

BlueMedicare Value (PPO) offered by Florida Blue

Annual Notice of Change for 2027

You're enrolled as a member of BlueMedicare Value (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in BlueMedicare Value (PPO).
- To change to a **different plan**, visit [Medicare.gov](https://www.Medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.floridablue.com/medicare/forms or call Member Services at 1-800-926-6565 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-800-926-6565 (TTY users call 711) for more information. 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. This call is free.
- This information is available in an alternate format, including large print, audio and braille. Please call Member Services at the number listed above if you need plan information in another format.

About BlueMedicare Value (PPO)

- Florida Blue is a PPO plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.
- When this material says "we," "us," or "our," it means Florida Blue. When it says "plan" or "our plan," it means BlueMedicare Value (PPO).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in BlueMedicare Value (PPO).** Starting January 1, 2027, you'll get your medical and drug coverage through BlueMedicare Value (PPO). Go to Section 2 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	\$0	\$0
Deductible	<u>In-Network</u> \$0 <u>Out-of-Network</u> \$950 for Medicare-covered services received out-of-network.	<u>In-Network</u> \$0 <u>Out-of-Network</u> \$0 for Medicare-covered services received out-of-network.
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$6,750 From network and out-of-network providers combined: \$10,100	From network providers: \$5,900 From network and out-of-network providers combined: \$10,100
Primary care office visits	<u>In-Network</u> \$0 copay per visit <u>Out-of-Network</u> Primary care visits: 50% of the total cost after you reach your \$950 out-of-network deductible	<u>In-Network</u> \$0 copay per visit <u>Out-of-Network</u> Primary care visits: 50% of the total cost
Specialist office visits	<u>In-Network</u> \$60 copay per visit <u>Out-of-Network</u> 50% of the total cost per visit after you reach your \$950 out-of-network deductible	<u>In-Network</u> \$50 copay per visit <u>Out-of-Network</u> 50% of the total cost

	2026 (this year)	2027 (next year)
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	<u>In-Network</u> \$385 copay per day for days 1 - 7 \$0 copay per day for days 8 - 90 <u>Out-of-Network</u> 50% of the total cost per visit after you reach your \$950 out-of-network deductible.	<u>In-Network</u> \$385 copay per day for days 1-7 \$0 copay per day for days 8 - 90 <u>Out-of-Network</u> 50% of the total cost per visit

	2026 (this year)	2027 (next year)
Part D drug coverage (Go to Section 1.7 for details including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible \$615 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) except for covered insulin products and most adult Part D vaccines.	Part D drug coverage deductible \$597 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) except for covered insulin products and most adult Part D vaccines.
	Copay/Coinsurance during the Initial Coverage Stage:	Copay/Coinsurance during the Initial Coverage Stage:
	Drug Tier 1: \$0	Drug Tier 1: \$0
	Drug Tier 2: \$0	Drug Tier 2: \$0
	Drug Tier 3: 21%	Drug Tier 3: 19%
	You pay no more than \$35 per month supply of each covered insulin product on this tier	You pay no more than \$35 per month supply of each covered insulin product on this tier
	Drug Tier 4: 30%	Drug Tier 4: 28%
	You pay no more than \$35 per month supply of each covered insulin product on this tier	You pay no more than \$35 per month supply of each covered insulin product on this tier

	2026 (this year)	2027 (next year)
	Drug Tier 5: 25% You pay no more than \$35 per month supply of each covered insulin product on this tier Drug Tier 6: \$0 Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	Drug Tier 5: 27% You pay no more than \$35 per month supply of each covered insulin product on this tier Drug Tier 6: \$0 Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1

Changes to Benefits & Costs for Next Year

Section 1.1 – Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium	\$0	\$0
(You must also continue to pay your Medicare Part B premium.)		<i>There is no change for the upcoming year</i>

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

Cost	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount	\$6,750	\$5,900
Your costs for covered medical services (such as copayments) from network providers count toward your in-network maximum out-of-pocket amount.		Once you've paid \$5,900 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2026 (this year)	2027 (next year)
Your costs for prescription drugs don't count toward your maximum out-of-pocket amount.		
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	\$10,100	\$10,100 Once you've paid \$10,100 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory* <https://providersearch.floridablue.com/> to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at <https://providersearch.floridablue.com/>.
- Call Member Services at 1-800-926-6565 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-926-6565 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* <https://providersearch.floridablue.com/> to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at <https://providersearch.floridablue.com/>.
- Call Member Services at 1-800-926-6565 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-926-6565 (TTY users call 711) for help.

