

## ***BlueMedicare Patriot (PPO) offered by Florida Blue***

### **Annual Notice of Change for 2027**

You're enrolled as a member of BlueMedicare Patriot (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 Patriot (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](https://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 Patriot (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 Patriot (PPO).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in BlueMedicare Patriot (PPO).** Starting January 1, 2027, you'll get your medical through BlueMedicare Patriot (PPO). Go to Section 2 for more information about how to change plans and deadlines for making a change.
- This plan doesn't include Medicare Part D drug coverage, and you can't be enrolled in a separate Medicare Part D drug plan and this plan at the same time. Note: If you don't have Medicare drug coverage, or creditable drug coverage (as good as Medicare's), for 63 days or more, you may have to pay a late enrollment penalty that is added to your monthly premium if you enroll in Medicare drug coverage in the future.

Table of Contents

**Summary of Important Costs for 2027 .....3**

**SECTION 1      Changes to Benefits & Costs for Next Year.....5**

    Section 1.1 – Changes to the Monthly Plan Premium .....5

    Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount .....5

    Section 1.3 – Changes to the Provider Network.....6

    Section 1.4 – Changes to Benefits & Costs for Medical Services.....6

**SECTION 2      How to Change Plans..... 16**

    Section 2.1 – Deadlines for Changing Plans ..... 16

    Section 2.2 – Are there other times of the year to make a change?..... 16

**SECTION 3      Get Help Paying for Prescription Drugs ..... 17**

**SECTION 4      Questions? ..... 17**

    Get Help from BlueMedicare Patriot (PPO) .....17

    Get Free Counseling about Medicare ..... 18

    Get Help from Medicare..... 18

## Summary of Important Costs for 2027

|                                                                                                                                                                  | 2026 (this year)                                                                                                                                                             | 2027 (next year)                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>Go to Section 1.1 for details.                                                                                                   | \$0                                                                                                                                                                          | \$0                                                                                                                                      |
| <b>Deductible</b>                                                                                                                                                | <u><b>In-Network</b></u><br>\$0<br><br><u><b>Out-of-Network</b></u><br>\$950 for Medicare-covered services received out-of-network.                                          | <u><b>In-Network</b></u><br>\$0<br><br><u><b>Out-of-Network</b></u><br><b>\$0 for Medicare-covered services received out-of-network.</b> |
| <b>Maximum out-of-pocket amount</b><br>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<br><br>From network and out-of-network providers combined: \$10,100                                                                          | <b>From network providers: \$6,750</b><br><br><b>From network and out-of-network providers combined: \$10,100</b>                        |
| <b>Primary care office visits</b>                                                                                                                                | <u><b>In-Network</b></u><br>\$0 copay per visit<br><br><u><b>Out-of-Network</b></u><br>50% of the total cost per visit after you reach your \$950 out-of-network deductible  | <u><b>In-Network</b></u><br><b>\$0 copay per visit</b><br><br><u><b>Out-of-Network</b></u><br><b>50% of the total cost per visit</b>     |
| <b>Specialist office visits</b>                                                                                                                                  | <u><b>In-Network</b></u><br>\$55 copay per visit<br><br><u><b>Out-of-Network</b></u><br>50% of the total cost per visit after you reach your \$950 out-of-network deductible | <u><b>In-Network</b></u><br><b>\$55 copay per visit</b><br><br><u><b>Out-of-Network</b></u><br><b>50% of the total cost per visit</b>    |

|                                                                                                                                                                                                                                                                             | 2026 (this year)                                                                                                                                                                                                                    | 2027 (next year)                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient hospital stays</b><br><br>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. | <b><u>In-Network</u></b><br>\$385 copay per day for days 1 - 7<br><br>\$0 copay per day for days 8 - 90<br><br><b><u>Out-of-Network</u></b><br>50% of the total cost per visit after you reach your \$950 out-of-network deductible | <b><u>In-Network</u></b><br><b>\$385 copay per day for days 1 - 7</b><br><br><b>\$0 copay per day for days 8 - 90</b><br><br><b><u>Out-of-Network</u></b><br><b>50% of the total cost per visit</b> |

## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 – Changes to the Monthly Plan Premium

|                                                                                                                                  | 2026 (this year) | 2027 (next year)                                           |
|----------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium.)                                     | \$0              | \$0<br><br><i>There is no change for the upcoming year</i> |
| <b>Part B premium reduction</b><br>This amount will be deducted from your Part B premium. This means you'll pay less for Part B. | \$100            | \$100                                                      |

