BlueMedicare Select (PPO) offered by Florida Blue

Annual Notice of Change for 2026

You're enrolled as a member of BlueMedicare Select (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, 2025, you'll stay in BlueMedicare Select (PPO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* 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 1-800-955-8770) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services number at 1-800-926-6565 (TTY users call 1-800-955-8770) 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 Select (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 Select (PPO).

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- **If you do nothing by December 7, 2025, you'll automatically be enrolled in BlueMedicare Select (PPO).** Starting January 1, 2026, you'll get your medical and drug coverage through BlueMedicare Select (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$28.00	**$58.20**
Deductible	**In-Network** $0 **Out-of-Network** $950 for Medicare-covered services received out-of-network.	**In-Network** **$0** **Out-of-Network** **$1,500 for Medicare-covered services received out-of-network.**
Maximum out-of-pocket amount This is the most 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:** **$6,750** **From network and out-of-network providers combined:** **$10,100**
Primary care office visits	**In-Network** $0 copay per visit **Out-of-Network** Primary care visits: 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **$0 copay per visit** **Out-of-Network** **Primary care visits: 50% of the total cost after you reach your $1,500 out-of-network deductible**
Specialist office visits	**In-Network** $49 copay per visit	**In-Network** **$55 copay per visit**

	2025 (this year)	2026 (next year)
	Out-of-Network 42% of the total cost per visit after you reach your $950 out-of-network deductible	**Out-of-Network** **50% of the total cost per visit after you reach your $1,500 out-of-network deductible**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**In-Network** $345 copay per day for days 1 - 5 $0 copay per day for days 6 - 90 **Out-of-Network** $495 copay per day after $950 out-of-network deductible for days 1-27 $0 copay per day for days 28-90	**In-Network** **$385 copay per day for days 1- 7** **$0 copay per day for days 8 - 90** **Out-of-Network** **$495 copay per day for days 1-27 after you reach your $1,500 out-of-network deductible** **$0 copay per day for days 28-90**

	2025 (this year)	2026 (next year)
Part D drug coverage deductible (Go to Section 1.7 for details.)	$590 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.	**$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 (Go to Section 1.7 for details including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	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: $10	**Drug Tier 2:** **$0**
	Drug Tier 3: 21%	**Drug Tier 3:** **21%**
	You pay up to $35 per month supply of each covered insulin product on this tier	**You pay up to $35 per month supply of each covered insulin product on this tier**
	Drug Tier 4: 25%	**Drug Tier 4:** **30%**
	You pay up to $35 per month supply of each covered insulin product on this tier	**You pay up to $35 per month supply of each covered insulin product on this tier**
	Drug Tier 5: 25%	**Drug Tier 5:** **25%**
	You pay up to $35 per month supply of each covered insulin product on this tier	**You pay up to $35 per month supply of each covered insulin product on this tier**

	2025 (this year)	2026 (next year)
	Drug Tier 6: $0 Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	**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

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$28.00	**$58.20**

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 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.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

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.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network	$6,750	**$6,750** **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 from network**

	2025 (this year)	2026 (next year)
maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.		**providers for the rest of the calendar year.**
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your plan premium and 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 2026 *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 1-800-955-8770) 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 1-800-955-8770) for help.

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 2026 *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 1-800-955-8770) 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 1-800-955-8770) for help.

Section 1.5 – Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Acupuncture	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Advanced Imaging Services	**In-Network** You pay a $30 copay for advanced imaging at a Physician's Office You pay a $30 copay for advanced imaging at an Independent Diagnostic Testing Facility (IDTF)	**In-Network** **You pay a $75 copay for advanced imaging at a Physician's Office** **You pay a $100 copay for advanced imaging at an Independent Diagnostic Testing Facility (IDTF)**

	2025 (this year)	2026 (next year)
	You pay a $150 copay for advanced imaging at an Outpatient Hospital You pay a $30 copay for a diagnostic ultrasound at a Physician's Office You pay a $30 copay for a diagnostic ultrasound at an Independent Diagnostic Testing Facility (IDTF) You pay a $150 copay for a diagnostic ultrasound at an Outpatient Hospital Facility **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**You pay a $250 copay for advanced imaging at an Outpatient Hospital** **You pay a $0 copay for a Diagnostic Ultrasound at a physician office, Independent Diagnostic Testing Facility (IDTF) or Outpatient Hospital** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Allergy Testing (Office)	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Ambulance	**In-Network** You pay a $155 copay for one-way trip ground or air ambulance **Out-of-Network** You pay $155 copay for one-way trip ground or air ambulance	**In-Network** **You pay a $0 copay for facility-to-facility transfer via ground ambulance** **You pay a $285 copay for one-way trip ground ambulance**

