

BlueMedicare Patriot (PPO) offered by Florida Blue

Annual Notice of Changes for 2024

You are currently enrolled as a member of BlueMedicare Patriot. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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. 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).
 - Think about how much you will spend on premiums, deductibles, and cost-sharing.
- Check to see if your primary care doctors, specialists, hospitals and other providers will be in our network next year.
- 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 www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.
- 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, 2023, you will stay in BlueMedicare Patriot.

- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with BlueMedicare Patriot.
- If you recently moved into, currently live in, or just moved out of 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.

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 Patriot

- 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 Patriot.
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Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for BlueMedicare Patriot in several important areas. **Please note this is only a summary of costs.**

| Cost | 2023 (this year) | 2024 (next year) |
|--|---|---|
| Monthly plan premium (See Section 1.1 for details.) | \$0 | \$0 |
| Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.) | From network providers: \$5,500 From in-network and out-of-network providers combined: \$8,950 | From network providers: \$5,500 From in-network and out-of-network providers combined: \$8,950 |
| Doctor office visits | <p><u>In-Network</u> Primary Care visits: \$10 copay per visit</p> <p>Specialist Visits: \$45 copay per visit</p> <p><u>Out-of-Network</u> Primary care visits: 47% of the total cost per visit</p> <p>Specialist visits: 47% of the total cost per visit</p> | <p><u>In-Network</u> Primary Care visits: \$10 copay per visit</p> <p>Specialist Visits: \$45 copay per visit</p> <p><u>Out-of-Network</u> Primary care visits: 45% of the total cost per visit</p> <p>Specialist visits: 45% of the total cost per visit</p> |

| Cost | 2023 (this year) | 2024 (next year) |
|---------------------------------|--|--|
| Inpatient hospital stays | <p><u>In-Network</u> Days 1-4: \$350 copay per day (per Medicare-covered stay)</p> <p>After the 4th day, the plan pays 100% of the covered expenses</p> <p><u>Out-of-Network</u> 47% of the total cost</p> | <p><u>In-Network</u> Days 1-4: \$350 copay per day (per Medicare-covered stay)</p> <p>After the 4th day, the plan pays 100% of the covered expenses</p> <p><u>Out-of-Network</u> 45% of the total cost</p> |

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| Monthly premium | \$0 | \$0 |
| (You must also continue to pay your Medicare Part B premium.) | BlueMedicare Patriot will reduce your monthly Medicare Part B premium by up to \$50 | BlueMedicare Patriot will reduce your monthly Medicare Part B premium by up to \$75 |

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. 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 | 2023 (this year) | 2024 (next year) |
|--|------------------|---|
| In-network maximum out-of-pocket amount | \$5,500 | \$5,500 |
| Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. | | Once you have paid \$5,500 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. |
| Combined maximum out-of-pocket amount | \$8,950 | \$8,950 |
| Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your | | Once you have paid \$8,950 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 |

| Cost | 2023 (this year) | 2024 (next year) |
|--|------------------|---|
| combined maximum out-of-pocket amount. | | in-network or out-of-network providers for the rest of the calendar year. |

Section 1.3 – Changes to the Provider Network

Updated directories are located on our website at www.floridablue.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) 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 | 2023 (this year) | 2024 (next year) |
|---|---|--|
| Acupuncture | Prior Authorization is required for over 12 visits, in-network only. <u>Out-of-Network</u> You pay 47% of the total cost | Medical Necessity review is required for over 12 visits, in-network only. <u>Out-of-Network</u> You pay 45% of the total cost |
| Advanced Imaging Services | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Ambulatory Surgical Center (ASC) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| At Home Care Program | <u>In-Network</u> At Home Care, 60 hours per year. Services include support | At Home Care is <u>not</u> covered |

| Cost | 2023 (this year) | 2024 (next year) |
|--|--|--|
| | with Instrumental Activities of Daily Living (IADL). | |
| Blood Services (3 pint deductible waived) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Cardiac rehabilitation services | <p>Prior Authorization may be required for services, in-network only.</p> <p><u>In-Network</u> You pay a \$40 copay for cardiac rehabilitation services</p> <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p>Prior authorization is <u>not</u> required for cardiac rehabilitation.</p> <p><u>In-Network</u> You pay a \$35 copay for cardiac rehabilitation services</p> <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Chiropractic | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Dental Services* (additional benefits) | | |
| Periodic Oral Evaluation | <p><u>Out-of Network</u> Member pays up front and is reimbursed 53% of non-participating rates</p> | <p><u>Out-of Network</u> Member pays up front and is reimbursed 55% of non-participating rates</p> |
| Comprehensive Oral Evaluation | <p><u>In-Network</u> You pay a \$0 copay for a comprehensive oral evaluation 1 per lifetime, per dentist</p> <p><u>Out-of-Network</u> Member pays up front and is reimbursed 53% of non-participating rates</p> | <p><u>In-Network</u> You pay a \$0 Copay for Comprehensive oral evaluations (D0150) are limited to 1 per lifetime, per dentist but also count against the 2 evaluation limit per calendar year.</p> <p><u>Out-of-Network</u> Member pays up front and is reimbursed 55% of non-participating rates</p> |

