



2027 Enrollment Guide

Plan for your changing needs with a Medicare Advantage plan that gives you extra benefits, not extra costs.

Charlotte, Collier, Lee, Manatee and Sarasota Counties

BlueMedicare Focus (HMO C-SNP) H1035-056

Welcome

Inside, there's everything you need to become a part of the Florida Blue Medicare community.

This booklet will help make enrolling in your BlueMedicareSM plan as easy as possible. It also explains what will happen immediately after you're enrolled, and how to start finding out just how Blue means more to you.

This booklet contains:



A **summary of benefits** included in your plan



Information about your plan's **provider network** and how to find a doctor



Information on Medicare **prescription drug benefits** and how to save as much money as possible on prescription drugs



Enrollment steps that will walk you through the process



All the forms you need to enroll in your plan



Information on what happens **after you enroll** in your plan and what to expect

Questions? Ask your agent or give us a call.

1-855-217-4362 (TTY: 711)

October 1 to March 31: 7 days a week from 8 a.m. to 8 p.m. local time and from **April 1 to September 30:** Monday through Saturday, from 8 a.m. to 8 p.m. local time and closed on Sundays. We are closed most major holidays.

Table of Contents

About Medicare Advantage

What is Medicare Advantage?	4
Important Medicare Enrollment Information	5

My Benefits

Benefits at-a-Glance	6
Summary of Benefits.....	9

Enrollment Information

Ready to sign up?	28
Forms Used for Enrollment.....	29
Pre-Enrollment Checklist	30
Individual Enrollment Form	31
Protected Health Information Authorization	47
Scope of Sales Appointment Confirmation Form	51
Enrollment Checklist	59

What's Next?

How to make the most of your Medicare Dollars.....	68
What you can expect in the first 90 days.....	70

What is Medicare Advantage?

Medicare Advantage plans are health plans offered by private insurers that contract with Medicare.

ORIGINAL MEDICARE

Provided by the federal government



Covers hospital stays, skilled nursing facilities and home health care



Covers doctor visits and many outpatient services, such as lab tests, X-rays and physical therapy

MEDICARE SUPPLEMENT PLAN



Covers some or all out-of-pocket costs not covered by Parts A and B, like deductibles, copays and coinsurance

MEDICARE PART D PLAN



Covers prescription drugs

MEDICARE ADVANTAGE PLAN

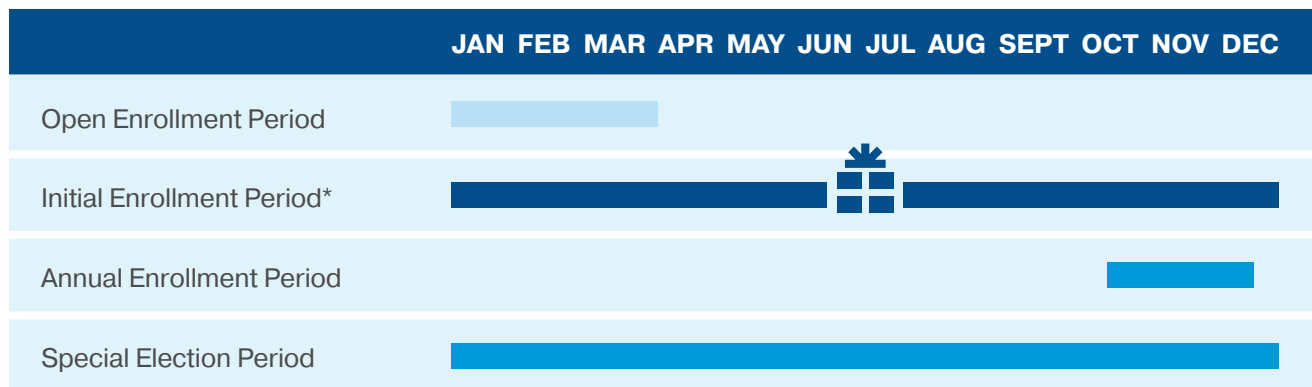
Offered by private insurance companies



Combines **Original Medicare** Part A and Part B in one plan

Many plans offer additional benefits not covered by Original Medicare, plus **MAPD plans** include prescription drug coverage.

Important Medicare Enrollment Information



* 3 months before/after and including the month of your 65th birthday.

Open Enrollment Period (OEP)

OEP runs **January 1 through March 31**. During this period if you are enrolled in a Medicare Advantage (MA) plan, you are allowed to make a one-time election to go to another MA plan or to Original Medicare. If you enroll in Original Medicare, you may also purchase a Medicare Supplement and/or a Prescription Drug Plan.

Note: There is no guaranteed-issue enrollment period for Medicare Supplement plans.

Initial Enrollment Period

When you become eligible for Medicare, you can enroll in Original Medicare or a Medicare health or Prescription Drug Plan three months before the month you turn 65, the **month of your birthday**, and the three months after the month of your birthday.

Annual Enrollment Period (AEP)

Every year, from **October 15 through December 7**, you can switch, drop or join the Medicare Advantage or Medicare Prescription Drug Plan of your choosing. You can also enroll in Original Medicare. Your plan selection becomes effective January 1 of the following year.

Special Election Period (SEP)

After certain events, such as a recent move or losing your employer or union coverage, you may be eligible for a Special Election Period. If you think you qualify, talk to your local sales agent.

Benefits at-a-Glance

BlueMedicare Focus (HMO C-SNP) H1035-056

To get a complete list of services we cover, you can view the Evidence of Coverage for this plan on our website, FloridaBlue.com/Medicare/Forms. If you are a member, you can view the Evidence of Coverage by logging in to your online member account.

Plan Costs & Details

How much is the monthly premium?	\$0 You must continue to pay your Medicare Part B premium. This plan has a Part B Premium Rebate of \$130.
How much is the deductible?	\$0
Is there any limit on how much I will pay for my covered medical services?	\$3,400 for services you receive from In-Network providers

Medical & Hospital Benefits

Doctor's Office Visits	\$0 copay Primary Care Physician \$15 copay Specialist
Preventive Care	\$0 copay
Inpatient Hospital	Days 1-7: \$145 copay per day. After the 7th day the plan pays 100% of covered expenses.
Outpatient Hospital	\$140 copay except for Observation Services
Outpatient Surgery	\$115 copay in an Ambulatory Surgical Center \$140 copay in an Outpatient Hospital Facility
Urgently Needed Services	\$65 copay at Urgent and Convenient Care Centers
Emergency Room	\$150 copay

Part D Prescription Drug Benefits¹

Deductible	\$700 per year for Part D prescription drugs. Applies to Tiers 4 and 5.
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Out-of-Pocket Max	\$2,400
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Tier 1 (Preferred Generic)	\$0 copay
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Tier 2 (Generic)	\$0 copay
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Tier 3 (Preferred Brand)	19% coinsurance
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Tier 4 (Non-Preferred)	Deductible then 26% coinsurance
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Tier 5 (Specialty)	Deductible then 25% coinsurance
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Tier 6 (Select Care)	\$0 copay
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Mail Order	Same copays/coinsurance as listed above
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¹ What you pay for a 31-day supply during the initial coverage phase. You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible, if applicable.