	2025 (this year)	2026 (next year)
		You pay 20% of the total cost for one-way trip air ambulance **Out-of-Network** **You pay $285 copay for one-way trip ground ambulance** **You pay 20% of the total cost for one-way trip air ambulance**
Ambulatory Surgical Center (ASC)	**In-Network** You pay a $0 copay for a diagnostic colonoscopy in an Ambulatory Surgical Center (ASC) You pay a $120 copay for all other services performed at an Ambulatory Surgical Center (ASC) **Out-of-Network** You pay 42% of the total cost after you reach your $950out-of-network deductible	**In-Network** **You pay a $275 copay for a diagnostic colonoscopy in an Ambulatory Surgical Center (ASC)** **You pay a $275 copay for all other services performed at an Ambulatory Surgical Center (ASC)** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Barium Enema	**In-Network** You pay a $0 copay for a Barium Enema **Out-of-Network** You pay 42% of the total cost	**Barium Enema is not covered**
Blood Services (3 pint deductible waived)	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**

	2025 (this year)	2026 (next year)
Cardiac rehabilitation services	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Caregiver Support	**In-Network** $0 copay Coverage provides digital support for caregivers to share updates, manage tasks, and find senior care resources using our participating vendor. Benefits include: • A web-based tool that contains educational content • Access for caregivers • and family members to post: updates and videos, • tools to manage documents, • search tools (i.e., senior housing search and in-home care search). See the "Evidence of Coverage" for benefit details. **Out-of-Network** Coverage is limited to services from plan-approved vendors	**Caregiver Support is not covered**
Chiropractic Services	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Dental Services* (additional benefits)		

	2025 (this year)	2026 (next year)
	Out-of-Network Member pays up front and is reimbursed 58% of non-participating rates	**Out-of-Network** **Member pays up front and is reimbursed 50% of non-participating rates**
Diabetes Self-Management Training	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**
Diabetic Prevention Program	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**
Diabetic Retinal Exam	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**
Diabetic Supplies and Diabetic Therapeutic Shoes and Inserts	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Diagnostic Procedures and Tests	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Digital Rectal Exams	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**
Durable Medical Equipment (DME)	**In-Network** You pay a 0% coinsurance for durable medical equipment **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a 20% coinsurance for durable medical equipment** **You pay a 0% coinsurance for standard raised toilet seat and/or standard tub seat** **Out-of-Network** **You pay 50% of the total cost after you reach**

	2025 (this year)	2026 (next year)
		your $1,500 out-of-network deductible
EKG Following Welcome Visit	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**
Emergency Services	**In- and Out-of-Network** You pay a $125 copay per visit	**In- and Out-of-Network** **You pay a $130 copay per visit**
Glaucoma Screenings	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**
Hearing Aids	**Out-of-Network** Member must submit receipts for reimbursement at 58%	**Out-of-Network** **Member must submit receipts for reimbursement at 50%**
Hearing Exams (Routine), includes Fitting of Hearing Aid	**Out-of-Network** Member must submit receipts for reimbursement at 58% of maximum allowed	**Out-of-Network** **Member must submit receipts for reimbursement at 50% of maximum allowed**
Home Health Services	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Inpatient Hospital - Acute	**In-Network** $345 copay per day for days 1 - 5 and $0 copay after day 5 $0 copay per day for days 6 - 90 **Out-of-Network** $495 copay per day after $950 out-of-network deductible for days 1-27 $0 copay per day for days 28-90	**In-Network** **$385 copay per day for days 1-7 and $0 copay after day 7** **$0 copay per day for days 8 - 90** **Out-of-Network** **$495 copay per day for days 1-27 after you reach your $1,500 out-of-network deductible**