Section 1.5 – Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Acupuncture	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Advanced Imaging Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Allergy Testing (Office)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost

	2026 (this year)	2027 (next year)
Ambulance	<u>In-Network</u> You pay a \$0 copay for facility-to-facility transfer via ground ambulance	<u>In-Network</u> You pay a \$330 copay for facility-to-facility transfer via ground ambulance
Ambulatory Surgical Center (ASC)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Blood Services (3 pint deductible waived)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Cardiac rehabilitation services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Chiropractic Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Diabetic Monitors	<u>In-Network</u> You pay a \$0 copay for diabetic monitors Preferred Brands - Abbott (FreeStyle Lite), Ascencia (Contour) You pay a \$0 copay for Non-Preferred Brands - All	<u>In-Network</u> You pay 0% coinsurance for diabetic monitors Preferred Brands - Abbott (FreeStyle Lite), Ascencia (Contour) and Continuous Glucose Monitors (CGMs) Freestyle Libre and Dexcom You pay 20% coinsurance for Non-Preferred Brands - All

	2026 (this year)	2027 (next year)
	others including LifeScan (OneTouch) <u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	others such as LifeScan (OneTouch) and MiniMed CGM <u>Out-of-Network</u> You pay 50% of the total cost
Diabetic Retinal Exam	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Diabetic Supplies and Diabetic Therapeutic Shoes and Inserts	<u>In-Network</u> You pay a \$0 copay for diabetic supplies and diabetic therapeutic shoes and inserts <u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>In-Network</u> You pay 0% coinsurance for diabetic supply Preferred Brands - Abbott (FreeStyle Lite), Ascencia (Contour) and Continuous Glucose Monitors (CGMs) Freestyle Libre and Dexcom You pay 20% coinsurance for diabetic supply Non-Preferred Brands - All others such as LifeScan (OneTouch) and MiniMed CGM You pay a \$0 copay for diabetic therapeutic shoes and inserts <u>Out-of-Network</u> You pay 50% of the total cost
Diagnostic Procedures and Tests	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost

	2026 (this year)	2027 (next year)
Durable Medical Equipment (DME)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Home Health Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Inpatient Hospital - Acute	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Inpatient Hospital - Psychiatric	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Intensive Cardiac Rehabilitation	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Intensive Outpatient Program Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Laboratory	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Lymphedema Therapy	<u>In-Network</u> You pay a \$0 copay for Lymphedema Therapy	<u>In-Network</u> You pay a \$55 copay for Lymphedema Therapy <u>Out-of-Network</u> You pay 50% of the total cost

	2026 (this year)	2027 (next year)
	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	
Medical Supplies	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Covered Dental (Non-Routine)	<u>In-Network</u> You pay a \$60 copay for Medicare Covered Dental (Non-Routine)	<u>In-Network</u> You pay a \$50 copay for Medicare Covered Dental (Non-Routine)
	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Covered Eye Examination (Non-Routine)	<u>In-Network</u> You pay a \$60 copay for physician services to diagnose and treat eye diseases and conditions	<u>In-Network</u> You pay a \$50 copay for physician services to diagnose and treat eye diseases and conditions
	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Covered Eye Wear (Non-Routine)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Covered Hearing Examination (Non-Routine)	<u>In-Network</u> You pay a \$60 copay for Medicare Covered Hearing Examination (Non-Routine)	<u>In-Network</u> You pay a \$50 copay for Medicare Covered Hearing Examination (Non-Routine)
	<u>Out-of-Network</u>	<u>Out-of-Network</u> You pay 50% of the total cost

	2026 (this year)	2027 (next year)
	You pay 50% of the total cost after you reach your \$950 out-of-network deductible	
Medicare Part B Prescription Drugs (chemotherapy drugs)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Part B Prescription Drugs (including insulin drugs via DME)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Part B Prescription Drugs Avastin[®] (bevacizumab)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Part B Prescription Drugs (Allergy Injection)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Medicare Part B Prescription Drugs (All Other Part B Drugs)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Occupational Therapy Rehabilitation	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Opioid Treatment Program	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Other Health Care Professional	<u>Out-of-Network</u>	<u>Out-of-Network</u> You pay 50% of the total cost