Additional Benefits

Vision Services	\$0 copay for one routine eye exam annually. \$225 allowance per year towards the purchase of lenses, frames or contact lenses.
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Hearing Services and Hearing Aids	\$0 copay for one routine hearing exam per year. \$0 copay for evaluation and fitting of hearing aids. Up to 2 hearing aids every year. Copayment varies based on the device selected.
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Additional Benefits (continued)

Dental Services

\$2,000 annual maximum allowance for the following services:

- Oral exams, cleanings, and X-rays
- Fluoride treatments
- Simple and surgical extractions
- Dentures, complete or partial and associated adjustments and repairs
- Fillings, root canals, and crowns
- Deep cleaning, root planing, and full mouth debridement

Allowance cannot be used for implants, orthodontics, or cosmetic dentistry.

Refer to the Evidence of Coverage for coverage limits and frequency. We negotiate discounted prices with dentists in our network; if you use more dental services than your plan covers, you will be charged the discounted negotiated rates.

Over-the-Counter items, Approved Food, and Transportation Allowance

\$105 monthly allowance to cover your eligible OTC items, approved food purchases, and transportation costs. Your allowance will reload at the beginning of each month, and any unused funds will expire at the end of each month.

HealthyBlue Rewards

Earn reward dollars to spend on healthy food and everyday health items when you complete certain activities.

SilverSneakers® Fitness Program

- 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.

All benefits are not available on all plans. HMO coverage is offered by Florida Blue Medicare, Inc., DBA Florida Blue Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association. Florida Blue Medicare is an HMO plan with a Medicare contract. Enrollment in Florida Blue Medicare depends on contract renewal. ©2026 Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. All rights reserved. SilverSneakers is a registered trademark of Tivity Health, Inc. ©2026 Tivity Health, Inc. All rights reserved. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. View the Discrimination and Accessibility Notice at floridablue.com/ndnotice, plus information on our free language assistance services. Or call 1-800-926-6565 (TTY: 711). Vea la Notificación de Discriminación y Accesibilidad en floridablue.com/es/ndnotice, además de información sobre nuestros servicios gratuitos de asistencia lingüística. O llame al 1-800-926-6565 (TTY: 711). HealthyBlue Rewards Program (HealthyBlue) restrictions and limitations may apply. Eligible members who opt in to participate in HealthyBlue Rewards must complete the activity and redeem rewards no later than December 31st of the benefit year. Unredeemed rewards will expire by December 31st of the benefit year or if you disenroll from the plan. Participation in HealthyBlue Rewards is voluntary and offered at no additional cost to you. The food, transportation, and OTC Flex allowance is a monthly benefit and any unused amounts do not roll over to the next month. The Florida Blue Medicare C-SNP is available to Medicare members who have at least one of the qualifying chronic conditions. Qualifying conditions include diabetes mellitus, cardiovascular disorders, or chronic heart failure. The healthy food benefit listed is a special supplemental benefit for the chronically ill (SSBCI). Eligibility is based on meeting the CMS definition of a "chronically ill enrollee" and all applicable plan coverage criteria.

2027 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

BlueMedicare Focus (HMO C-SNP) H1035-056

1/1/2027 – 12/31/2027



Our service area includes:

Charlotte, Collier, Lee, Manatee and Sarasota Counties

This is a summary of what our plan covers and what you pay. For a complete list of covered services, limitations and exclusions, you may view the **“Evidence of Coverage”**. For a complete list of the drugs we cover you may view the List of Covered Drugs (**“Formulary”**). The “Evidence of Coverage” and “Formulary” for these plans are on our website, www.floridablue.com/medicare/forms or you can call us for assistance.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You* 2027 handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

To join, you must:

- be entitled to Medicare Part A; and
- be enrolled in Medicare Part B; and
- live in **our service area**; and
- be diagnosed with Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes Mellitus.

Our H1035-056 service area includes the following counties in Florida: Charlotte, Collier, Lee, Manatee, and Sarasota

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, you may pay more for these services.

- You can see our plan's provider and pharmacy directory on our website (<https://providersearch.floridablue.com/>). 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: 711.**
- **If you are not a member of this plan, call us at 1-855-601-9465, TTY: 711.**
 - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
 - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at www.floridablue.com/medicare.

Important Information

Throughout this document you will see the symbols below.

- * Services with this symbol may require approval in advance (a referral) from your Primary Care Doctor (PCP) in order for the plan to cover them.
- ◇ Services with this symbol may require prior authorization from the plan before you receive services.

If you do not get a referral or prior authorization when required, you may have to pay the full cost of the services. Please refer to the "Evidence of Coverage" for more information about services that require a referral and/or prior authorization from the plan.

Monthly Premium, Deductible and Limits

Monthly Plan Premium	\$0 You must continue to pay your Medicare Part B premium.
Part B Premium Buy-Down	BlueMedicare Focus will reduce your monthly Medicare Part B premium by up to \$130
Annual Deductible	\$0 per year for medical services \$700 per year for Part D prescription drugs applies to Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs - There is no deductible for insulins.
Maximum Out-of-Pocket Responsibility (MOOP) (does not include prescription drugs)	\$3,400 - This is the most you pay for Medicare-covered medical services from in-network providers for the year. - Once you reach the maximum out-of-pocket (MOOP), our plan pays 100% of covered medical services. - Premium and prescription drug costs do not count toward your MOOP.

Medical and Hospital Benefits

Inpatient Hospital Coverage ♦ (Covers an unlimited number of days for an inpatient hospital stay)	• \$145 copay per day for days 1-7 • \$0 copay per day for days 8-90
Outpatient Hospital Coverage	• Medicare-covered services♦: \$140 copay per visit • Observation Services: \$150 copay per visit
Ambulatory Surgical Center (ASC) Services	• Surgery services♦: \$115 copay
Doctor Visits	• PCP: \$0 copay • Specialist*: \$15 copay
Preventive Care (Medicare-covered Services)	\$0 copay • Abdominal aortic aneurysm screenings • Alcohol misuse screenings & counseling • Bone mass measurements • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • Cervical & vaginal cancer screenings • Colorectal cancer screenings ◦ Blood-based biomarker tests ◦ Colonoscopies ◦ Computed tomography (CT) colonography ◦ Fecal occult blood tests ◦ Flexible sigmoidoscopies ◦ Multi-target stool DNA tests • Counseling to prevent tobacco use & tobacco-caused disease • Depression screenings • Diabetes screenings • Diabetes self-management training • Glaucoma screenings • Hepatitis B shots • Hepatitis B Virus (HBV) infection screenings • Hepatitis C screening tests

	• HIV screenings • Lung cancer screenings • Mammograms (screening) • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Obesity behavioral therapy • One-time “Welcome to Medicare” preventive visit • Pre-exposure prophylaxis (PrEP) for HIV prevention • Prostate cancer screenings • Sexually transmitted infections screenings & counseling • Shots: ◦ COVID-19 vaccines ◦ Flu shots ◦ Hepatitis B shots ◦ Pneumococcal shots • Yearly “Wellness” visit • Any additional preventive services approved by Medicare during the contract year will be covered
Emergency Care	• \$150 copay Copay is waived if admitted to same hospital within 48 hours of an emergency room visit.
Worldwide Emergency Care (does not include emergency transportation) If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.	• \$150 copay • Worldwide emergency and worldwide urgently needed services have a combined \$25,000 coverage limit. The copay for worldwide emergency care is waived if admitted to the same hospital. • There is no coverage for care outside of the emergency room or emergency hospital admission.