	2025 (this year)	2026 (next year)
		$0 copay per day for days 28-90
Inpatient Hospital - Psychiatric	**In-Network** You pay a $318 copay per day for days 1 - 5 and $0 copay per days 6-90 **Out-of-Network** You pay $495 copay per day after $950 out-of-network deductible for days 1-27 $0 copay per day for days 28-90	**In-Network** **You pay a $350 copay per days 1-6 and $0 copay per days 7-90** **Out-of-Network** **You pay $495 copay per day for days 1-27 after you reach your $1,500 out-of-network deductible** **$0 copay per day for days 28-90**
Intensive Cardiac Rehabilitation	**In-Network** You pay a $55 copay for intensive cardiac rehabilitation **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a $50 copay for intensive cardiac rehabilitation** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Intensive Outpatient Program Services	**In-Network** You pay a $20 copay for intensive outpatient program services **Out-of-Network** You pay a $40 copay after you reach your $950 out-of-network deductible	**In-Network** **You pay a $50 copay for intensive outpatient program services** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Kidney Disease Education Services	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost**

	2025 (this year)	2026 (next year)
Laboratory	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Lymphedema Therapy	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medical Supplies	**In-Network** You pay a a 0% coinsurance for Medical Supplies **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a 20% coinsurance for Medical Supplies** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Covered Dental (Non-Routine)	**In-Network** You pay a $49 copay for Medicare Covered Dental (Non-Routine) **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a $55 copay for Medicare Covered Dental (Non-Routine)** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Covered Eye Examination (Non-Routine)	**In-Network** You pay a $49 copay for for physician services to diagnose and treat eye diseases and conditions **Out-of-Network**	**In-Network** **You pay a $55 copay for for physician services to diagnose and treat eye diseases and conditions** **Out-of-Network**

	2025 (this year)	2026 (next year)
	You pay 42% of the total cost after you reach your $950 out-of-network deductible	**You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Covered Eye Wear (Non-Routine)	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Covered Hearing Examination (Non-Routine)	**In-Network** You pay a $49 copay for Medicare Covered Hearing Examination (Non-Routine) **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a $55 copay for Medicare Covered Hearing Examination (Non-Routine)** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Part B Prescription Drugs **(chemotherapy drugs)**	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Part B Prescription Drugs **(including insulin drugs via DME)**	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Part B Prescription **Avastin ® (bevacizumab)**	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Medicare Part B Prescription Drugs **(Allergy Injection)**	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**

	2025 (this year)	2026 (next year)
Medicare Part B Prescription Drugs **(All Other Part B Drugs)**	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Occupational Therapy Rehabilitation	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Opioid Treatment Program	**In-Network** You pay a $20 copay for each Opioid Treatment **Out-of-Network** You pay a $40 copay after you reach your $950 out-of-network deductible	**In-Network** **You pay a $40 copay for each Opioid Treatment** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Other Health Care Professional	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Outpatient Hospital Facility (per visit) (Surgery and Other)	**In-Network** You pay a $150 copay per visit **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a $325 copay per visit** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Outpatient Hospital Observation	**In-Network** You pay a $125 copay for outpatient hospital observation **Out-of-Network**	**In-Network** **You pay a $130 copay for outpatient hospital observation**

	2025 (this year)	2026 (next year)
	You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Outpatient Hospital Services	**In-Network** You pay a $0 copay for a diagnostic colonoscopy in an outpatient hospital You pay a $150 copay for a diagnostic bronchoscopy in an outpatient hospital You pay a $150 copay for all other outpatient hospital services **Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**In-Network** **You pay a $325 copay for a diagnostic colonoscopy in an outpatient hospital** **You pay a $0 copay for a diagnostic bronchoscopy in an outpatient hospital** **You pay a $325 copay for all other outpatient hospital services** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Outpatient Mental Health Therapy	**In-Network** You pay a $20 copay for each Outpatient Mental Health Therapy (Group or Individual Session) **Out-of-Network** You pay a $40 copay after you reach your $950 out-of-network deductible	**In-Network** **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** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**

	2025 (this year)	2026 (next year)
Outpatient Substance Use Disorder Services	**In-Network** You pay a $20 copay for each Substance Use Disorder Services (Group or Individual Session) **Out-of-Network** You pay a $40 copay after you reach your $950 out-of-network deductible	**In-Network** **You pay a $30 copay for each Substance Use Disorder Services Group Session** **You pay a $40 copay for each Substance Use Disorder Services Individual Session** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Partial Hospitalization (Outpatient Mental Health Sessions)	**In-Network** You pay a $20 copay for Partial Hospitalization (Outpatient Mental Health Sessions) **Out-of-Network** You pay a $40 copay after you reach your $950 out-of-network deductible	**In-Network** **You pay a $50 copay for Partial Hospitalization (Outpatient Mental Health Sessions)** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Physical Therapy Rehabilitation	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Physician Specialist	**In-Network** You pay a $49 copay for Physician Specialist **Out-of-Network** You pay 42% of the total cost after you reach	**In-Network** **You pay a $55 copay for Physician Specialist** **Out-of-Network** **You pay 50% of the total cost after you reach**