| Cost | 2023 (this year) | 2024 (next year) |
|--|---|---|
| Diagnostic Imaging (X-rays) | <u>Out-of-Network</u> Member pays up front and is reimbursed 53% of non-participating rates | <u>Out-of-Network</u> Member pays up front and is reimbursed 55% of non-participating rates |
| Dental Prophylaxis (Cleanings) | <u>Out-of-Network</u> Member pays up front and is reimbursed 53% of non-participating rates | <u>Out-of-Network</u> Member pays up front and is reimbursed 55% of non-participating rates |
| Oral and Maxillofacial Surgery | <u>Out-of-Network</u> Member pays up front and is reimbursed 53% of non-participating rates | <u>Out-of-Network</u> Member pays up front and is reimbursed 55% of non-participating rates |
| Prosthodontics, Removeable (Adjust complete denture - maxillary, Adjust complete denture - mandibular, Adjust partial denture - maxillary, Adjust partial denture - mandibular) | <u>Out-of-Network</u> Member pays up front and is reimbursed 53% of non-participating rates | <u>Out-of-Network</u> Member pays up front and is reimbursed 55% of non-participating rates |
| Diabetic Prevention Program | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Diabetic Supplies and Diabetic Therapeutic Shoes and Inserts | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Diagnostic Procedures and Tests | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Durable Medical Equipment | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Emergency Services | <u>In- and Out-of-Network</u> You pay a \$90 copay per visit | <u>In- and Out-of-Network</u> You pay a \$120 copay per visit |

| Cost | 2023 (this year) | 2024 (next year) |
|--|--|--|
| Eyeglass Frames and Lenses (Vision Materials) | <p><u>In-Network</u> \$250 Allowance per year towards the purchase of lenses, frames or contacts</p> <p>Member responsible for costs exceeding the Benefit Maximum</p> <p><u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 53% of the in-network allowed amount.</p> <p>Member is responsible for all amounts in excess of the 53% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance.</p> <p>Total reimbursement is subject to the annual maximum plan benefit allowance.</p> | <p><u>In-Network</u> \$200 Allowance per year towards the purchase of lenses, frames or contacts</p> <p>Member responsible for costs exceeding the Benefit Maximum</p> <p><u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 55% of the in-network allowed amount.</p> <p>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.</p> <p>Total reimbursement is subject to the annual maximum plan benefit allowance.</p> |
| Health Education | You pay a \$0 copay for Health Education provided through meQuilibrium's digital coaching platform. | Health Education is <u>not</u> covered |
| Hearing Aids | <p>\$500 maximum allowance for each hearing aid.</p> <p>Up to 2 hearing aids every year.</p> <p>Hearing aids must be purchased through NationsHearing to receive in-network benefits.</p> <p><u>In-Network</u> You pay a \$0 copay</p> | <p>Up to 2 hearing aids every year. Hearing aids must be purchased through NationsHearing to receive in-network benefits.</p> <p><u>In-Network</u> You pay the following copay depending on device level for each hearing aid.</p> |

| Cost | 2023 (this year) | 2024 (next year) |
|---|--|--|
| | <p>Subject to Benefit Maximum.</p> <p>Member is responsible for any amount after the benefit allowance has been applied.</p> <p><u>Out-of-Network</u> Member must submit receipts for reimbursement at 53% of maximum allowed.</p> <p>Subject to Benefit Maximum.</p> <p>Member is responsible for any amount after the benefit allowance has been applied.</p> | <p>Entry \$350.00 per device</p> <p>Basic \$525.00 per device</p> <p>Prime \$825.00 per device</p> <p>Preferred \$1,125.00 per device</p> <p>Advanced \$1,425.00 per device</p> <p>Premium \$1,825.00 per device</p> <p>Subject to Benefit Maximum.</p> <p>Member is responsible for any amount after the benefit maximum has been applied.</p> <p><u>Out-of-Network</u> Member must submit receipts for reimbursement at 55% of customary price of approved entry-level hearing aid devices. Up to 2 devices a year.</p> |
| Hearing Exams, includes Fitting of Hearing Aid | <p><u>Out-of-Network</u> Member must submit receipts for reimbursement at 53% of maximum allowed.</p> | <p><u>Out-of-Network</u> Member must submit receipts for reimbursement at 55% of maximum allowed</p> |
| Home Health Services | <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Intensive Cardiac Rehabilitation | <p>Prior Authorization may be required for services, in-network only.</p> <p><u>In-Network</u> You pay a \$50 for intensive cardiac rehabilitation</p> <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p>Prior authorization is <u>not</u> required for intensive cardiac rehabilitation.</p> <p><u>In-Network</u> You pay a \$65 for intensive cardiac rehabilitation</p> <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |

| Cost | 2023 (this year) | 2024 (next year) |
|--|---|---|
| Inpatient Hospital - Acute | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Inpatient Hospital - Psychiatric | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Kidney Disease Education Services | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Laboratory | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Medicare Covered Dental (Non-Routine) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Medicare Covered Eye Examination (Non-Routine) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Medicare Covered Eye Wear (Non-Routine) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Medicare Covered Hearing Examination (Non-Routine) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Medicare Part B Drugs (including Insulin Drugs via DME) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Mental Health Specialty-Non Physician | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Occupational Therapy Rehabilitation | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Opioid Treatment Programs | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Other Health Care Professional | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |

| Cost | 2023 (this year) | 2024 (next year) |
|--|--|---|
| Outpatient Hospital Observation | <u>In-Network</u> You pay a \$90 copay for outpatient hospital observation | <u>In-Network</u> You pay a \$120 copay for outpatient hospital observation |
| | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Outpatient Hospital Services | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Outpatient Substance Abuse Services | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Partial Hospitalization (Outpatient Mental Health Sessions) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Physical and Speech Therapy Rehabilitation | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Physician Specialist | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Podiatry | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Preventive Services | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Primary Care Physician (PCP) | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Prosthetics, Orthotics and Related Supplies | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |
| Psychiatric Services | <u>Out-of-Network</u> You pay 47% of the total cost | <u>Out-of-Network</u> You pay 45% of the total cost |

| Cost | 2023 (this year) | 2024 (next year) |
|--|--|---|
| Pulmonary Rehabilitation Services | <p>Prior Authorization may be required for services, in-network only.</p> <p><u>In-Network</u> You pay a \$20 copay for pulmonary rehabilitation services</p> <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p>Prior Authorization is <u>not</u> required for Pulmonary Rehabilitation Services.</p> <p><u>In-Network</u> You pay a \$15 copay for pulmonary rehabilitation services</p> <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Supervised Exercise Therapy (SET) | <p><u>In-Network</u> You pay a \$20 copay for supervised exercise therapy (SET)</p> <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p><u>In-Network</u> You pay a \$25 copay for supervised exercise therapy (SET)</p> <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Skilled Nursing Facility | <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Telehealth Services | <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Therapeutic Radiological Services | <p><u>Out-of-Network</u> You pay 47% of the total cost</p> | <p><u>Out-of-Network</u> You pay 45% of the total cost</p> |
| Vision Exams (Routine) | <p><u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 53% of the in-network allowed amount.</p> | <p><u>Out-of-Network</u> Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 55% of the in-network allowed amount.</p> |
| Worldwide Emergency/Urgent Services | <p><u>In- and Out-of-Network</u> You pay a \$125 copay for worldwide emergency/urgent services.</p> | <p><u>In- and Out-of-Network</u> You pay a \$120 copay for worldwide emergency/urgent services.</p> |

| Cost | 2023 (this year) | 2024 (next year) |
|--------|--|--|
| X-Rays | Out-of-Network You pay 47% of the total cost | Out-of-Network You pay 45% of the total cost |

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in BlueMedicare Patriot

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 Patriot.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 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, there may be 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 Patriot.
 - To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BlueMedicare Patriot.
- To **change to Original Medicare without a prescription drug plan**, you must either:

- o Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
- o – 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 3 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, 2024.

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, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of 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.

SECTION 4 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 5 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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or 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 (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida's AIDS Drug Assistance Program 1-800-352-2437 (TTY: 1-888-503-7118), or mail them at: HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399. **Note:** 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.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Call Florida's AIDS Drug Assistance Program 1-800-352-2437 (TTY: 1-888-503-7118), or mail them at: HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Florida's AIDS Drugs Assistance Program 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.

SECTION 6 Questions?

Section 6.1 – Getting Help from BlueMedicare Patriot

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 2024 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 2024. For details, look in the 2024 *Evidence of Coverage* for BlueMedicare Patriot. 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. 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*).

Section 6.2 – 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 2024

Read the *Medicare & You 2024* 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. Visit floridablue.com/ndnotice for information on our free language assistance services.

Nosotros cumplimos con las leyes federales de derechos civiles aplicables y no discriminamos por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Para información sobre nuestros servicios gratuitos de asistencia lingüística, visite floridablue.com/es/ndnotice.

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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 pagsaling-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 quý vị cần thông dịch viên xin gọi 1-800-926-6565. sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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.

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

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 Italiano 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。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。

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