee of **Okaloosa County Bd of County Commissioners** the benefits of this Agreement as set forth in the Evidence of Coverage beginning on each enrollee's effective date.

The Group has selected the following plan and premium: **Blue Medicare Advanced Platinum PPO- $259.12 pmpm and Platinum Rx - $195.00 pmpm.**

The Group's Agreement is effective as of October 1, 2021.

IN WITNESS WHEREOF, the parties have executed this Agreement as of 7-8-2021.

Blue Cross Blue Shield of Florida, Inc. (DBA Florida Blue)

By: Kevin Kenney
(Signature)

Name: Kevin Kenney
(Please Print or Type)

Title: Vice President, Medicare Business Performance and Integration

Okaloosa County Bd of County Commisioners

By: Carolyn N. Ketchel
(Signature) JUL 06 2021

SEAL

Name: Carolyn N. Ketchel
(Please Print or Type)

Title: Chairman

CONTRACT, LEASE, AGREEMENT CONTROL FORM

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Monitor's Telephone #: 850-689-5978

Monitor's FAX # or E-mail: KBIRD@MYOKALOOSA.COM

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BLUE MEDICARE
MEDICARE FOR RETIREES
EXPIRES: 09/30/2021 W/4 1 YR RENEWALS

Florida Blue

2020 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

BlueMedicare Group PPO (Employer PPO)

1/1/2020 – 12/31/2020

PPO2Rx2

Okaloosa County BOCC #41954

The plan's service area includes:

Nationwide

Y0011_34916 0819 CMS Accepted

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You may also view the "Evidence of Coverage" for this plan on our website, **www.floridablue.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **http://www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

You and your dependent(s) can join this plan if you are a retired employee of the group and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and enrolled in Medicare Part B
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer.

Neither you nor your dependent(s) are eligible for this plan if:

- You are an active employee of the group, or
- You are a retired employee of the group with a dependent who is an active employee of the group and has coverage through the group's plan for active employees.

Our service area includes all 50 states and the District of Columbia

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Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network to receive medical services, you may pay more for these services. If you use pharmacies that are not in our network to fill your covered Part D drugs, the plan will generally not cover your drugs.

- You can see our plan's provider and pharmacy directory at our website (**www.floridablue.com/medicare**). Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- If you are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
- If you are not a member of this plan, call us at 1-855-601-9465, TTY: 1-800-955-8770.
    - We are available October 1 to March 31, 7 days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
    - From April 1 to September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time.
- Or visit our website at **www.floridablue.com/medicare.**

Important Information

Through this document you will see the "◊" symbol. Services with this symbol may require prior authorization from the plan before you receive the services from network providers. If you do not get a prior authorization when required, you may have to pay out-of-network cost-sharing, even though you received services from a network provider. Please contact your doctor or refer to the Evidence of Coverage (EOC) for more information about services that require a prior authorization from the plan.

Monthly Premium, Deductible and Limits

Monthly Plan Premium	▪ **$271.78 for PPO2Rx2** You must continue to pay your Medicare Part B premium.
Deductible	▪ In-Network: **$0** ▪ Out-of-Network: **$2,000** ▪ **$75** per year for brand name Part D prescription drugs
Maximum Out-of-Pocket Responsibility	▪ **$2,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$4,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in and out-of-network providers combined.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Care ◊	▪ **$250** copay per day, days 1-7 ▪ **$0** copay per day, after day 7	▪ **40%** coinsurance after $2,000 out-of-network deductible
Outpatient Hospital Care	▪ **$75** copay per visit for Medicare-covered observation services ▪ **$250** copay for all other services ◊	▪ **40%** coinsurance after $2,000 out-of-network deductible
Ambulatory Surgical Center	▪ **$175** copay in an ambulatory surgical center	▪ **40%** coinsurance after $2,000 out-of-network deductible
Doctor's Office Visits	▪ **$35** copay per primary care visit ▪ **$50** copay per specialist visit	▪ **40%** coinsurance after $2,000 out-of-network deductible
Preventive Care	▪ **$0** copay ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse screening and counseling ▪ Annual Wellness Visit ▪ Bone mass measurements ▪ Breast cancer screening (mammograms) ▪ Cardiovascular disease screening and intensive behavioral therapy ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening ▪ Depression screening ▪ Diabetes screening and self-management training ▪ Glaucoma screening ▪ Hepatitis B and C screening ▪ HIV screening ▪ Intensive Behavioral Therapy for Obesity	▪ **40%** coinsurance

	In-Network	Out-of-Network
	▪ Lung cancer screening ▪ Medical nutrition therapy ▪ Prostate cancer screening ▪ Sexually transmitted infections - screening and high-intensity behavioral counseling to prevent them ▪ Smoking and tobacco use cessation counseling ▪ Vaccines for influenza, pneumonia and Hepatitis B ▪ Welcome to Medicare preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	**Medicare Covered Emergency Care** ▪ **$75** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$75** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	
Urgently Needed Services	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$50** 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. ▪ **$50** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$75** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	