### 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.

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

|                                                                                                                                                                           | 2026 (this year) | 2027 (next year)                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Combined maximum out-of-pocket amount</b>                                                                                                                              | \$10,100         | \$10,100                                                                                                                                                                                                                             |
| Your costs for covered medical services (such as copayments) from in-network and out-of-network providers <b>count</b> toward your combined maximum out-of-pocket amount. |                  | <b>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 in-network or out-of-network providers for the rest of the calendar year.</b> |

### 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 Benefits & Costs for Medical Services

|                    | 2026 (this year)                                                                                                   | 2027 (next year)                                              |
|--------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <b>Acupuncture</b> | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |

|                                                  | 2026 (this year)                                                                                                                                                                               | 2027 (next year)                                                                                                                                                        |
|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Advanced Imaging Services</b>                 | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost                                                                                                           |
| <b>Allergy Testing (Office)</b>                  | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost                                                                                                           |
| <b>Ambulatory Surgical Center (ASC)</b>          | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost                                                                                                           |
| <b>Blood Services (3 pint deductible waived)</b> | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost                                                                                                           |
| <b>Cardiac Rehabilitation</b>                    | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost                                                                                                           |
| <b>Chiropractic Services</b>                     | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost                                                                                                           |
| <b>Diabetic Monitors</b>                         | <b><u>In-Network</u></b><br>You pay a \$0 copay for diabetic monitors Preferred Brands - Abbott (FreeStyle Lite), Ascencia (Contour)<br><br>You pay a \$0 copay for Non-Preferred Brands - All | <b><u>In-Network</u></b><br>You pay 0% coinsurance for diabetic monitors Preferred Brands - Abbott (FreeStyle Lite), Ascencia (Contour) and Continuous Glucose Monitors |

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

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

|                                                                             | 2026 (this year)                                                                                                                                                                           | 2027 (next year)                                                                                                                           |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                             | <p>You pay a 0% coinsurance for medical supplies</p> <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p> | <p><b>You pay a 20% coinsurance for medical supplies</b></p> <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p> |
| <b>Medicare Covered Dental (Non-Routine)</b>                                | <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                      | <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p>                                                              |
| <b>Medicare Covered Eye Examination (Non-Routine)</b>                       | <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                      | <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p>                                                              |
| <b>Medicare Covered Eye Wear (Non-Routine)</b>                              | <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                      | <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p>                                                              |
| <b>Medicare Covered Hearing Examination (Non-Routine)</b>                   | <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                      | <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p>                                                              |
| <b>Medicare Part B Prescription Drugs (chemotherapy drugs)</b>              | <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                      | <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p>                                                              |
| <b>Medicare Part B Prescription Drugs (including insulin drugs via DME)</b> | <p><b><u>Out-of-Network</u></b><br/>           You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                      | <p><b><u>Out-of-Network</u></b><br/> <b>You pay 50% of the total cost</b></p>                                                              |

|                                                                              | 2026 (this year)                                                                                                   | 2027 (next year)                                              |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <b>Medicare Part B Prescription Drugs</b><br><b>Avastin ® (bevacizumab)</b>  | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Medicare Part B Prescription Drugs</b><br><b>(Allergy Injection)</b>      | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Medicare Part B Prescription Drugs</b><br><b>(All Other Part B Drugs)</b> | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Occupational Therapy Rehabilitation</b>                                   | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Opioid Treatment Program</b>                                              | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Other Health Care Professional</b>                                        | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Outpatient Hospital Facility (per visit) (Surgery and Other)</b>          | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Outpatient Hospital Observation</b>                                       | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |

|                                                                    | 2026 (this year)                                                                                                   | 2027 (next year)                                              |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <b>Outpatient Hospital Services</b>                                | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Outpatient Mental Health Therapy</b>                            | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Outpatient Substance Use Disorder Services</b>                  | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Partial Hospitalization (Outpatient Mental Health Sessions)</b> | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Physical Therapy Rehabilitation</b>                             | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Physician Specialist</b>                                        | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Podiatry</b>                                                    | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Primary Care Physician</b>                                      | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost |
| <b>Prosthetics, Orthotics and Related Supplies</b>                 | <b><u>Out-of-Network</u></b>                                                                                       | <b><u>Out-of-Network</u></b><br>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                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Psychiatric Services</b>              | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                                                                                                                                                                                                                                                         | <b><u>Out-of-Network</u></b><br><b>You pay 50% of the total cost</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Pulmonary Rehabilitation Services</b> | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                                                                                                                                                                                                                                                         | <b><u>Out-of-Network</u></b><br><b>You pay 50% of the total cost</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>SilverSneakers® Fitness Program</b>   | <b><u>In- and Out-of-Network</u></b> <ul style="list-style-type: none"> <li>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.</li> <li>Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.</li> </ul> | <b><u>In- Network</u></b> <ul style="list-style-type: none"> <li><b>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.</b></li> <li><b>Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.</b></li> </ul><br><b><u>Out-of-Network</u></b><br><br><b>Member must pay 100% of billed charges and submit the itemized receipt for reimbursement of 10% of billed charges.</b> |

