BlueMedicare Value (PPO) offered by Florida Blue

Annual Notice of Changes for 2025

You are currently enrolled as a member of BlueMedicare Value. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.floridablue.com/medicare/forms. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.
- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost-sharing.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in BlueMedicare Value.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with BlueMedicare Value.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-926-6565 for additional information. (TTY users should call 1-800-955-8770). 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.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About BlueMedicare Value

- Florida Blue is a PPO plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.
- When this document says “we,” “us,” or “our," it means Florida Blue. When it says “plan” or “our plan,” it means BlueMedicare Value.

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for BlueMedicare Value in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. (See Section 1.1 for details.)	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $4,900 From network and out-of-network providers combined: $8,950	From network providers: $5,100 From network and out-of-network providers combined: $10,100
Doctor office visits	**In-Network** Primary care visits: $0 copay per visit Specialist visits: Level 1 - $35 copay per visit Level 2 - $45 copay per visit **Out-of-Network** Primary care visits: 45% of the total cost Specialist visits: 45% of the total cost	**In-Network** Primary Care visits: $0 copay per visit Specialist Visits: $45 copay per visit **Out-of-Network** Primary care visits: 42% of the total cost Specialist visits: 42% of the total cost
Inpatient hospital stays	**In-Network** You pay a $275 copay per days 1-6 and $0 copay after day 6 Copay per day (per Medicare-covered stay) which	**In-Network** You pay a $320 copay per days 1-6 and $0 copay after day 6 Copay per day (per Medicare-covered stay). You will

Cost	2024 (this year)	2025 (next year)
	includes day of admission and day of discharge **Out-of-Network** 45% of the total cost	not be charged a copay for the day of discharge **Out-of-Network** 42% of the total cost
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $150 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) except for covered insulin products and most adult Part D vaccines. Copay/Coinsurance during the Initial Coverage Stage:	Deductible: $175 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) except for covered insulin products and most adult Part D vaccines. Copay/Coinsurance during the Initial Coverage Stage:
	• Drug Tier 1: $0 copay	• Drug Tier 1: $0 copay
	• Drug Tier 2: $0 copay	• Drug Tier 2: $0 copay
	• Drug Tier 3: $47 copay You pay up to $35 per month supply of each covered insulin product on this tier	• Drug Tier 3: 25% of the total cost You pay up to $35 per month supply of each covered insulin product on this tier
	• Drug Tier 4: $100 copay	• Drug Tier 4: 25% of the total cost You pay up to $35 per month supply of each covered insulin product on this tier

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 5: 30% of the total cost	• Drug Tier 5: 30% of the total cost You pay up to $35 per month supply of each covered insulin product on this tier
	• Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	• Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

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

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

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,900	$5,100 Once you have paid $5,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2024 (this year)	2025 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$8,950	$10,100 Once you have paid $10,100 out-of-pocket for covered Part A and Part B services, you will 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 and Pharmacy Networks

Amounts you pay for your prescription drugs may 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.

Updated directories are located on our website at www.floridablue.com/medicare. At the top navigation, click Member Resources, then click Find a Doctor or Find a Pharmacy. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory*** www.floridablue.com/medicare **to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory*** www.floridablue.com/medicare **to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Acupuncture	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Advanced Imaging Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Allergy Testing (Office)	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Ambulatory Surgical Center (ASC)	**In-Network** $150 for a diagnostic colonoscopy in an Ambulatory Surgical Center (ASC) **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $0 copay for a diagnostic colonoscopy in an Ambulatory Surgical Center (ASC) **Out-of-Network** You pay 42% of the total cost
Blood Services (3 pint deductible waived)	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Cardiac Rehabilitation	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Chiropractic	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Dental Services* (additional benefits) **Periodic Oral Evaluation**	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates

Cost	2024 (this year)	2025 (next year)
Limited Oral Evaluation	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Comprehensive Oral Evaluation	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Diagnostic Imaging (X–rays)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Diagnostic Imaging (X–rays) Intraoral periapical	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Diagnostic Imaging (X–rays) Bitewings X-Rays	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Diagnostic Imaging (X–rays) Panoramic radiographic image	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Dental Prophylaxis (Cleanings)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates

Cost	2024 (this year)	2025 (next year)
Dental Prophylaxis (Fluoride)	**In-Network** 2 per calendar year either D1206 or D1208 **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 per calendar year either D1206 or D1208 **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Other Preventive Services (application of caries arresting medicament)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Restorative Services	**In-Network** 2 restorations per calendar year (combined with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 restorations per calendar year (combined with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Crowns	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates

Cost	2024 (this year)	2025 (next year)
Crowns (Core build-up including any pins when required), (Pin retention per tooth in addition to restoration), (Post and core in addition to crown indirectly fabricated)	**In-Network** 1 per calendar year (combined with D2950, D2951, D2952) $0 Copay **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	Crowns (Core build-up including any pins when required), (Pin retention per tooth in addition to restoration), (Post and core in addition to crown indirectly fabricated) are not covered
Endodontics (Root Canal)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Periodontics (Scaling and Root Planing)	**In-Network** 1 per quadrant per 24 month period **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 per quadrant per 36 month period **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Periodontics (Full Mouth Debridement to enable comprehensive evaluation and diagnosis)	**In-Network** 1 per 36 month period to be completed on the same day as D0150 or D1110 $0 Copay **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	Periodontics (Full Mouth Debridement to enable comprehensive evaluation and diagnosis) are not covered

Cost	2024 (this year)	2025 (next year)
Periodontics (Periodontal Maintenance)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics, Removable	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Repair of broken complete denture base mandibular, maxillary)	**In-Network** 2 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics-Replace missing or broken teeth, complete denture (each tooth)	**In-Network** 2 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Repair resin partial denture base mandibular, maxillary)	**In-Network** 2 per calendar year, 5 maximum per 5 years (either	**In-Network** 1 per calendar year, 5 maximum per 5 years (either

Cost	2024 (this year)	2025 (next year)
	D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Repair or replace broken clasp)	**In-Network** 2 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Replace broken teeth-per tooth)	**In-Network** 2 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** 1 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Add tooth to existing partial denture)	**In-Network** 2 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611,	**In-Network** 1 per calendar year, 5 maximum per 5 years (either D5511, D5512, D5520, D5611,

Cost	2024 (this year)	2025 (next year)
	D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	D5612, D5621, D5622, D5630, D5640, D5650, D5660) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Rebase complete maxillary or mandibular denture)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Reline complete maxillary or mandibular denture chair side)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Reline maxillary or mandibular partial denture chair side)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Reline complete maxillary or mandibular denture-laboratory)	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Prosthodontics (Reline maxillary or mandibular partial denture-laboratory	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates

Cost	2024 (this year)	2025 (next year)
Oral and Maxillofacial Surgery	**In-Network** Maximum of 4 per calendar year (combined with D7140, D7210, D7220, D7230, D7240, D7241, D7250) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates	**In-Network** Maximum of 2 per calendar year (combined with D7140, D7210, D7220, D7230, D7240, D7241, D7250) **Out-of-Network** Member pays up front and is reimbursed 58% of non-participating rates
Diabetes Self-Management Training	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Diabetic Prevention Program	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Diabetic Supplies and Diabetic Therapeutic Shoes and Inserts	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Diagnostic Procedures and Tests	**In-Network** You pay a $35 copay for level 1, $45 copay for level 2 for a diagnostic procedure or test in a physican specialist office **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $45 copay for a diagnostic procedure or test in a physican specialist office **Out-of-Network** You pay 42% of the total cost
Durable Medical Equipment	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Emergency Services	**In- and Out-of-Network** You pay a $120 copay per visit	**In- and Out-of-Network** You pay a $125 copay per visit
Eyeglass Frames and Lenses (Vision Materials)	**Out-of-Network** Member must pay 100% of the charges and submit the itemized receipt(s) for	**Out-of-Network** Member must pay 100% of the charges and submit the itemized receipt(s) for

Cost	2024 (this year)	2025 (next year)
	reimbursement of 55% of the in-network allowed amount. Member is responsible for all amounts in excess of the 55% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance. Total reimbursement is subject to the annual maximum plan benefit allowance.	reimbursement of 58% of the in-network allowed amount. Member is responsible for all amounts in excess of the 58% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance. Total reimbursement is subject to the annual maximum plan benefit allowance.
Hearing Aids	**Out-of-Network** Member must submit receipts for reimbursement at 55%	**Out-of-Network** Member must submit receipts for reimbursement at 58%
Hearing Exams (Routine), including Fitting of a Hearing Aid	**Out-of-Network** Member must submit receipts for reimbursement at 55% of maximum allowed	**Out-of-Network** Member must submit receipts for reimbursement at 58% of maximum allowed
Home Health Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Inpatient Hospital - Acute	**In-Network** You pay a $275 copay per days 1-6 and a $0 copay after day 6 Your daily copay includes the day of admission through the day of discharge. **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $320 copay per days 1-6 and a $0 copay after day 6 You will not be charged a copay for the day of discharge. **Out-of-Network** You pay 42% of the total cost
Inpatient Hospital - Psychiatric	**In-Network** Your daily copay includes the day of admission through the day of discharge.	**In-Network** You will not be charged a copay for the day of discharge. **Out-of-Network**

