BlueMedicare Patriot (PPO) offered by Florida Blue

Annual Notice of Change for 2026

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

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

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in BlueMedicare Patriot (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 Patriot (PPO)

- Florida Blue is a PPO plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.
- When this material says "we," "us," or "our," it means Florida Blue. When it says "plan" or "our plan," it means BlueMedicare Patriot (PPO).

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- **If you do nothing by December 7, 2025, you'll automatically be enrolled in BlueMedicare Patriot (PPO).** Starting January 1, 2026, you'll get your medical coverage through BlueMedicare Patriot (PPO)**.** Go to Section 2 for more information about how to change plans and deadlines for making a change.
- This plan doesn't include Medicare Part D drug coverage, and you can't be enrolled in a separate Medicare Part D drug plan and this plan at the same time. Note: If you don't have Medicare drug coverage, or creditable drug coverage (as good as Medicare's), for 63 days or more, you may have to pay a late enrollment penalty if you enroll in Medicare drug coverage in the future.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* (Go to Section 1.1 for details.)	$0	**$0**
Deductible	**In-Network** $0 **Out-of-Network** $0 for Medicare-covered services received out-of-network.	**In-Network** **$0** **Out-of-Network** **$950 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: $5,500 From in-network and out-of-network providers combined: $8,950	**From network providers: $6,750** **From in-network and out-of-network providers combined: $10,100**
Primary care office visits	**In-Network** $0 copay per visit **Out-of-Network** 42% of the total cost per visit	**In-Network** **$0 copay per visit** **Out-of-Network** **50% of the total cost per visit after you reach your $950 out-of-network deductible**
Specialist office visits	**In-Network** $45 copay per visit **Out-of-Network** 42% of the total cost per visit	**In-Network** **$55 copay per visit** **Out-of-Network** **50% of the total cost per visit after you reach your $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
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** $350 copay per day for days 1 - 4 $0 copay per day for days 5 - 90 **Out-of-Network** 42% of the total cost per visit	**In-Network** **$385 copay per day for days 1 - 7** **$0 copay per day for days 8 - 90** **Out-of-Network** **50% of the total cost per visit after you reach your $950 out-of-network deductible.**

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.)	$0	**$0** ***There is no change for the upcoming year***
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	$75	**$100**

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

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

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from network providers **count** toward your in-network maximum out-of-pocket amount.	$5,500	**$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 for the rest of the calendar year.**

	2025 (this year)	2026 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount.	$8,950	**$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 in-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 Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Acupuncture	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
Advanced Imaging Services	**In-Network** You pay a $0 copay for advanced imaging at a Physician's Office You pay a $0 copay for advanced imaging at an Independent Diagnostic Testing Facility (IDTF) You pay a $75 copay for advanced imaging at an Outpatient Hospital You pay a $0 copay for a diagnostic ultrasound at a Physician's Office You pay a $0 copay for a diagnostic ultrasound at an Independent Diagnostic Testing Facility (IDTF) You pay a $75 copay for a diagnostic ultrasound at an Outpatient Hospital Facility **Out-of-Network** You pay 42% of the total cost	**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)** **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 $950 out-of-network deductible**
Allergy Testing (Office)	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Ambulance	**In-Network** You pay a $250 copay for one-way trip ground or air ambulance	**In-Network** **You pay a $0 copay for facility-to-facility transfer via ground ambulance**

	2025 (this year)	2026 (next year)
	Out-of-Network You pay $250 copay for one-way trip ground or air ambulance	**You pay a $275 copay for one-way trip ground ambulance** **You pay a 20% of the total cost for one-way trip air ambulance** **Out-of-Network** **You pay $275 copay for one-way trip ground ambulance** **You pay a 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 at an Ambulatory Surgical Center (ASC) You pay a $300 copay for all other services performed at an Ambulatory Surgical Center (ASC) **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $300 copay for a diagnostic colonoscopy at an Ambulatory Surgical Center (ASC)** **You pay a $300 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 $950 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**

	2025 (this year)	2026 (next year)
Blood Services (3 pint deductible waived)	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Cardiac Rehabilitation	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 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

	2025 (this year)	2026 (next year)
Chiropractic Services	**In-Network** You pay a $20 copay for chiropractic services **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $15 copay for chiropractic services** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Dental Services* (additional benefits)	**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	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Diagnostic Procedures and Tests	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 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	**In-Network** You pay a 20% coinsurance for Durable Medical Equipment **Out-of-Network**