	In-Network	Out-of-Network
Diagnostic Services/ Labs/Imaging◊	**Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$30** copay at an outpatient hospital facility **X-Rays** ▪ **$100** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$250** 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 ▪ **$175** copay at a physician's office ▪ **$175** copay at an IDTF ▪ **$250** copay at an outpatient hospital facility **Radiation Therapy** ▪ **$50** copay at all locations	▪ **40%** coinsurance after $2,000 out-of-network deductible
Hearing Services	**Medicare-Covered Hearing Services ◊** ▪ **$50** copay for exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** ▪ **40%** coinsurance after $2,000 out-of-network deductible for exams to diagnose and treat hearing and balance issues
Dental Services	**Medicare-Covered Dental Services ◊** ▪ **$50** copay for non-routine dental care	**Medicare-Covered Dental Services** ▪ **40%** coinsurance after $2,000 out-of-network deductible for non-routine dental
Vision Services	**Medicare-Covered Vision Services** ▪ **$50** copay for physician services to diagnose and treat eye diseases and conditions ▪ **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) ▪ **$0** copay for one diabetic retinal exam per year ▪ **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery	**Medicare-Covered Vision Services** ▪ **40%** coinsurance after $2,000 out-of-network deductible

	In-Network	Out-of-Network
Mental Health Care ◊	**Inpatient Mental Health Services** ▪ **$250** copay per day, days 1-7 ▪ **$0** copay per day, days 8-90 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **$40** copay	**Inpatient Mental Health Services** ▪ **40%** coinsurance after $2,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **40%** coinsurance after $2,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊	▪ **$0** copay per day, days 1-20 ▪ **$100** copay per day, days 21-100 Our plan covers up to 100 days in a SNF per benefit period.	▪ **40%** coinsurance after $2,000 out-of-network deductible
Physical Therapy ◊	▪ **$40** copay per visit	▪ **40%** coinsurance after $2,000 out-of-network deductible
Ambulance ◊	▪ **$150** copay for each Medicare-covered trip (one-way)	▪ **$150** copay for each Medicare-covered trip (one-way)
Transportation	▪ Not covered	▪ Not covered
Medicare Part B Drugs ◊	▪ **$10** copay for allergy injections ▪ **20%** coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs	▪ **40%** coinsurance after $2,000 out-of-network deductible

Part D Prescription Drug Benefits 

Deductible Stage

This plan has a **$75** deductible for brand drugs. The deductible does not apply to generic drugs.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,020**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost sharing below applies to a one-month (31-day) supply.

	Standard Retail (31-day supply)	**Mail Order (90-day supply)**
Tier 1 - Preferred Generic	**$15** copay	**$8** copay
Tier 2 - Generic	**$15** copay	**$8** copay
Tier 3 - Preferred Brand	**$45** copay	**$135** copay
Tier 4 - Non-Preferred Brand/Drug	**$85** copay	**$255** copay
Tier 5 - Specialty Tier	**25%** of the cost	Not available

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what any Part D plan has paid and what you have paid) reaches **$4,020**.

You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **$6,350**.

During the Coverage Gap Stage:

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs, throughout the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350**, you pay:

- **$3.60** copay for generic and **$8.95** copay for all other drugs.

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 cost sharing.
- 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.

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies ◊	▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips	▪ **40%** coinsurance after $2,000 out-of-network deductible
Medicare Diabetes Prevention Program	▪ **$0** copay for Medicare-covered services	▪ **$0** copay for Medicare-covered services
Podiatry	▪ **$50** copay for each Medicare-covered podiatry visit	▪ **40%** coinsurance after $2,000 out-of-network deductible
Chiropractic	▪ **$20** copay for each Medicare-covered chiropractic visit	▪ **40%** coinsurance after $2,000 out-of-network deductible
Medical Equipment and Supplies ◊	▪ **20%** coinsurance for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** coinsurance for all other plan approved, Medicare-covered durable medical equipment	▪ **40%** coinsurance after $2,000 out-of-network deductible
Occupational and Speech Therapy ◊	▪ **$40** copay per visit	▪ **40%** coinsurance after $2,000 out-of-network deductible

You Get More with BlueMedicare

	In-Network	Out-of-Network
HealthyBlue Rewards 	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.	
SilverSneakers® Fitness Program 	▪ College Save: As a SilverSneakers member, you can accumulate tuition discount points for savings on college tuition (up to one year off full tuition) for students that you designate ▪ Gym membership and classes available at 16,000+ 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 ▪ Classes such as line dance and Latin-style dance, indoor and outdoor boot camp, walking groups, and many more	

Disclaimers

Florida Blue is a PPO and Rx plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

This information is not a complete description of benefits. Call 1-855-601-9465 (TTY: 1-800-955-8770) for more information.