Cost	2024 (this year)	2025 (next year)
	Out-of-Network You pay 45% of the total cost	You pay 42% of the total cost
Intensive Cardiac Rehabilitation	**In-Network** You pay a $65 copay for intensive cardiac rehabilitation **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $55 copay for intensive cardiac rehabilitation **Out-of-Network** You pay 42% of the total cost
Kidney Disease Education Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Laboratory	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Medicare Covered Dental (Non-Routine)	**In-Network** You pay a $35 copay for Level 1 non-routine dental care You pay a $45 copay for Level 2 (all other) non-routine dental care **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $45 copay for non-routine dental care **Out-of-Network** You pay 42% of the total cost
Medicare Covered Eye Examination (Non-Routine)	**In-Network** You pay a $35 copay for Level 1 physician services to diagnose and treat eye diseases and conditions You pay a $45 copay for Level 2 (all other) services to diagnose and treat eye diseases and condition **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $45 copay for physician services to diagnose and treat eye diseases and conditions **Out-of-Network** You pay 42% of the total cost

Cost	2024 (this year)	2025 (next year)
Medicare Covered Eye Wear (Non-Routine)	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Medicare Covered Hearing Examination (Non-Routine)	**In-Network** You pay a $35 copay for Level 1 exams to diagnose and treat hearing and balance issues You pay a $45 copay for Level 2 (all other) exams to diagnose and treat hearing and balance issues **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $45 copay for exams to diagnose and treat hearing and balance issues **Out-of-Network** You pay 42% of the total cost
Medicare Part B Prescription Drugs (including insulin via DME)	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Medicare Part B Prescription Drugs **Avastin ® (bevacizumab)**	**In-Network** You pay 20% of the total cost for each injection of Avastin ® (bevacizumab) covered for eye injections	**In-Network** You pay a $0 copay for each injection of Avastin ® (bevacizumab) covered for eye injections
Medicare Part B Prescription Drugs **(Allergy Injection)**	**In-Network** You pay a $5 copay for allergy injections (in office) **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $0 copay for allergy injections (in office) **Out-of-Network** You pay 42% of the total cost
Mental Health Specialty-Non Physician	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Occupational Therapy Rehabilitation	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Opioid Treatment Programs	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost

Cost	2024 (this year)	2025 (next year)
Other Health Care Professional	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Outpatient Hospital Observation	**In-Network** You pay a $120 copay for outpatient hospital observation **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $125 copay for outpatient hospital observation **Out-of-Network** You pay 42% of the total cost
Outpatient Hospital Facility (per visit) (Surgery and Other)	**In-Network** You pay a $225 copay for Outpatient Hospital Services	**In-Network** You pay a $295 copay for Outpatient Hospital Services
Outpatient Hospital Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Outpatient Hospital Services **(Diagnostic Colonoscopy)**	**In-Network** You pay a $225 copay for Outpatient Hospital Services This copay also includes diagnostic colonoscopy.	**In-Network** You pay a $0 copay for diagnostic colonoscopy
Outpatient Substance Abuse Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Over-the-Counter Items	**In-Network** $70 each quarter. Balance does not roll over to next quarter. You may use your quarterly benefit for one or more orders until the maximum amount has been used for the quarter.	**In-Network** $56 each quarter. Balance does not roll over to next quarter. You may use your quarterly benefit for one or more orders until the maximum amount has been used for the quarter.
Partial Hospitalization (Outpatient Mental Health Sessions)	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost

Cost	2024 (this year)	2025 (next year)
Physical, Speech or Occupational Therapy Rehabilitation	**In-Network** You pay a $40 for lymphedema therapy **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $0 copay for lymphedema therapy **Out-of-Network** You pay 42% of the total cost
Physician Specialist	**In-Network** You pay a $35 copay per visit at Level 1 Physician Specialist You pay a $45 copay per visit for Level 2 (all other) Physician Specialist **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $45 copay per visit at Physician Specialist **Out-of-Network** You pay 42% of the total cost
Podiatry	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Preventive Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Primary Care Physician	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Prosthetics, Orthotics and Related Supplies	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Psychiatric Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Pulmonary Rehabilitation Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost

Cost	2024 (this year)	2025 (next year)
Skilled Nursing Facility (SNF)	**In-Network** $0 copay per day for days 1-20 $160 copay per day for days 21-100 **Out-of-Network** You pay 45% of the total cost	**In-Network** $0 copay per day for days 1-20 $214 copay per day for days 21-100 **Out-of-Network** You pay 42% of the total cost
Supervised Exercise Therapy (SET)	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Telehealth Services **(Dermatology)**	**In-Network** You pay a $35 copay per visit at Level 1 Physician Specialist You pay a $45 copay per visit for Level 2 (all other) Physician Specialist **Out-of-Network** You pay 45% of the total cost	**In-Network** You pay a $45 copay per visit at Physician Specialist **Out-of-Network** You pay 42% of the total cost
Therapeutic Radiological Services	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost
Vision Exams (Routine)	**Out-of-Network** Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 55% 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 58% of the in-network allowed amount.
Worldwide Emergency/Urgent Services	**In- and Out-of-Network** You pay a $120 copay for worldwide emergency/urgent services.	**In- and Out-of-Network** You pay a $125 copay for worldwide emergency/urgent services.
X-Rays	**Out-of-Network** You pay 45% of the total cost	**Out-of-Network** You pay 42% of the total cost

Section 1.5 – Changes to Part D Prescription 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 plan 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 are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider or the LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2024, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **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 will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the 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 do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $150 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) 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.	The deductible is $175 Applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) 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.

Changes to Your Cost-Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** For 2024 you paid a $47 copayment for drugs on Tier 3 Preferred Brand and $100 copayment for drugs on Tier 4 Non-Preferred Drug. For 2025 you will pay 25% coinsurance for drugs on Tier 3 and 25% coinsurance for drugs on Tier 4. The costs in this chart are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: ***Tier 1-Preferred Generic:*** You pay $0 per prescription. ***Tier 2-Generic:*** You pay $0 per prescription. ***Tier 3-Preferred Brand:*** You pay $47 per prescription. You pay up to $35 per month supply of each covered insulin product on this tier. ***Tier 4-Non-Preferred Drug:*** You pay $100 per prescription. ***Tier 5-Specialty Tier:*** You pay 30% of the total cost. ***Tier 6-Select Care Drugs:*** You pay $0 per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: ***Tier 1-Preferred Generic:*** You pay $0 per prescription. ***Tier 2-Generic:*** You pay $0 per prescription. ***Tier 3-Preferred Brand:*** You pay 25% of the total cost. You pay up to $35 per month supply of each covered insulin product on this tier. ***Tier 4-Non-Preferred Drug:*** You pay 25% of the total cost. You pay up to $35 per month supply of each covered insulin product on this tier. ***Tier 5-Specialty Tier:*** You pay 30% of the total cost. You pay up to $35 per month supply of each covered insulin product on this tier. ***Tier 6-Select Care Drugs:*** You pay $0 per prescription. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Stage	2024 (this year)	2025 (next year)
Most adult Part D vaccines are covered at no cost to you.		

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

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

SECTION 2 Administrative Changes

	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-800-926-6565 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BlueMedicare Value

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our BlueMedicare Value.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- - *OR* - You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Florida Blue offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from BlueMedicare Value.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueMedicare Value.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

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 (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer 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).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at 1-800-963-5337 (TTY users should call 1-800-955-8770). You can learn more about SHINE by visiting their website (www.FLORIDASHINE.org).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;

- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, please 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 new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **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 this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-800-926-6565 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from BlueMedicare Value

Questions? We're here to help. Please call Member Services at 1-800-926-6565. (TTY only, call 1-800-955-8770). We are 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 *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for BlueMedicare Value. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.floridablue.com/medicare/forms. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Visit our Website

You can also visit our website at www.floridablue.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/Drug List*).

Section 7.2 – Getting Help from Medicare

To get information directly 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 should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. View the Discrimination and Accessibility Notice at floridablue.com/ndnotice, plus information on our free language assistance services. Or call 1-800-352-2583 (TTY: 1-800-955-8770).

Puede ver la notificación de no discriminación y accesibilidad, además de información sobre nuestros servicios gratuitos de asistencia lingüística en floridablue.com/es/ndnotice. O llame al 1-800-352-2583 (TTY: 1-877-955-8773).

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-926-6565. (TTY users should call 1-800-955-8770). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-926-6565 (TTY: 1-877-955-8773). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-926-6565。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-926-6565。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-926-6565. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-926-6565. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-926-6565. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-926-6565. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-926-6565. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-926-6565. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Form CMS-10802
(Expires 12/31/25)

Form Approved
OMB# 0938-1421

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مساعدتك. هذه خدمة مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-926-6565. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-926-6565. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-926-6565. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-926-6565. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-926-6565. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-926-6565. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-926-6565 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。