	2026 (this year)	2027 (next year)
	You pay 50% of the total cost after you reach your \$950 out-of-network deductible	
Outpatient Hospital Facility (per visit) (Surgery and Other)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Outpatient Hospital Observation	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Outpatient Hospital Services	<u>In-Network</u> You pay a \$0 copay for a diagnostic bronchoscopy in an outpatient hospital	<u>In-Network</u> You pay a \$350 copay for a diagnostic bronchoscopy in an outpatient hospital
	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Outpatient Mental Health Therapy	<u>In-Network</u> You pay a \$30 copay for each Outpatient Mental Health Therapy Group Session	<u>In-Network</u> You pay a \$30 copay for each Outpatient Mental Health Therapy Group Session
	You pay a \$40 copay for each Outpatient Mental Health Therapy Individual Session	You pay a \$60 copay for each Outpatient Mental Health Therapy Individual Session
	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Outpatient Substance Use Disorder Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Over-the-Counter Items	<u>In-Network</u> \$30 each quarter. Balance does not roll over to next quarter.	<u>In-Network</u> \$45 each quarter. Balance does not roll over to next

	2026 (this year)	2027 (next year)
	You may use your quarterly benefit for one or more orders until the maximum amount has been used for the quarter. <u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount. Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance.	quarter. You may use your quarterly benefit for one or more orders until the maximum amount has been used for the quarter. <u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount. Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance.
Partial Hospitalization (Outpatient Mental Health Sessions)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Physical Therapy Rehabilitation	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Physician Specialist	<u>In-Network</u> You pay a \$60 copay per visit at Physician Specialist <u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>In-Network</u> You pay a \$50 copay per visit at Physician Specialist <u>Out-of-Network</u> You pay 50% of the total cost
Podiatry	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost

	2026 (this year)	2027 (next year)
Primary Care Physician	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Prosthetics, Orthotics and Related Supplies	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Psychiatric Services	<u>In-Network</u> You pay a \$30 copay for each Psychiatric Services Group Session You pay a \$40 copay for each Psychiatric Services Individual Session <u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>In-Network</u> You pay a \$30 copay for each Psychiatric Services Group Session You pay a \$60 copay for each Psychiatric Services Individual Session <u>Out-of-Network</u> You pay 50% of the total cost
Pulmonary Rehabilitation Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
SilverSneakers® Fitness Program	<u>In- and Out-of-Network</u> 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.	<u>In- Network</u> 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.

	2026 (this year)	2027 (next year)
	Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.	Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more. <u>Out-of-Network</u> Member must pay 100% of billed charges and submit the itemized receipt for reimbursement of 10% of billed charges. Member is responsible for all amounts in excess of the reimbursable benefit amount.
Skilled Nursing Facility (SNF)	<u>In-Network</u> You pay a \$0 copay per days 1 - 20 \$218 copay per days 21 - 100 <u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>In-Network</u> You pay a \$0 copay per days 1 - 20 \$221 copay per days 21 - 100 <u>Out-of-Network</u> You pay 50% of the total cost
Speech Therapy Rehabilitation	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Supervised Exercise Therapy (SET)	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
Telehealth Services	<u>In-Network</u>	<u>In-Network</u>

2026 (this year)	2027 (next year)
You pay the following for each benefit listed below: • Dermatology Services: \$60 copay • Mental Health Specialty Services: \$40 copay • Psychiatry Specialty Services: \$40 copay	You pay the following for each benefit listed below: • Dermatology Services: \$50 copay • Mental Health Specialty Services: \$60 copay • Psychiatry Specialty Services: \$60 copay
<u>Out-of-Network</u> You pay the following for each benefit listed below: • Provider of Choice: 50% of the total cost after you reach your \$950 out-of-network deductible • Occupational Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible • Physical Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible • Speech Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible • Dermatology Services: 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay the following for each benefit listed below: • Provider of Choice: 50% of the total cost • Occupational Therapy: 50% of the total cost • Physical Therapy: 50% of the total cost • Speech Therapy: 50% of the total cost • Dermatology Services: 50% of the total cost • Mental Health Specialty Services: 50% of the total cost • Psychiatry Specialty Services: 50% of the total cost • Opioid Treatment: 50% of the total cost • Substance Use Disorder Services: 50% of the total cost • Dietician Services: 50% of the total cost