	2025 (this year)	2026 (next year)
	your $950 out-of-network deductible	**your $1,500 out-of-network deductible**
Podiatry	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Preventive Services (Medicare-Covered)	**In-Network** You pay a $0 copay for Medicare-Covered Preventive Services • Colorectal cancer screening **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $0 copay for Medicare-Covered Preventive Services** • **Colorectal cancer screenings** o **Blood-based biomarker tests** o **Colonoscopies** o **Computed tomography (CT) colonography** o **Fecal occult blood tests** o **Flexible sigmoidoscopies** o **Multi-target stool DNA tests** • **Hepatitis B Virus (HBV) infection screenings** • **Pre-exposure prophylaxis (PrEP) for HIV prevention** **Out-of-Network** **You pay 50% of the total cost**
Primary Care Physician	**Out-of-Network** You pay 42% of the total cost after you reach	**Out-of-Network** **You pay 50% of the total cost after you reach**

	2025 (this year)	2026 (next year)
	your $950 out-of-network deductible	**your $1,500 out-of-network deductible**
Prosthetics, Orthotics and Related Supplies	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Psychiatric Services	**In-Network** You pay a $20 copay for each Psychiatric Services (Group or Individual Session) **Out-of-Network** You pay $40 copay after you reach your $950 out-of-network deductible	**In-Network** **You pay a $30 copay for each Psychiatric Services Group Session** **You pay a $40 copay for each Psychiatric Services Individual Session** **Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Pulmonary Rehabilitation Services	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Skilled Nursing Facility (SNF)	**In-Network** You pay a $0 copay per days 1 - 20 $214 copay per days 21 - 100 **Out-of-Network** You pay a $250 copay per day after you reach your $950 out-of-network deductible for days 1-58	**In-Network** **You pay a $0 copay per days 1 - 20** **$218 copay per days 21 - 100** **Out-of-Network** **You pay a $250 copay per day for days 1-58 after you reach your**

	2025 (this year)	2026 (next year)
	\$0 copay per day for days 59-100	**\$1,500 out-of-network deductible** **\$0 copay per day for days 59-100**
Speech Therapy Rehabilitation	**Out-of-Network** You pay 42% of the total cost after you reach your \$950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your \$1,500 out-of-network deductible**
Supervised Exercise Therapy (SET)	**Out-of-Network** You pay 42% of the total cost after you reach your \$950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your \$1,500 out-of-network deductible**
Telehealth Services	**In-Network** You pay the following for each benefit listed below: • Dermatology Services: \$49 copay • Mental Health Specialty Services: \$20 copay • Psychiatry Specialty Services: \$20 copay • Opioid Treatment: \$20 copay • Substance Use Disorder Services: \$20 copay **Out-of-Network** You pay the following for each benefit listed below: • Provider of Choice: 42% of the total cost after you reach your \$950 out-of-network deductible	**In-Network** **You pay the following for each benefit listed below:** • **Dermatology Services: \$55 copay** • **Mental Health Specialty Services: \$40 copay** • **Psychiatry Specialty Services: \$40 copay** • **Opioid Treatment: \$40 copay** • **Substance Use Disorder Services: \$40 copay** **Out-of-Network** **You pay the following for each benefit listed below:**

	2025 (this year)	2026 (next year)
	• Occupational Therapy: 42% of the total cost after you reach your $950 out-of-network deductible • Physical Therapy: 42% of the total cost after you reach your $950 out-of-network deductible • Speech Therapy: 42% of the total cost after you reach your $950 out-of-network deductible • Dermatology Services: 42% of the total cost after you reach your $950 out-of-network deductible • Mental Health Specialty Services: $40 copay after you reach your $950 out-of-network deductible • Psychiatry Specialty Services: $40 copay after you reach your $950 out-of-network deductible • Opioid Treatment: $40 copay after you reach your $950 out-of-network deductible • Substance Use Disorder Services: $40 copay after you reach your $950 out-of-network deductible	• **Provider of Choice: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Occupational Therapy: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Physical Therapy: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Speech Therapy: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Dermatology Services: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Mental Health Specialty Services: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Psychiatry Specialty Services: 50% of the total cost after you reach your $1,500 out-of-network deductible**