	2025 (this year)	2026 (next year)
		You pay 50% of the total cost after you reach your $950 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**
Eyeglass Frames and Lenses (Vision Materials)	**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. 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	**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.** **Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance.** **Total reimbursement is subject to the annual maximum plan benefit allowance**
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 a 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	**Out-of-Network**

	2025 (this year)	2026 (next year)
		You pay 50% of the total cost after you reach your $950 out-of-network deductible
Inpatient Hospital - Acute	**In-Network** You pay a $350 copay per day for days 1 - 4 $0 copay per day for days 5 - 90 Copay per Medicare-covered stay includes the day of admission and the day of discharge. **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $385 copay per day for days 1- 7** **$0 copay per day for days 8 - 90** **Copay per Medicare-covered stay includes the day of admission and the day of discharge.** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Inpatient Hospital - Psychiatric	**In-Network** You pay a $318 copay per day for days 1 - 5 and $0 copay per day for days 6 - 90. **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $350 copay per day for days 1 - 6 and $0 copay per day for days 7 - 90.** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Intensive Cardiac Rehabilitation	**In-Network** You pay a $55 copay for intensive cardiac rehabilitation **Out-of-Network** You pay 42% of the total cost	**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 $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
Intensive Outpatient Program Services	**In-Network** You pay a $20 copay for intensive outpatient program services **Out-of-Network** You pay 42% of the total cost	**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 $950 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**
Laboratory	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Lymphedema Therapy	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medical Supplies	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medicare Covered Dental (Non-Routine)	**In-Network** You pay a $45 copay for Medicare Covered Dental (Non-Routine) **Out-of-Network** You pay 42% of the total cost	**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 $950 out-of-network deductible**
Medicare Covered Eye Examination (Non-Routine)	**In-Network** You pay a $45 copay for for physician services to diagnose and treat eye diseases and conditions	**In-Network** **You pay a $55 copay for for physician services to diagnose and treat eye diseases and conditions**

	2025 (this year)	2026 (next year)
	Out-of-Network You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medicare Covered Eye Wear (Non-Routine)	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medicare Covered Hearing Examination (Non-Routine)	**In-Network** You pay a $45 copay for Medicare Covered Hearing Examination (Non-Routine) **Out-of-Network** You pay 42% of the total cost	**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 $950 out-of-network deductible**
Medicare Part B Prescription Drugs **(chemotherapy drugs)**	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medicare Part B Prescription Drugs **(including insulin drugs via DME)**	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medicare Part B Prescription Drugs **Avastin ® (bevacizumab)**	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Medicare Part B Prescription Drugs **(Allergy Injection)**	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 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	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Occupational Therapy Rehabilitation	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Opioid Treatment Program	**In-Network** You pay a $20 copay for each Opioid Treatment **Out-of-Network** You pay 42% of the total cost	**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 $950 out-of-network deductible**
Other Health Care Professional	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Outpatient Hospital Facility (per visit) (Surgery and Other)	**In-Network** You pay a $300 copay per visit **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $350 copay per visit** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Outpatient Hospital Observation	**In-Network** You pay a $125 copay for outpatient hospital observation **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $130 copay for outpatient hospital observation** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
Outpatient Hospital Services	**In-Network** You pay a $0 copay for a diagnostic colonoscopy in an outpatient hospital You pay a $300 copay for all other outpatient hospital services **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $350 copay for a diagnostic colonoscopy in an outpatient hospital** **You pay a $350 copay for all other outpatient hospital services** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 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 42% of the total cost	**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 $950 out-of-network deductible**
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 42% of the total cost	**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 $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
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 42% of the total cost	**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 $950 out-of-network deductible**
Physical Therapy Rehabilitation	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Physician Specialist	**In-Network** You pay a $45 copay per visit for Physician Specialist **Out-of-Network** You pay 42% of the total cost	**In-Network** **You pay a $55 copay per visit for Physician Specialist** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Podiatry	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 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**

	2025 (this year)	2026 (next year)
		○ **Computed tomography (CT) colonography** ○ **Fecal occult blood tests** ○ **Flexible sigmoidoscopies** ○ **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	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Prosthetics, Orthotics and Related Supplies	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 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 42% of the total cost	**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 $950 out-of-network deductible**
Pulmonary Rehabilitation Services	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network**