Urgently Needed Services	• Urgent Care Center: \$65 copay • Convenient Care Center: \$65 copay
Worldwide Urgent Care (does not include emergency transportation)	• \$150 copay • Worldwide emergency and worldwide urgently needed services have a combined \$25,000 coverage limit. The copay for worldwide urgently needed services is not waived if admitted to the hospital.
If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.	
Diagnostic Services/ Labs/Imaging *◇	
Tests and Procedures	• Independent Diagnostic Testing Facility (IDTF): \$50 copay • Outpatient Hospital Facility: \$50 copay • Allergy Testing: \$0 copay
Laboratory Services	• Independent Clinical Laboratory: \$0 copay • Outpatient Hospital Facility: \$35 copay
X-Rays	• Physician's Office: \$0 copay • IDTF: \$0 copay • Outpatient Hospital Facility: \$100 copay
Advanced Imaging Services (MRI, MRA, PET, CT scan, Nuclear Medicine Testing)	• Physician's Office: \$75 copay • IDTF: \$100 copay • Outpatient Hospital Facility: \$250 copay

Radiation Therapy

- 20% coinsurance

Hearing Services

Medicare-Covered *

- \$15 copay

Additional Hearing Services

- Routine hearing exam: \$0 copay
- Evaluation and fitting: \$0 copay
- See chart below for copay of each hearing aid for up to 2 hearing aids every year.

Technology Level	Copay Per Hearing Aid Device
Entry	\$350.00 per device
Basic	\$525.00 per device
Prime	\$825.00 per device
Preferred	\$1,125 per device
Advanced	\$1,425.00 per device
Premium	\$1,825.00 per device

Subject to Benefit Maximum. Member is responsible for any amount after the benefit maximum has been applied.

NOTE: Hearing aids must be purchased through our participating provider to receive in-network benefits.

Dental Services♦

Medicare-Covered

- \$15 copay for non-routine dental care (dental services that are covered when medically necessary (e.g., jaw surgery, tooth extraction before radiation, or dental exam prior to kidney transplant).

Additional Dental Services

- **Preventive and Comprehensive Dental:** You receive up to \$2,000 every year to use toward dental services. You can use this allowance for covered dental care such as:
 - Exams, cleanings, fluoride treatment , and X-rays
 - Fillings, crowns, root canals
 - Dentures, extractions and other dental needs.

	• Allowance may NOT be used for implants, orthodontics, or cosmetic related services. • <i>See the Evidence of Coverage for full details, including frequency limits and provider network information.</i>
Vision Services	
Medicare-Covered	• Physician Services*: \$15 copay • Glaucoma Screening: \$0 copay • Diabetic Retinal Exam: \$0 copay • Eyeglasses or Contact Lenses: \$0 copay One pair after cataract surgery
Additional Vision Services (subject to annual maximum benefit allowance)	• Routine Eye Exam: \$0 copay • Lenses, frames or contacts: \$0 copay • Member responsible for any amounts in excess of the \$225 annual maximum plan benefit allowance.
Mental Health Services ♦	
Inpatient Psychiatric Hospital	• \$250 copay per day for days 1-7 • \$0 copay per day for days 8-90 90 days maximum per stay with a lifetime maximum of 190 days
Outpatient Mental Health Therapy	• Individual sessions: \$40 copay • Group sessions: \$30 copay
Skilled Nursing Facility (SNF) ♦	• \$0 copay per day for days 1-20 • \$221 copay per day for days 21-100 (Covers up to 100 days per benefit period)
Physical Therapy *♦	• Physician's Office: \$40 copay • Specialist Office: \$40 copay • Outpatient Rehab Facility: \$40 copay • Outpatient Hospital: \$40 copay
Speech Therapy *♦	• Physician's Office: \$40 copay • Specialist Office: \$40 copay • Outpatient Rehab Facility: \$40 copay • Outpatient Hospital: \$40 copay

Occupational Therapy *◇	• Physician's Office: \$40 copay • Specialist Office: \$40 copay • Outpatient Rehab Facility: \$40 copay • Outpatient Hospital: \$40 copay
Lymphedema Therapy *◇	• \$0 copay for Lymphedema Therapy
Ambulance (one-way trip)	<u>In-Network ◇</u> • Ground: \$330 copay • Facility-to-facility transfers: \$0 copay for transfer via ground ambulance • Air: 20% of the total cost <u>Out-of-Network</u> • Ground: \$330 copay • Facility-to-facility transfers: \$330 copay for transfer via ground ambulance • Air: 20% of the total cost
Transportation	• <u>Not</u> Covered
Medicare Part B Drugs◇	• Allergy Injections: 0% coinsurance • Chemotherapy drugs: Up to 20% coinsurance • Other Part B drugs: Up to 20% coinsurance • Part B Insulin: Up to \$35 copay

Part D Prescription Drug Benefits

Deductible Stage:

- The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of \$700 which applies to Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs. You must pay the full cost of your Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs until you reach the plan's deductible amount. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. For all other drugs, you will not have to pay any deductible. The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.
- Once you have paid \$700 which applies to Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

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.

- In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you have paid a combined total of **\$2,400**, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. You may get your drugs at network retail and mail order pharmacies.

Tier Drug Coverage	Standard Retail/LTC/Mail Order (31-day supply)	Standard Retail/Mail Order (90 to 100-day supply)
Tier 1 - Preferred Generic	\$0 copay	\$0 copay
Tier 2 - Generic	\$0 copay	\$0 copay
Tier 3 - Preferred Brand	19% coinsurance	19% coinsurance
Tier 4 - Non-Preferred Drug	26% coinsurance	26% coinsurance
Tier 5 - Specialty Tier	25% coinsurance	N/A
Tier 6 - Select Care Drugs	\$0 copay	\$0 copay

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the drug tier, even if you haven't paid your deductible.

Catastrophic Coverage Stage:

- You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$2,400** limit for the calendar year. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You will stay in this payment stage until the end of the calendar year.

Additional Information About Drug Coverage

- For a complete list of the drugs we cover see the plan's **"Formulary"** and to see information about the cost of drugs see the plan's **"Evidence of Coverage"**. These documents are on our website, (www.floridablue.com/medicare/forms) or you can call us. If you request a formulary exception, and the plan approves it, you will pay **Tier 4 (Non-Preferred Drug)** cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.
- Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.

Medicare Prescription Payment Plan

- The Medicare Prescription Payment Plan is a payment option to help Medicare beneficiaries spread out their out-of-pocket drug costs across the calendar year (January to December). Participation is voluntary and there is no cost to enroll. You can enroll in the payment plan by speaking with your Agent of Record (AOR) or by calling our dedicated Election support line at 1-800-926-6565 or 1-833-696-2087, (TTY – 711) 8am — 8pm ET Mon – Fri, (voicemails monitored on weekends), 8am — 8pm ET 7 days a week (during Annual Enrollment Period (AEP)).
- For more information about the payment plan, speak with agent or visit our website at <https://www.floridablue.com/medicare/member/prescription-drug-payments>.