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. 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.

If you have any questions please contact 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 – March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday – Friday, 8:00 a.m. – 8:00 p.m. local time.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-926-6565 (TTY: 1-877-955-8773). ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-926-6565 (TTY: 1-877-955-8773).

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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Section 1557 Notification: Discrimination is Against the Law

We 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.

We 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)
- 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:

- Health and vision coverage: 1-800-352-2583
- 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 discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (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

Dental, life, and disability coverage:
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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 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

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.
ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **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

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

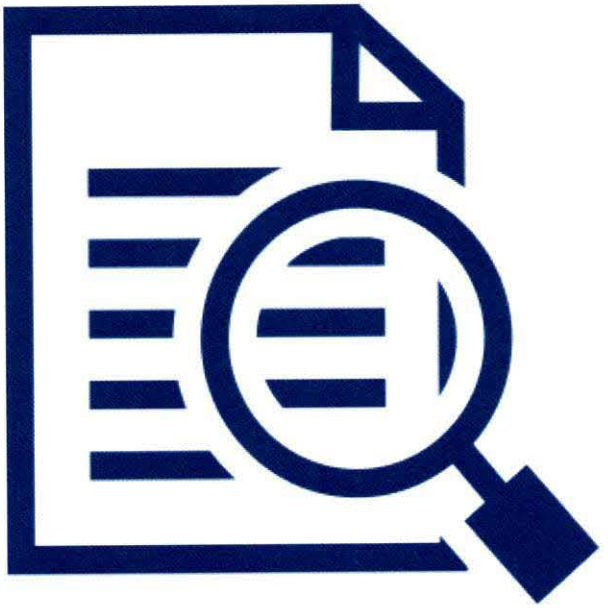
2020 Summary of Benefits
Medicare Prescription Drug Plans

BlueMedicare Group Rx (Employer PDP)

1/1/2020 – 12/31/2020

Rx2-Only

Okaloosa County BOCC #41954



The plans' service area includes:
Nationwide

Y0011_34925 0819 CMS Accepted

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You may also view the "Evidence of Coverage" for this plan on our website, **www.floridablue.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **http://www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

You and your dependent(s) can join this plan if you are a retired employee of the group and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and/or enrolled in Medicare Part B,
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer.

Neither you nor your dependent(s) are eligible for this plan if:

- You are an active employee of the group, or
- You are a retired employee of the group with a dependent who is an active employee of the group and has coverage through the group's plan for active employees.

Our service area includes all 50 states and the District of Columbia.

Which pharmacies can I use?

- In most situations, you must use our network pharmacies to fill your prescriptions for covered Part D drugs.
- You can also use our mail-order pharmacy to have your prescription delivered to your home.
- Want to see if your pharmacy is in our pharmacy network, or if these plans cover your prescription drugs? Just visit our website at **www.floridablue.com/medicare**. Or see how we cover any medication you may be taking in our comprehensive formulary (list of covered Part D drugs).

Have Questions? Call Us

- If you are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
- If you are not a member of this plan, call us at 1-855-601-9465, TTY: 1-800-955-8770.
    - We are available October 1 to March 31, 7 days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
    - From April 1 to September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time.
- Or visit our website at **www.floridablue.com/medicare**

Important Information

Our plans group each medication into a tier. The number of tiers may vary based on the plan you choose. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible (for BlueMedicare Premier Rx only), Initial Coverage, Coverage Gap and Catastrophic Coverage.

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$139.03 for Rx2** You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.

Part D Prescription Drug Benefits

Deductible Stage

This plan has a **$75** deductible for brand drugs. The deductible does not apply to generic drugs.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,020**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost sharing below applies to a one-month (31-day) supply.

	Standard Retail (31-day supply)	**Mail Order (90-day supply)**
Tier 1 - Preferred Generic	**$15** copay	**$8** copay
Tier 2 - Generic	**$15** copay	**$8** copay
Tier 3 - Preferred Brand	**$45** copay	**$135** copay
Tier 4 - Non-Preferred Brand/Drug	**$85** copay	**$255** copay
Tier 5 - Specialty Tier	**25%** of the cost	Not available

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what any Part D plan has paid and what you have paid) reaches **$4,020**.

You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **$6,350**.

<u>During the Coverage Gap Stage:</u>

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs, throughout the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350**, you pay:

- **$3.60** copay for generic and **$8.95** copay for all other drugs.

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 cost sharing.
- 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.

Disclaimers

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

This information is not a complete description of benefits. Call 1-855-601-9465 (TTY: 1-800-955-8770) for more information.

If you have any questions please contact 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 – March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday – Friday, 8:00 a.m. – 8:00 p.m. local time.

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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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.