	2026 (this year)	2027 (next year)
	• Mental Health Specialty Services: 50% of the total cost after you reach your \$950 out-of-network deductible • Psychiatry Specialty Services: 50% of the total cost after you reach your \$950 out-of-network deductible • Opioid Treatment: 50% of the total cost after you reach your \$950 out-of-network deductible • Substance Use Disorder Services: 50% of the total cost after you reach your \$950 out-of-network deductible • Dietician Services: 50% of the total cost after you reach your \$950 out-of-network deductible	
Therapeutic Radiological Services	<u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>Out-of-Network</u> You pay 50% of the total cost
X-Rays	<u>In-Network</u> You pay a \$15 copay for X-Rays in a Physician's Office or IDTF <u>Out-of-Network</u> You pay 50% of the total cost after you reach your \$950 out-of-network deductible	<u>In-Network</u> You pay a \$57 copay for X-Rays in a Physician's Office or IDTF <u>Out-of-Network</u> You pay 50% of the total cost

Section 1.6 – Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically and posted online at www.floridablue.com/medicare/forms/formulary.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier.

Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-926-6565 (TTY users call 711) for more information.

Section 1.7 – Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2026, call Member Services at 1-800-926-6565 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs until you reach the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach \$2,400.

• **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	\$615	\$597
	During this stage, you pay \$0 cost-sharing for drugs on Tier 1 (Preferred Generic) \$0 cost-sharing for drugs on Tier 2 (Generic) \$0 cost-sharing for drugs on Tier 6 (Select Care Drugs) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	During this stage, you pay \$0 cost-sharing for drugs on Tier 1 (Preferred Generic) \$0 cost-sharing for drugs on Tier 2 (Generic) \$0 cost-sharing for drugs on Tier 6 (Select Care Drugs) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more

information about the costs of vaccines, or information about the costs for a long-term supply; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (next year)
Tier 1-Preferred Generic: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	\$0 Your cost for a one-month mail order prescription is \$0.	\$0 Your cost for a one-month mail order prescription is \$0.
Tier 2-Generic: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	\$0 Your cost for a one-month mail order prescription is \$0.	\$0 Your cost for a one-month mail order prescription is \$0.
Tier 3-Preferred Brand: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	21% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail order prescription is 21% of the total cost.	19% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail order prescription is 19% of the total cost.
Tier 4-Non-Preferred Drug: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	30% of the total cost You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail order prescription is 30% of the total cost.	28% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail order prescription is 28% of the total cost.

	2026 (this year)	2027 (next year)
Tier 5-Specialty Tier We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	25% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail order prescription is 25% of the total cost.	27% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail order prescription is 27% of the total cost.
Tier 6-Select Care Drugs: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	\$0 Your cost for a one-month mail order prescription is \$0.	\$0 Your cost for a one-month mail order prescription is \$0.

SECTION 2

How to Change Plans

To stay in BlueMedicare Value (PPO), you don’t need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you’ll automatically be enrolled in our BlueMedicare Value (PPO).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You’ll be automatically disenrolled from BlueMedicare Value (PPO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can’t join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you’ll automatically be disenrolled from BlueMedicare Value (PPO).

- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-800-926-6565 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [Medicare.gov](https://www.medicare.gov), check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 4), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Florida Blue Medicare offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 2.1 – Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 - December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1- March 31, 2027.

Section 2.2 – Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 3 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
 - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call Florida's ADAP directly at 1-800-352-2437 (TTY: 1-888-503-7118), or mail them at: HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-800-926-6565 (TTY users should call 711) or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 4 Questions?

Get Help from BlueMedicare Value (PPO)

- **Call Member Services at 1-800-926-6565. (TTY users call 711.)**

We're available for phone calls 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. Calls to these numbers are free.

- **Read your 2027 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for BlueMedicare Value (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.floridablue.com/medicare/forms or call Member Services at 1-800-926-6565 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.floridablue.com/medicare**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Florida, the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

Call SHINE to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call SHINE at 1-800-963-5337. Learn more about SHINE by visiting (www.FLORIDASHINE.org).

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with [Medicare.gov](https://www.medicare.gov)**

You can chat live at [Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit [Medicare.gov](https://www.Medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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)
civilrightscordinator@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:

TTY: 1-800-926-6565 (لذوي الإعاقة السمعية) Medicare: 1-800-333-2227 برنامج FEP: 1-800-352-2583 برنامج 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 Medicare 6565-926-800-1 یا 2227-333-800-1 و برای FEP بگیرید. برای

T'áá free yíníłta'go saad bee áká anilyeedígíí, ałk'ida'ánígíí, dóó t'áá ajilii 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).