Additional Medical Benefits

Podiatry \$25 copay

Medicare-covered

Chiropractic \$20 copay

(manual manipulation of the spine to correct subluxation)

Telehealth *◇

A referral may be needed for certain services.

A Prior Authorization may be required for certain services.

- Urgently Needed Services: \$65 copay
- PCP: \$0 copay
- Occupational Therapy: \$40 copay
- Physical Therapy: \$40 copay
- Speech Therapy: \$40 copay
- Dermatology Services: \$15 copay
- Mental Health Specialty Services: \$40 copay
- Psychiatry Specialty Services: \$40 copay
- Opioid Treatment: \$40 copay
- Substance Use Disorder Services: \$40 copay
- Diabetes Self-Management Training: \$0 copay
- Dietician Services: \$0 copay

Diabetic Supplies Available at Florida Blue Medicare contracted retail or mail-order pharmacies.

Preferred Brands:

- 0% coinsurance Abbott (eg. Freestyle Lite) and Ascensia (Contour®) glucose meters, test strips, and lancets.
- 0% coinsurance Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies (other brands may require prior authorization)

Non-Preferred Brands:

- 20% coinsurance Glucose meters, test strips, lancets, and continuous glucose monitors. All others, such as LifeScan (OneTouch), MiniMed CGM may require prior authorization.

Insulin, alcohol swabs, insulin syringes, and needles for self-administration in the home are covered under Medicare Part D pharmacy benefit, with applicable co-pays and deductibles.

Please note: Medical supplies (e.g. alcohol swabs, gauze, syringes) are not covered under Part D unless used for insulin administration.

Glucose meters and test strips can also be obtained through our participating DME network.

Initial fill of a CGM with an insulin pump can be obtained through our participating DME provider.

Medicare Diabetes Prevention Program (MDPP)

- \$0 copay

Durable Medical Equipment (DME) and Supplies ♦

- Motorized Wheelchairs/Electric Scooters: 20% coinsurance
- All Other DME: 20% coinsurance

Additional Benefits

SilverSneakers® Fitness Program

- You get a basic membership to any SilverSneakers® participating fitness facility. 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.

Over-the-Counter Items, Healthy Food*, and Transportation

A Blue Dollars Benefits MasterCard® Prepaid Card will be mailed to you with a **combined** monthly allowance \$105 to cover your eligible OTC items, healthy food purchases, and transportation costs. Your allowance will reload at the beginning of each month, and any unused funds will expire at the end of each month.

- Over-the-Counter items
- Healthy Food*
- Transportation

*The healthy food benefit is part of a special supplemental program for members with certain chronic conditions. Qualifying chronic conditions include cardiovascular disorders, chronic heart failure, diabetes mellitus.

Eligibility is based on meeting the Centers for Medicare and Medicaid Services' definition of "chronically ill enrollee" and all applicable plan coverage criteria.

**HealthyBlue
Rewards**

- Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars Benefits MasterCard® Prepaid Card for completing and/or reporting certain preventive care and screenings.
- Rewards are available after opting in to the program.

**Blue Dollars
Benefits
MasterCard®
Prepaid Card**

- **Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.**
 - Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan.
 - Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply.
 - The Blue Dollars card will be mailed directly to you and replenished depending on your plan benefits.
 - *See Over-the-Counter Items, Healthy Foods, and Transportation*
-

Disclaimers

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

If you have any questions, please contact our Member Services number at 1-800-926-6565 (TTY users should call 711). Our hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

HMO coverage is offered by Florida Blue Medicare, Inc., DBA Florida Blue Medicare, 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.

The Benefits Mastercard® Prepaid Card, is issued by The Bancorp Bank, N.A., pursuant to license by Mastercard International Incorporated and Card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated. Valid only in the U.S. No cash access. Eligible allowance and rewards amounts cannot be combined. Additional limitations or restrictions may apply. Subscription type services like Walmart+, Instacart, Shipt, Amazon are not eligible.

Participation in HealthyBlue Rewards is voluntary and offered at no additional cost to you.

HealthyBlue Rewards Program (HealthyBlue) restrictions and limitations may apply. Eligible members who opt in to participate in HealthyBlue Rewards must complete the activity and redeem rewards no later than December 31st of the benefit year. Unredeemed rewards will expire by December 31st of the benefit year or if you disenroll from the plan. If you need help with your HealthyBlue Rewards account or for full details on current program rules, visit FloridaBlue.com/HealthyBlue or call 1-800-926-6565 (TTY: 711).

The Florida Blue Medicare Chronic Condition Special Needs Plan (C-SNP) is available to Medicare members who have at least one of the qualifying chronic conditions. Qualifying conditions include diabetes mellitus, certain cardiovascular disorders, and chronic heart failure. The healthy food benefit listed is a special supplemental benefit for the chronically ill (SSBCI). Eligibility is based on meeting the CMS definition of a "chronically ill enrollee" and all applicable plan coverage criteria.

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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, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Postal Employee Program (PEP): 1-844-960-2583
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

Health and vision coverage (including FEP and PEP 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@bcbsfl.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 or Civil Rights 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>, or 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 www.hhs.gov/ocr/office/file/index.html

Visit www.floridablue.com/disclaimer/ndnotice to view an electronic version of this notice.
87768 0825R

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-800-352-2583, a FEP al 1-800-333-2227, a Medicare al 1-800-926-6565, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòm ki disponib gratis. Rele nan 1-800-352-2583, FEP 1-800-333-2227, oswa rele Medicare nan 1-800-926-6565 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-800-352-2583 联邦雇员计划(FEP)1-800-333-2227 医疗保险 (Medicare)1-800-926-6565 听障专线 (TTY)711。

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-800-352-2583, le FEP au 1-800-333-2227, le Medicare au 1-800-926-6565 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على

1-800-352-2583 برنامج FEP: 1-800-333-2227 برنامج Medicare: 1-800-926-6565 (لذوي الإعاقة السمعية) TTY: 711)

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-800-352-2583, FEP: 1-800-333-2227, Medicare: 1-800-926-6565, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-800-352-2583, FEP 1-800-333-2227, 메디케어 1-800-926-6565, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે.

1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711) પર કોલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-800-352-2583、FEP 1-800-333-2227、メディケア 1-800-926-6565 (TTY 711) までお電話ください。

خدمات رایگان زبانی، کمک‌های جانبی، و قالب‌های جایگزین در دسترس هستند. با شماره 1-800-352-2583 تماس بگیرید. برای FEP 2227-333-800-1 و برای Medicare 6565-926-800-1 با (TTY: 711) تماس بگیرید.

T'áá free yíníłta'go saad bee áká anilyeedígíí, atk'ida'ánígíí, dóó t'áá ajitii hane' bee áká anilyeedígíí t'éiyá éí hołne'. 1-800-352-2583 bich'í' náhodoonih, FEP bich'í' 1-800-333-2227 bich'í' náhodoonih, Medicare bich'í' 1-800-926-6565 bich'í' náhodoonih, (TTY 711).

Enrollment Forms



Steps that will walk you through
the process and **all the forms**
you need to enroll in your plan

Ready to sign up?

Have your Medicare ID card handy, and let's get started!

Choose the way to enroll that's best for you.