	2025 (this year)	2026 (next year)
		You pay 50% of the total cost after you reach your $950 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 42% of the total cost	**In-Network** **You pay a $0 copay per days 1 - 20** **$218 copay per days 21 - 100** **Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Speech Therapy Rehabilitation	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Supervised Exercise Therapy (SET)	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Telehealth Services	**In-Network** You pay the following for each benefit listed below: • Urgently Needed Services: $30 copay • Provider of Choice: $0 copay • Occupational Therapy: $40 copay • Physical Therapy: $40 copay • Speech Therapy: $40 copay • Dermatology Services: $45 copay	**In-Network** **You pay the following for each benefit listed below:** • **Urgently Needed Services: $50 copay** • **Provider of Choice: $0 copay** • **Occupational Therapy: $40 copay** • **Physical Therapy: $40 copay** • **Speech Therapy: $40 copay**

	2025 (this year)	2026 (next year)
	• Mental Health Specialty Services: $20 copay • Psychiatry Specialty Services: $20 copay • Opioid Treatment: $20 copay • Substance Use Disorder Services: $20 copay • Diabetes Self-Management Training: $0 copay • Dietician Services: $0 copay	• **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** • **Diabetes Self-Management Training: $0 copay** • **Dietician Services: $0 copay**
	Out-of-Network You pay the following for each benefit listed below: • Urgently Needed Services: $30 copay • Provider of Choice: 42% of the total cost • Occupational Therapy: 42% of the total cost • Physical Therapy: 42% of the total cost • Speech Therapy: 42% of the total cost • Dermatology Services: 42% of the total cost • Mental Health Specialty Services: 42% of the total cost • Psychiatry Specialty Services: 42% of the total cost • Opioid Treatment: 42% of the total cost	**Out-of-Network** **You pay the following for each benefit listed below:** • **Urgently Needed Services: $50 copay** • **Provider of Choice: 50% of the total cost after you reach your $950 out-of-network deductible** • **Occupational Therapy: 50% of the total cost after you reach your $950 out-of-network deductible** • **Physical Therapy: 50% of the total cost after you reach your $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
	• Substance Use Disorder Services: 42% of the total cost • Diabetes Self-Management Training: 42% of the total cost • Dietician Services: 42% of the total cost	• **Speech Therapy: 50% of the total cost after you reach your $950 out-of-network deductible** • **Dermatology Services: 50% of the total cost after you reach your $950 out-of-network deductible** • **Mental Health Specialty Services: 50% of the total cost after you reach your $950 out-of-network deductible** • **Psychiatry Specialty Services: 50% of the total cost after you reach your $950 out-of-network deductible** • **Opioid Treatment: 50% of the total cost after you reach your $950 out-of-network deductible** • **Substance Use Disorder Services: 50% of the total cost after you reach your $950 out-of-network deductible** • **Diabetes Self-Management Training: 50% of the total cost** • **Dietician Services: 50% of the total cost after you reach your $950 out-of-network deductible**

	2025 (this year)	2026 (next year)
Therapeutic Radiological Services	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**
Urgently Needed Services	**In- and Out-of-Network** You pay $30 copay for each urgent care visit to a Convenient Care Canter and/or Urgent Care Center	**In- and Out-of-Network** **You pay $50 copay for each urgent care visit to a Convenient Care Canter and/or Urgent Care Center**
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 service	**In- and Out-of-Network** **You pay $130 copay for worldwide emergency/urgent service**
X-Rays	**Out-of-Network** You pay 42% of the total cost	**Out-of-Network** **You pay 50% of the total cost after you reach your $950 out-of-network deductible**

SECTION 2 How to Change Plans

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

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

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from BlueMedicare Patriot (PPO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from BlueMedicare Patriot (PPO).

- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-800-926-6565 (TTY users call 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 3).
- **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 4), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Florida Blue Medicare offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly premiums, and cost-sharing amounts.

Section 2.1 – Deadlines for Changing Plans

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

If you enrolled in a Medicare Advantage plan for January 1, 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 (with or without separate Medicare drug coverage) between January 1 - March 31, 2026.

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

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

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

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

SECTION 3 Get Help Paying for Prescription Drugs

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

Extra Help from Medicare. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan, yearly deductibles, and coinsurance. Also, those who qualify won't have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- Social Security at 1-800-772-1213 between 8 am and 7 pm, Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778; or
- Your State Medicaid Office.

SECTION 4 Questions?

Get Help from BlueMedicare Patriot (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, look in the *2026 Evidence of Coverage* for BlueMedicare Patriot (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.floridablue.com/medicare/forms 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*).

Get Free Counseling about Medicare

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

Call SHINE to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call SHINE at 1-800-963-5337 (TTY only, call 1-800-955-8770). 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 should 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). 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 (لذوي الإعاقة السمعية TTY: 711)

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

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

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

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

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

1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711) પર 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 1-800-926-6565 با (TTY: 711) تماس بگیرید. برای FEP 1-800-333-2227 با.

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).