	2025 (this year)	2026 (next year)
	• Diabetes Self-Management Training: 42% of the total cost • Dietician Services: 42% of the total cost after you reach your $950 out-of-network deductible	• **Opioid Treatment: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Substance Use Disorder Services: 50% of the total cost after you reach your $1,500 out-of-network deductible** • **Diabetes Self-Management Training: 50% of the total cost** • **Dietician Services: 50% of the total cost after you reach your $1,500 out-of-network deductible**
Therapeutic Radiological Services	**Out-of-Network** You pay 42% of the total cost after you reach your $950 out-of-network deductible	**Out-of-Network** **You pay 50% of the total cost after you reach your $1,500 out-of-network deductible**
Vision Exams (Routine)	**Out-of-Network** Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 58% of the in-network allowed amount.	**Out-of-Network** **Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount.**
Worldwide Emergency/Urgent Services	**In- and Out-of-Network** You pay $125 copay for worldwide emergency/urgent services	**In- and Out-of-Network** **You pay $130 copay for worldwide emergency/urgent services**
X-Rays	**Out-of-Network** You pay 42% of the total cost after you reach	**Out-of-Network** **You pay 50% of the total cost after you reach**

	2025 (this year)	2026 (next year)
	your $950 out-of-network deductible	**your $1,500 out-of-network deductible**

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.

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 1-800-955-8770) 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, 2025, call Member Services at 1-800-926-6565 (TTY users call 1-800-955-8770) 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. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Preferred Brand, Non-Preferred Drug and 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 total drug costs reach $2,100.

- ***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.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	$590 During this stage, you pay $0 cost-sharing for drugs on Tier 1 (Preferred Generic); $10 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.	**$615** **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 $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	**2026 (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.	$10 Your cost for a one-month mail order prescription is $10.	**$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 up to $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.	**21% of the total cost.** **You pay up to $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.**
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.	25% of the total cost You pay up to $35 per month supply of each covered insulin product on this tier.	**30% of the total cost.** **You pay up to $35 per month supply of each covered insulin product on this tier.**

	2025 (this year)	2026 (next year)
	Your cost for a one-month mail order prescription is 25% of the total cost.	**Your cost for a one-month mail order prescription is 30% of the total cost.**
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 up to $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.	**25% of the total cost.** **You pay up to $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.**
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.**

Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year	**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 2026.**

	2025 (this year)	2026 (next year)
	(January-December). You may be participating in this payment option.	**To learn more about this payment option, call us at 1-800-926-6565 (TTY users call 1-800-955-8770) or visit www.Medicare.gov.**

SECTION 3 How to Change Plans

To stay in BlueMedicare Select (PPO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our BlueMedicare Select (PPO).

If you want to change plans for 2026 follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from BlueMedicare Select (PPO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from BlueMedicare Select (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 1-800-955-8770) 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 www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Florida Blue Medicare offers other Medicare health plans and Medicare prescription drug plans. These other plans can have different coverage, monthly premiums, and cost-sharing amounts.

Section 3.1 – 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, 2026, 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 (either with or without separate Medicare drug coverage) between January 1- March 31, 2026.

Section 3.2 – 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 4 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. **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. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-800-926-6565 (TTY users call 1-800-955-8770) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from BlueMedicare Select (PPO)

- **Call Member Services at 1-800-926-6565. (TTY users call 1-800-955-8770).**

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 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the *2026 Evidence of Coverage* for BlueMedicare Select (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 1-800-955-8770) 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 www.Medicare.gov**

You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

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

- **Visit 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* 2026**

The *Medicare & You* 2026 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 www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. 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
- 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 members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator or Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html

Visit **www.floridablue.com/disclaimer/ndnotice** to view an electronic version of this notice.
87768 0625R

Form Approved
OMB# 0938-1421

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 fòma ki disponib gratis. Rele nan 1-800-352-2583, FEP 1-800-333-2227, oswa rele Medicare nan 1-800-926-6565 (TTY 711).

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

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

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

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

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

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

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

T’áá free yíníłta’go saad bee áká anilyeedígíí, ałk’ida’áníígíí, dóó t’áá ajiłii hane’ bee áká anilyeedígíí t’éiyá éí hołne’. 1-800-352-2583 bich’į’ náhodoonih, FEP bich’į’ 1-800-333-2227 bich’į’ náhodoonih, Medicare bich’į’ 1-800-926-6565 bich’į’ náhodoonih, (TTY 711).