Paper: Use the paper enrollment form provided. Once you are done filling it out, you can mail the form to Florida Blue. (One form must be filled out for each person who enrolls.)



Online: Use the online form at **floridablue.com/medicare**. You'll be guided through the process of completing and submitting the enrollment form and the system will prompt you if you left anything missing or incomplete.



Licensed Sales Agent: An agent can help you choose the best plan for YOU and can also offer you help in filling out and submitting the enrollment form. The agent will be employed by or contracted with Florida Blue and may be paid based on your enrollment in a plan.

- Visit your local Florida Blue Center or agent; or
- Call and speak with one of our agents at **1-855-217-4362** (TTY: 711).

Helpful tips for filling out your enrollment form.

- ✓ No matter which way you choose to enroll, make sure you don't skip any sections. If you leave out information, it may delay your start date.
- ✓ When choosing a plan, select only ONE plan name.
- ✓ Where requested, be sure to fill in the Part A and Part B effective dates from your Medicare ID card.
- ✓ If you choose an HMO plan, write in your choice for a primary care physician (PCP). If you do not write in your choice for a PCP, one will be assigned to you.
- ✓ If you are not signing up between October 15 and December 7, be sure to complete the "Attestation of Eligibility for an Enrollment Period" section.

Forms Used for Enrollment

Pre-Enrollment Checklist

This form provides important information you need to know before purchasing a plan.

Individual Enrollment Form

This is the form you complete to enroll in a Florida Blue Medicare Advantage plan. There may be more than one version of the enrollment form included. Look for the version that includes the name of the plan you chose.

Protected Health Information Authorization for Customer Service Inquiries

Complete this form if you need to give us permission to release your health information to someone. Send the original, not a photocopy, with your enrollment form. Otherwise, we will protect this information and release it only to you.

Scope of Sales Appointment (SOA) Confirmation Form

According to Medicare guidelines, agents can talk to you only about products you choose to discuss. Medicare asks you to complete an SOA form that shows which Medicare Advantage and/or Medicare Prescription Drug plans you wish to discuss. The form is intended to protect you. Completing the form does not mean you have enrolled in a plan. Your agent can complete this form with you by phone instead of using a paper copy.

Enrollment Verification Checklist

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

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-601-9465 (TTY: 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **floridablue.com/medicare** or call 1-855-601-9465 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctors) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select new doctors.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Except in emergency or urgent situations, we do not cover services provided by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

You must complete all items unless they are indicated as optional. You can't be denied coverage for not including information that is marked as optional.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Florida Blue Medicare
P.O. Box 45296
Jacksonville, FL 32232-5296

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call BlueMedicare Focus at 1-800-966-4092. TTY users can call 1-800-955-8770.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a BlueMedicare Focus al 1-800-966-4092/1-877-955-8773 (TTY) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Individual Enrollment Form

- BlueMedicare **Focus** (HMO C-SNP) \$0 per month

By providing a telephone number(s), you confirm that you are the subscriber and/or authorized user of the phone numbers, provided and you consent to receive calls and text messages at those number(s) from, and on behalf of, Blue Cross and Blue Shield of Florida, Inc., Florida Blue Medicare, Inc., and their affiliates, including calls and texts using an automated telephone dialing system, prerecorded or artificial voice messages, or both. The types of calls and texts you consent to receive include messages about your plan and benefits, messages about servicing your account, and healthcare-related and informational messages that are not for marketing purposes. You may revoke your consent at any time. Message and data rates may apply. Message frequency varies. Major carriers supported. Our Terms of Use and Privacy Policy also apply and are available online at floridablue.com.

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

Medicare Number:	Part A Effective Date:	Part B Effective Date:
	M M D D Y Y Y Y	M M D D Y Y Y Y

Accessible Format (Select One): ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please read and answer these important questions (Questions 2–5 are optional):

1. Will you have other **prescription** drug coverage (like VA, TRICARE) in addition to BlueMedicare Focus? ☐ Yes ☐ No

Name of other coverage:

ID # for this coverage:

Group # for this coverage:

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

Name of Institution:

Phone Number: (

Address (number and street):

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

Medicaid number:

4. Do you or your spouse work? ☐ Yes ☐ No

5. Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Paying Your Plan Premiums

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

- Get a bill

- ☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a VOIDED check or provide the account information below. Your email is required for this option and will be used for EFT notifications only.

Account holder name:

Bank routing number:

Bank account number:

Account type: ☒ Checking ☐ Savings

E-mail:

- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check

I get monthly benefits from: ☐ Social Security ☐ RRB

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

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay BlueMedicare Focus the Part D-IRMAA.

Attestation of Eligibility for an Enrollment Period

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

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

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):
- ☐ I recently was released from incarceration. I was released on (insert date):
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date):
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date):
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):
- ☐ I recently left a PACE program on (insert date):
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):
- ☐ I am leaving employer or union coverage on (insert date):
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I was enrolled in a plan that is experiencing financial difficulties to such an extent that a State or territorial regulatory authority has placed the organization in receivership.
- ☐ I was enrolled in a plan identified with the low performing icon (LPI).

If none of these statements applies to you or you're not sure, please contact BlueMedicare Focus at 1-800-966-4092 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. Our hours are 8 a.m. to 8 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Please Read and Sign Below. By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueMedicare Focus.
- I understand that my response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).

- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my BlueMedicare Focus coverage begins, I must get all of my medical and prescription drug benefits from BlueMedicare Focus. Benefits and services provided by BlueMedicare Focus and contained in my BlueMedicare Focus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueMedicare Focus will pay for benefits or services that are not covered.
- BlueMedicare Focus serves a specific service area. If I move out of the area that BlueMedicare Focus serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
- Release of Information: By joining this Medicare health plan, I acknowledge that BlueMedicare Focus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that BlueMedicare Focus will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

- I understand that my signature (or the signature of the person legally authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that

- 1) This person is authorized under State law to complete this enrollment, and
- 2) Documentation of this authority is available upon request from Medicare.

Signature: _____

Today's Date:

M	M	D	D	Y	Y	Y	Y
---	---	---	---	---	---	---	---

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ **Relationship to Enrollee:** _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. We will send you a verification message after you enroll. Once verified, we will send you important information about your plan and other information, including how to set-up your on-line account and how to opt-in to paperless communications.

These communications may contain Protected Health Information (PHI) that is protected by applicable law and by providing your email address you agree and understand that communications may be unencrypted, and you agree to accept the risk that unencrypted electronic communications may be intercepted and/or read by a third party. You agree that you are solely responsible for the accuracy, privacy, and security of the email addresses provided. You also agree to the Privacy Policy and Platform Terms of Use found at <https://www.floridablue.com/disclaimer/privacy> and <https://www.floridablue.com/disclaimer/terms>.

E-mail: |

Medicare Prescription Payment Plan Participation (Completion of this section is optional.)

☐ Yes, I would like to participate in the Medicare Prescription Payment Plan.

- I understand this section is a request to participate in the Medicare Prescription Payment Plan. BlueMedicare Focus will contact me if they need more information.
- I understand that signing below means I have read and understand this section and the “Terms and Conditions” below.
- BlueMedicare Focus will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active. Until then, I understand that I’m not a participant in the Medicare Prescription Payment Plan.