|                                          | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Member is responsible for all amounts in excess of the reimbursable benefit amount.</b>                                                                                                                                                                                                                                                                                                                                                      |
| <b>Skilled Nursing Facility (SNF)</b>    | <p><b><u>In-Network</u></b><br/>You pay a \$0 copay per days 1 - 20</p> <p>\$218 copay per days 21 - 100</p> <p><b><u>Out-of-Network</u></b><br/>You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                                                                                                                                                                                             | <p><b><u>In-Network</u></b><br/>You pay a \$0 copay per days 1 - 20</p> <p><b>\$221 copay per days 21 - 100</b></p> <p><b><u>Out-of-Network</u></b><br/>You pay 50% of the total cost</p>                                                                                                                                                                                                                                                       |
| <b>Speech Therapy Rehabilitation</b>     | <p><b><u>Out-of-Network</u></b><br/>You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                                                                                                                                                                                                                                                                                                          | <p><b><u>Out-of-Network</u></b><br/>You pay 50% of the total cost</p>                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Supervised Exercise Therapy (SET)</b> | <p><b><u>Out-of-Network</u></b><br/>You pay 50% of the total cost after you reach your \$950 out-of-network deductible</p>                                                                                                                                                                                                                                                                                                                                          | <p><b><u>Out-of-Network</u></b><br/>You pay 50% of the total cost</p>                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Telehealth Services</b>               | <p><b><u>Out-of-Network</u></b><br/>You pay the following for each benefit listed below:</p> <ul style="list-style-type: none"> <li>• Provider of Choice: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Occupational Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Physical Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible</li> </ul> | <p><b><u>Out-of-Network</u></b><br/>You pay the following for each benefit listed below:</p> <ul style="list-style-type: none"> <li>• <b>Provider of Choice: 50% of the total cost</b></li> <li>• <b>Occupational Therapy: 50% of the total cost</b></li> <li>• <b>Physical Therapy: 50% of the total cost</b></li> <li>• <b>Speech Therapy: 50% of the total cost</b></li> <li>• <b>Dermatology Services: 50% of the total cost</b></li> </ul> |

|                                          | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          | <ul style="list-style-type: none"> <li>• Speech Therapy: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Dermatology Services: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Mental Health Specialty Services: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Psychiatry Specialty Services: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Opioid Treatment: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Substance Use Disorder Services: 50% of the total cost after you reach your \$950 out-of-network deductible</li> <li>• Dietician Services: 50% of the total cost after you reach your \$950 out-of-network deductible</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Mental Health Specialty Services: 50% of the total cost</b></li> <li>• <b>Psychiatry Specialty Services: 50% of the total cost</b></li> <li>• <b>Opioid Treatment: 50% of the total cost</b></li> <li>• <b>Substance Use Disorder Services: 50% of the total cost</b></li> <li>• <b>Dietician Services: 50% of the total cost</b></li> </ul> |
| <b>Therapeutic Radiological Services</b> | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b><u>Out-of-Network</u></b><br><b>You pay 50% of the total cost</b>                                                                                                                                                                                                                                                                                                                     |
| <b>X-Rays</b>                            | <b><u>Out-of-Network</u></b><br>You pay 50% of the total cost after you reach your \$950 out-of-network deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b><u>Out-of-Network</u></b><br><b>You pay 50% of the total cost</b>                                                                                                                                                                                                                                                                                                                     |

## SECTION 2 How to Change Plans

**To stay in BlueMedicare Patriot (PPO), you don't need to do anything.** Unless you sign up for a different Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our BlueMedicare Patriot (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 Patriot (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,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from BlueMedicare Patriot (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 3).
- **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. As a reminder, Florida Blue Medicare offers other Medicare health plans and Medicare prescription drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

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### Section 2.1 – Deadlines for Changing Plans

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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.

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

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In certain situations, people may 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 may 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, yearly deductibles, and coinsurance. Also, those 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 can call 1-800-325-0778.
- Your State Medicaid Office.

### SECTION 4 Questions?

#### Get Help from BlueMedicare Patriot (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, look in the 2027 *Evidence of Coverage* for BlueMedicare Patriot (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](http://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](http://www.floridablue.com/medicare)**

Our website has the most up-to-date information about our provider network (*Provider Directory*).

## 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 Serving Health Insurance Needs of Elders (SHINE).

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](http://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](http://www.hhs.gov/ocr/office/file/index.html)

Visit [www.floridablue.com/disclaimer/ndnotice](http://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 1-800-333-2227 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).