Signature:

Today's Date:

M	M		D	D		Y	Y	Y	Y
---	---	--	---	---	--	---	---	---	---

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

Name: _____

Address:

Phone Number: () – Relationship to Enrollee:

Terms and Conditions

- The program is free to join, there are no fees or interest charged under the program, and the program does not lower the amount of cost-sharing you owe for your Part D prescriptions.
- If you qualify for Low Income Subsidy (LIS), enrollment in LIS is more advantageous than participation in the Medicare Prescription Payment Plan.
- You may opt out of the program at any time. If you opt out, you will still be responsible for paying any remaining balance.
- It is important to pay your bill monthly. Your participation in the Medicare Prescription Payment Plan will be terminated if you fail to pay your monthly billed amount before the end of the grace period.
- If you are disenrolled voluntarily or involuntarily from our Part D plan you will also be terminated from the Medicare Prescription Payment Plan. If you enroll in a different plan, you may opt into the Medicare Prescription Payment Plan under your new plan.
- We cannot require you to answer questions about or provide documentation to prove your ability to pay your Medicare Prescription Payment Plan balance as a condition of you participating in the Medicare Prescription Payment Plan. We also cannot obtain a copy of your credit report from a consumer reporting agency.
- The Part D appeals and grievance procedures will apply to the Medicare Prescription Payment Plan and are located in the Evidence of Coverage.

Office Use Only:

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

<<AgentName>>

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____

AEP: _____

SEP (type): _____

Not Eligible: _____

PCP First Name: _____

PCP Last Name: _____

PCP's FL Blue Provider ID Number

|_|_|_|_|_|_|_| (ie: 12345 or 12345A)

PCP's 10-digit National Provider ID (NPI) Number:

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Is enrollee currently a patient of this PCP?

☐ Yes ☐ No

Entity Name: _____

Five digit Entity ID number (if known):

|_|_|_|_|_|

Date Received by Agent: _____

Florida Blue Agent ID #: <<AgentID>>

Agent State License #: _____

Agent Confirmation #: _____

List Bill Entity: ☐ Yes ☐ No

Physician Group Name: _____

Physician Group's FL Blue Provider ID Number

|_|_|_|_|_|_|_|_| (ie: 12345 or 12345A)

Physician Group's 10-digit National Provider ID (NPI)

Number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Is enrollee currently a patient of this Physician Group?

☐ Yes ☐ No

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

You must complete all items unless they are indicated as optional. You can't be denied coverage for not including information that is marked as optional.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Florida Blue Medicare
P.O. Box 45296
Jacksonville, FL 32232-5296

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call BlueMedicare Focus at 1-800-966-4092. TTY users can call 1-800-955-8770.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a BlueMedicare Focus al 1-800-966-4092/1-877-955-8773 (TTY) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

This page intentionally left blank

Individual Enrollment Form

- BlueMedicare **Focus** (HMO C-SNP) \$0 per month

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date:	Sex:	Home Phone Number:	Mobile Phone Number:
M M D D Y Y Y Y	☐ M ☐ F	()	()

City:	County:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:
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Please take out your red, white and blue Medicare card to complete this section.

Medicare Number:

Part A Effective Date:

Part B Effective Date:

Language: ☐ Spanish

Accessible Format (Select One): ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Y0011 FBM2831 2026 C

Please read and answer these important questions (Questions 2–5 are optional):

1. Will you have other **prescription** drug coverage (like VA, TRICARE) in addition to BlueMedicare Focus? ☐ Yes ☐ No

Name of other coverage:

ID # for this coverage:

Group # for this coverage:

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

Name of Institution:

Phone Number: (

Address (number and street):

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

Medicaid number:

4. Do you or your spouse work? ☐ Yes ☐ No

5. Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Paying Your Plan Premiums

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

- Get a bill

- ☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a VOIDED check or provide the account information below. Your email is required for this option and will be used for EFT notifications only.

Account holder name:

Bank routing number:

Bank account number:

Account type: ☐ Checking ☐ Savings

E-mail:

- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check

I get monthly benefits from: ☐ Social Security ☐ RRB

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

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay BlueMedicare Focus the Part D-IRMAA.

Attestation of Eligibility for an Enrollment Period

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

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

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):
- ☐ I recently was released from incarceration. I was released on (insert date):
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date):
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date):
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):
- ☐ I recently left a PACE program on (insert date):
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):
- ☐ I am leaving employer or union coverage on (insert date):
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I was enrolled in a plan that is experiencing financial difficulties to such an extent that a State or territorial regulatory authority has placed the organization in receivership.
- ☐ I was enrolled in a plan identified with the low performing icon (LPI).

If none of these statements applies to you or you're not sure, please contact BlueMedicare Focus at 1-800-966-4092 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. Our hours are 8 a.m. to 8 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Please Read and Sign Below. By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueMedicare Focus.
- I understand that my response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).

- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my BlueMedicare Focus coverage begins, I must get all of my medical and prescription drug benefits from BlueMedicare Focus. Benefits and services provided by BlueMedicare Focus and contained in my BlueMedicare Focus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueMedicare Focus will pay for benefits or services that are not covered.
- BlueMedicare Focus serves a specific service area. If I move out of the area that BlueMedicare Focus serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
- Release of Information: By joining this Medicare health plan, I acknowledge that BlueMedicare Focus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that BlueMedicare Focus will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

- I understand that my signature (or the signature of the person legally authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that

- 1) This person is authorized under State law to complete this enrollment, and
- 2) Documentation of this authority is available upon request from Medicare.

Signature: _____

Today's Date:

M	M	D	D	Y	Y	Y	Y
---	---	---	---	---	---	---	---

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ **Relationship to Enrollee:** _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. We will send you a verification message after you enroll. Once verified, we will send you important information about your plan and other information, including how to set-up your on-line account and how to opt-in to paperless communications.

These communications may contain Protected Health Information (PHI) that is protected by applicable law and by providing your email address you agree and understand that communications may be unencrypted, and you agree to accept the risk that unencrypted electronic communications may be intercepted and/or read by a third party. You agree that you are solely responsible for the accuracy, privacy, and security of the email addresses provided. You also agree to the Privacy Policy and Platform Terms of Use found at <https://www.floridablue.com/disclaimer/privacy> and <https://www.floridablue.com/disclaimer/terms>.

E-mail: |

Medicare Prescription Payment Plan Participation (Completion of this section is optional.)

☐ Yes, I would like to participate in the Medicare Prescription Payment Plan.

- I understand this section is a request to participate in the Medicare Prescription Payment Plan. BlueMedicare Focus will contact me if they need more information.
- I understand that signing below means I have read and understand this section and the “Terms and Conditions” below.
- BlueMedicare Focus will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active. Until then, I understand that I’m not a participant in the Medicare Prescription Payment Plan.

Signature:

Today's Date:

M	M		D	D		Y	Y	Y	Y
---	---	--	---	---	--	---	---	---	---

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

Name: _____

Address:

Phone Number: () – Relationship to Enrollee:

Terms and Conditions

- The program is free to join, there are no fees or interest charged under the program, and the program does not lower the amount of cost-sharing you owe for your Part D prescriptions.
- If you qualify for Low Income Subsidy (LIS), enrollment in LIS is more advantageous than participation in the Medicare Prescription Payment Plan.
- You may opt out of the program at any time. If you opt out, you will still be responsible for paying any remaining balance.
- It is important to pay your bill monthly. Your participation in the Medicare Prescription Payment Plan will be terminated if you fail to pay your monthly billed amount before the end of the grace period.
- If you are disenrolled voluntarily or involuntarily from our Part D plan you will also be terminated from the Medicare Prescription Payment Plan. If you enroll in a different plan, you may opt into the Medicare Prescription Payment Plan under your new plan.
- We cannot require you to answer questions about or provide documentation to prove your ability to pay your Medicare Prescription Payment Plan balance as a condition of you participating in the Medicare Prescription Payment Plan. We also cannot obtain a copy of your credit report from a consumer reporting agency.
- The Part D appeals and grievance procedures will apply to the Medicare Prescription Payment Plan and are located in the Evidence of Coverage.

Office Use Only:

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

<<AgentName>>

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____

AEP: _____

SEP (type): _____

Not Eligible: _____

PCP First Name: _____

PCP Last Name: _____

PCP's FL Blue Provider ID Number

|_|_|_|_|_|_|_| (ie: 12345 or 12345A)

PCP's 10-digit National Provider ID (NPI) Number:

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Is enrollee currently a patient of this PCP?

☐ Yes ☐ No

Entity Name: _____

Five digit Entity ID number (if known):

|_|_|_|_|_|

Date Received by Agent: _____

Florida Blue Agent ID #: <<AgentID>>

Agent State License #: _____

Agent Confirmation #: _____

List Bill Entity: ☐ Yes ☐ No

Physician Group Name: _____

Physician Group's FL Blue Provider ID Number

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| (ie: 12345 or 12345A)

Physician Group's 10-digit National Provider ID (NPI)

Number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Is enrollee currently a patient of this Physician Group?

☐ Yes ☐ No

Protected Health Information Authorization for Customer Service Inquiries

Purpose

I am the member listed in Section I.

This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc., and Florida Blue Medicare, Inc. (together, "Florida Blue") to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

*Please complete this entire form
and return to:*

**Florida Blue
Access Authorization Unit
P.O. Box 45296
Jacksonville, FL 32232**

Section I

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

Member Name: _____

Member Number: _____

Group Number: _____ Date of Birth: _____

Section II

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

- Identifying information (e.g., name, address, age, gender);
- Health care coverage information (i.e., general & plan-specific benefit information);
- Past, present and future claims information (except for any period of time during which a Confidential Communication address¹ was in effect); and
- Coordination of Benefit Information.

Section III

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

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

Please Print:

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Section IV

By law, this authorization must indicate that persons other than Florida Blue receiving member's Protected Health Information may not have to obey federal health information privacy laws and member's Protected Health Information may be further released by those persons.

Protected Health Information Authorization for Customer Service Inquiries

(continued)

I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, Florida Blue will have no further liability as to the further release of my Protected Health Information by those designated persons.

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

Section V

This authorization will expire:

_____/_____/_____
Month Day Year

OR

The date member's Florida Blue health coverage ends

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

Section VI

Copy of Authorization

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

Section VII

Right to Withdraw Authorization

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

Section VIII

Signature

Member Signature: _____

Date: _____

If a legal representative signs this authorization form on behalf of the member, please complete the following information:

Legal Representative's Name²: _____

Date Signed: _____

Relationship to the member: _____

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

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

Health insurance is offered by Blue Cross and Blue Shield of Florida, D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO and Florida Blue Medicare, Inc, HMO subsidiaries of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.

Protected Health Information Authorization for Customer Service Inquiries

Purpose

I am the member listed in Section I.

This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc., and Florida Blue Medicare, Inc. (together, "Florida Blue") to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

Please complete this entire form and return to:

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P.O. Box 45296
Jacksonville, FL 32232**

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Member Number: _____

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

- Identifying information (e.g., name, address, age, gender);
- Health care coverage information (i.e., general & plan-specific benefit information);
- Past, present and future claims information (except for any period of time during which a Confidential Communication address¹ was in effect); and
- Coordination of Benefit Information.

Section III

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

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

Please Print:

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Section IV

By law, this authorization must indicate that persons other than Florida Blue receiving member's Protected Health Information may not have to obey federal health information privacy laws and member's Protected Health Information may be further released by those persons.

Protected Health Information Authorization for Customer Service Inquiries

(continued)

I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, Florida Blue will have no further liability as to the further release of my Protected Health Information by those designated persons.

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

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_____/_____/_____
Month Day Year

OR

The date member's Florida Blue health coverage ends

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

Section VI

Copy of Authorization

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

Section VII

Right to Withdraw Authorization

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

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Signature

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If a legal representative signs this authorization form on behalf of the member, please complete the following information:

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Date Signed: _____

Relationship to the member: _____

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

Health insurance is offered by Blue Cross and Blue Shield of Florida, D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO and Florida Blue Medicare, Inc, HMO subsidiaries of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

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

_____	☐	Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.		
_____	☐	Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).		
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.		
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.		
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.		
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.		
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.		

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

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

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

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

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
Plan Use Only:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	

Scope of Appointment documentation is subject to CMS record retention requirements

Health coverage is offered by Blue Cross and Blue Shield of Florida, DBA Florida Blue. HMO coverage is offered by Florida Blue Medicare Inc., which is an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent licensees of the Blue Cross and Blue Shield Association.

Agent, if the form was signed by the beneficiary at time of appointment, provide written explanation below why SOA was not documented prior to meeting:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

This page intentionally left blank

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

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

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Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.		
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.		

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

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

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

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

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
Plan Use Only:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	

Scope of Appointment documentation is subject to CMS record retention requirements

Health coverage is offered by Blue Cross and Blue Shield of Florida, DBA Florida Blue. HMO coverage is offered by Florida Blue Medicare Inc., which is an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent licensees of the Blue Cross and Blue Shield Association.

Agent, if the form was signed by the beneficiary at time of appointment, provide written explanation below why SOA was not documented prior to meeting:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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Enrollment Checklist

Applicant's Last Name: _____ Applicant's First Name: _____

Florida Blue is required by Medicare to contact you within 15 days of receiving your enrollment application. Within the next 15 days you will receive a letter from Florida Blue to verify that the Medicare Advantage or Part D Prescription Drug plan was fully explained. This will not affect your ability to enroll in the plan.

Your sales agent will review the following questions with you to verify that the Medicare Advantage or Part D Prescription Drug plan was fully explained. Check Yes or No as appropriate.

For Medicare Advantage plans

Yes ☐	No ☐	Do you understand that you have applied for a Medicare Advantage plan? This plan is not a Medicare Supplement "Medigap" plan. This plan replaces Original Medicare.
Yes ☐	No ☐	Do you understand that to enroll you must be "entitled" to Part A and enrolled in Part B?
Yes ☐	No ☐	Do you understand you must continue to pay your Medicare Part B premium (unless it is paid for you by Medicaid or another third party)?

For Part D Prescription Drug plans

Yes ☐	No ☐	Did the sales agent fully explain the prescription deductible associated with the plan (if applicable), and the amount?
Yes ☐	No ☐	Do you understand you have applied for a Part D Prescription Drug plan?
Yes ☐	No ☐	Do you understand to enroll you must have Medicare Part A and/or Part B?

For All plans

Yes ☐	No ☐	Did the sales agent fully explain your premium, benefits, copays, and coinsurance amounts?
Yes ☐	No ☐	Did the sales agent show you the Summary of Benefits and give you a copy?
Yes ☐	No ☐	Did the sales agent give you their contact information? (name, phone or business card)
Yes ☐	No ☐	Do you understand if you enroll in a Medicare Advantage plan and later decide to make a change, under most circumstances you are able to do so during the Annual Enrollment Period, October 15 -December 7 each year?

For Any plan that covers Prescription Drugs

Yes ☐	No ☐	Did the sales agent explain the plan's drug list (also referred to as a formulary) and drug tiers?
Yes ☐	No ☐	Do you understand that in most cases you must use a pharmacy in our drug plan network?
Yes ☐	No ☐	Did the sales agent confirm that your prescription drugs are covered under the plan's drug list?
Yes ☐	No ☐	Did the agent discuss the Medicare Prescription Payment Plan (M3P), a no cost, voluntary program that's intended to help spread out high-cost medications throughout the calendar year, and explained the billing process?

Drug Name

Covered

Tier

Cost

B vs. D*

PA

Qty Limits Step Therapy

	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						

**Some drugs may be covered under Medicare Part B or Part D. To determine coverage under the appropriate Medicare benefit, your doctor is required to submit a Medicare Part B vs. D coverage determination form to Florida Blue to obtain prior approval for these medications before the prescription is filled.*

Only for HMO & PPO plans

Yes ☐	No ☐	Did the sales agent fully explain the medical deductible associated with the plan, (if applicable), and the amount?
Yes ☐	No ☐	Do you understand that you must use in-network health care providers to get the in-network benefits, copays and coinsurances?
Yes ☐	No ☐	Do you understand that if you use out-of-network health care providers you will likely pay higher out-of-pocket costs? (Note: HMO members are not covered out-of-network, except in emergencies, urgent care and out-of-area dialysis.)
Yes ☐	No ☐	Did the sales agent confirm that your doctor(s) is(are) in-network for the plan that you selected?

Provider's Name

Par/Non-Par

Provider's Complete Address

Acknowledgement

My agent and I have reviewed all my doctor(s), hospital(s) and prescription drug(s) that I have provided today. We have discussed each provider's participating status within my plan as well as my cost share and any requirements or limits regarding my prescription drug(s). I understand that some network providers may be added or removed from the network at any time. For any additional providers or to get the most up-to-date information about my plan's network providers for my area or my prescription drugs, I will visit floridablue.com/medicare or call the Member Services Department at 1-800-926-6565, 8 a.m. – 8 p.m. local time, seven days a week from October 1 - March 31, except for Thanksgiving and Christmas. From April 1 - September 30, we are open Monday - Friday, 8 a.m. - 8 p.m. local time except for major holidays. (TTY: 711)

Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____

Florida Blue is a PPO and Rx (PDP) Plan with a Medicare contract. Florida Blue Medicare is an HMO Plan with a Medicare contract. Enrollment in Florida Blue or Florida Blue Medicare depends on contract renewal.

PPO and Rx (PDP) coverage is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Florida Blue Medicare, Inc., DBA Florida Blue Medicare. These companies are independent licensees of the Blue Cross and Blue Shield Association.

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For Part D Prescription Drug plans

Yes ☐	No ☐	Did the sales agent fully explain the prescription deductible associated with the plan (if applicable), and the amount?
Yes ☐	No ☐	Do you understand you have applied for a Part D Prescription Drug plan?
Yes ☐	No ☐	Do you understand to enroll you must have Medicare Part A and/or Part B?

For All plans

Yes ☐	No ☐	Did the sales agent fully explain your premium, benefits, copays, and coinsurance amounts?
Yes ☐	No ☐	Did the sales agent show you the Summary of Benefits and give you a copy?
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Drug Name

Covered

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Cost

B vs. D*

PA

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	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						
	Yes ☐	No ☐						

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What's Next?



Information on what happens
after you enroll in your plan
and what to expect

How to make the most of your Medicare Dollars



Stay In-Network

Be sure to select a doctor in your network. Except for emergency care, urgent care and dialysis services, you must go to in-network doctors to be covered. This is true even when the care you receive is medically necessary. Avoid unpredictable costs and have peace of mind by staying in your network.

How to find out which doctors, hospitals and pharmacies are in your plan's network:

There are a few ways to find out which doctors, hospital and pharmacies are in a plan's network. You can ask your agent for help, call Customer Service (see contact information on the Welcome page), or you can visit **floridablue.com/medicare** and follow these steps:



Click on
**Member
Resources**

Select
Find a Doctor



Enter the name
of the **doctor,
hospital or
pharmacy**
you're looking for



Use a Participating Pharmacy

Some of our participating chain pharmacies include:





Choose Generic or Lower-Tier Drugs

Reduce the amount you pay at the pharmacy by choosing generic or lower-tier drugs. New generic drugs become available nearly every day. Most generics, and many drugs in lower-cost tiers, work just as well as the brand or drugs in a higher-cost tier. Check with your doctor and discuss what options are best for you.

How to find out which drugs are covered:

You can find all covered drugs in the formulary, the list of drugs that your plan covers. It's also called a drug list or medication guide. To see our formulary, visit floridablue.com/medicare.

Click
on *Member*
Resources

Select
Find a Form

Choose
the formulary
for your plan in
the list



Choosing Your Primary Care Doctor Is Important

As a new member, one of your first—and most important—decisions is choosing a primary care doctor (PCP). Your PCP manages your overall health and coordinates specialized care and most covered services. Your PCP and any specialists you see work together as a team of professionals focused on you.

Provider and pharmacy networks can change at any time. You will receive notice when necessary.

What you can expect in the first 90 days

During your first 90 days of enrollment, you can get up and running quickly. Here are some things to look for.

To assure you that your application has been received and accepted, you will receive:

- ✓ Notification of Receipt of Application
- ✓ Notice That You Have Been Enrolled

You'll receive several items to keep all year:

- ✓ **BlueMedicare member ID card**
- ✓ **Information** on how to use your plan and locate plan documents

You may also receive a welcome call from Florida Blue to help you get more from your plan.

Throughout the year, we'll stay in touch. You'll receive:

- ✓ **Explanations of Benefits** to keep you up to date on any services and supplies you may have received during the previous month
- ✓ **Quarterly Newsletters** with health tips and advice on getting more from your plan
- ✓ **Calls from our Care Team** from time to time to help you stay on top of your health needs
- ✓ **Surveys** to let us know how we're doing



Want less mail?

Sign up for a secure member account at floridablue.com/medicare. You'll need your Florida Blue Medicare ID card to get started. Access your plan documents, check your out-of-pocket spending, and do more with your secure member account.

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Florida Blue HMO - H1035

For 2026, Florida Blue HMO - H1035 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★

Health Services Rating: ★★★★★

Drug Services Rating: ★★★★★



Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Florida Blue HMO 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 855-601-9465 (toll-free) or 800-955-8770 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time. Current members please call 800-926-6565 (toll-free) or 800-955-8770 (TTY).

The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

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Notes

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