BlueMedicare Value (PPO) offered by Florida Blue

Annual Notice of Changes for 2024

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 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).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies 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 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, 2024**. This will end your enrollment with BlueMedicare Value.
- 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 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 2024
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Summary of Important Costs for 2024

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

Cost	2023 (this year)	2024 (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: $4,500 From network and out-of-network providers combined: $8,950	From network providers: $4,900 From network and out-of-network providers combined: $8,950
Doctor office visits	**In-Network** Primary care visits: $0 copay per visit Specialist visits: Level 1 - $35 copay per visit Level 2 - $44 copay per visit **Out-of-Network** Primary care visits: 47% of the total cost per visit Specialist visits: 47% of the total cost per visit	**In-Network** Primary care visits: $0 copay per visit Specialist visits: Level 1 - $35 copay per visit Level 2 - $44 copay per visit **Out-of-Network** Primary care visits: 45% of the total cost per visit Specialist visits: 45% of the total cost per visit

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network** Days 1-6: $290 copay per day (per Medicare-covered stay) After the 6th day, the plan pays 100% of the covered expenses **Out-of-Network** 47% of the total cost	**In-Network** Days 1-6: $290 copay per day (per Medicare-covered stay) After the 6th day, the plan pays 100% of the covered expenses **Out-of-Network** 45% 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: $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:
	• 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 $35 per month supply of each covered insulin product on this tier	• Drug Tier 3: $47 copay You pay $35 per month supply of each covered insulin product on this tier
	• Drug Tier 4: $100 copay	• Drug Tier 4: $100 copay

Cost	2023 (this year)	2024 (next year)
	• Drug Tier 5: 30% of the total cost • Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs).	• Drug Tier 5: 30% of the total cost • 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.

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 (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

Cost	2023 (this year)	2024 (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.	$4,500	$4,900 Once you have paid $4,900 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 Once you have paid $8,950 out-of-pocket for

Cost	2023 (this year)	2024 (next year)
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.		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.

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.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.floridablue.com/medicare. 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 2024 *Provider Directory* 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 2024 *Pharmacy Directory* 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	2023 (this year)	2024 (next year)
Acupuncture	Prior Authorization is required for over 12 visits, in-network only. **Out-of-Network** You pay 47% of the total cost	Medical Necessity review is required for over 12 visits, in-network only. **Out-of-Network** You pay 45% of the total cost
Advanced Imaging Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Ambulance Services	**Out-of-Network** You pay a $310 copay for each Medicare-covered trip (one-way)	**Out-of-Network** You pay a $250 copay for each Medicare-covered trip (one-way)
Ambulatory Surgical Center (ASC)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
At Home Care Program	**In-Network** You pay a $0 copay for Home Care, 60 hours per year. Services include support with Instrumental Activities of Daily Living (IADL).	At Home Care is not covered
Blood Services (3 pint deductible waived)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Cardiac Rehabilitation	Prior Authorization may be required for services, in-network only. **In-Network** You pay a $40 copay for cardiac rehabilitation services **Out-of-Network** You pay 47% of the total cost	Prior authorization is not required for cardiac rehabilitation. **In-Network** You pay a $35 copay for cardiac rehabilitation services **Out-of-Network** You pay 45% of the total cost
Chiropractic	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost

Cost	2023 (this year)	2024 (next year)
Dental Services* (additional benefits)		
Periodic Oral Evaluation	**Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Limited Oral Evaluation	Limited oral evaluation is not covered	As necessary **In-Network** You pay a $0 Copay for limited oral evaluation **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Comprehensive Oral Evaluation	1 per lifetime, per dentist **Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	Comprehensive oral evaluations are limited to 1 per lifetime, per dentist but also count against the 2 evaluation limit per calendar year. **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Diagnostic Imaging (X–rays)	**Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates

Cost	2023 (this year)	2024 (next year)
Diagnostic Imaging (X–rays) Intraoral periapical	Diagnostic Imaging (X–rays) Intraoral periapical are not covered.	**In-Network** 1 set per calendar year You pay a $0 Copay for Diagnostic Imaging (X–rays) Intraoral periapical. **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Diagnostic Imaging (X–rays) Bitewings X-Rays	**Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Diagnostic Imaging (X–rays) Panoramic radiographic image	**Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	**Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Dental Prophylaxis (Cleanings)	2 cleanings per consecutive 12 months **Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	2 cleanings per calendar year combined limit for prophylaxis and periodontal maintenance **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates

Cost	2023 (this year)	2024 (next year)
Dental Prophylaxis (Fluoride)	Dental Prophylaxis (Fluoride) is not covered.	**In-Network** 2 per calendar year You pay a $0 Copay for Dental Prophylaxis (Fluoride) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Other Preventive Services (application of caries arresting medicament)	Other Preventive Services (application of caries arresting medicament) is not covered.	**In-Network** 2 per calendar year You pay a $0 Copay for Other Preventive Services (application of caries arresting medicament) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Restorative Services	Restorative Services are not covered.	**In-Network** 2 restorations per calendar year You pay a $0 Copay for Restorative Services **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates

Cost	2023 (this year)	2024 (next year)
Crowns	Crowns are not covered	**In-Network** 1 crown per calendar year only in conjunction with a covered root canal procedure You pay a $0 Copay for crowns in conjunction with a covered root canal procedure 1 per calendar year for core build-up, including any pins when required You pay a $0 Copay for core build-up **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Endodontics (Root Canal)	Endodontics are not covered	**In-Network** 1 per calendar year You pay a $0 Copay for Endodontics (Root Canal) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates

Cost	2023 (this year)	2024 (next year)
Periodontics	Peridontics are <u>not</u> covered	**<u>In-Network</u>** 1 per quadrant per 24 month period You pay a $0 Copay for Periodontics (Periodontal scaling and root planing) 1 per 36 month period not to be completed on the same day as cleaning or comprehensive oral evalution You pay a $0 Copay for full mouth debridement to enable comprehensive oral evaluation and diagnosis 2 cleanings per calendar year (combined limit for dental prophylaxis and periodontal maintenance) You pay a $0 Copay for periodontal maintenance **<u>Out-of-Network</u>** Member pays up front and is reimbursed 55% of non-participating rates

Cost	2023 (this year)	2024 (next year)
Prosthodontics, Removable **(Complete denture maxillary or mandibular, immediate denture maxillary or mandibular, partial denture maxillary or mandibular)**	Prosthodontics Removable (Complete denture maxillary or mandibular, immediate denture maxillary or mandibular, partial denture maxillary or mandibular) are not covered	**In-Network** 1 set per 60 months You pay a $0 Copay for Prosthodontics Removable **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Prosthodontics, Removable **(Adjust complete denture - maxillary, Adjust complete denture - mandibular, Adjust partial denture - maxillary, Adjust partial denture - mandibular)**	**In-Network** Maximum 2 per 12 consecutive months **Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	**In-Network** 1 per calendar year **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Prosthodontics, Removable **(Repair or replace dentures)**	Prosthodontics Removable (Repair or replace dentures) are not covered	**In-Network** 2 per calendar year, 5 maximum per 5 years You pay a $0 Copay for Prosthodontics Removable (repair or replace dentures) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates

Cost	2023 (this year)	2024 (next year)
Prosthodontics, Removable **(Reline or rebase dentures)**	Prosthodontics Removable (Reline or rebase dentures) are not covered	**In-Network** 1 per calendar year You pay a $0 Copay for Prosthodontics Removable (reline or rebase dentures) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Oral and Maxillofacial Surgery **Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	Maximum 2 per 12 consecutive months for an erupted or exposed tooth. Includes local anesthetic, suturing and routine postoperative care. **Out-of-Network** Member pays up front and is reimbursed 53% of non-participating rates	Maximum of 4 per calendar year **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Oral and Maxillofacial Surgery **(Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, removal of impacted tooth or removal of residual roots)**	Oral and Maxillofacial Surgery (Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated or removal of impacted tooth) is not covered	**In-Network** Maximum of 4 per calendar year You pay a $0 Copay for Oral and maxillofacial surgery (Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated,

Cost	2023 (this year)	2024 (next year)
		removal of impacted tooth or removal of residual roots) **Out-of-Network** Member pays up front and is reimbursed 55% of non-participating rates
Diabetic Prevention Program	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Diabetic Supplies and Diabetic Therapeutic Shoes and Inserts	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Diagnostic Procedures and Tests	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Durable Medical Equipment	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Emergency Services	**In- and Out-of-Network** You pay a $90 copay per visit	**In- and Out-of-Network** You pay a $120 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 53% of the in-network allowed amount. 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. 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 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.

Cost	2023 (this year)	2024 (next year)
Health Education	You pay a $0 copay for Health Education provided through meQuilibrium's digital coaching platform.	Health Education is not covered
Hearing Aids	**Benefit Maximum** $750 maximum allowance for each hearing aid. Up to 2 hearing aids every year. Hearing aids must be purchased through NationsHearing to receive in-network benefits. **In-Network** You pay a $0 copay Subject to Benefit Maximum. Member is responsible for any amount after the benefit allowance has been applied. **Out-of-Network** Member must submit receipts for reimbursement at 53% of maximum allowed. Subject to Benefit Maximum. Member is responsible for any amount after the benefit allowance has been applied.	**Benefit Maximum** Up to 2 hearing aids every year. Hearing aids must be purchased through NationsHearing to receive in-network benefits. **In-Network** You pay the following copay depending on device level for each hearing aid. Entry $350.00 per device Basic $525.00 per device Prime $825.00 per device Preferred $1,125.00 per device Advanced $1,425.00 per device Premium $1,825.00 per device Subject to Benefit Maximum. Member is responsible for any amount after the benefit maximum has been applied. **Out-of-Network** Member must submit receipts for reimbursement at 55% of customary price of approved entry-level hearing aid devices. Up to 2 devices a year.

Cost	2023 (this year)	2024 (next year)
Hearing Exams (Routine), including Fitting of a Hearing Aid	**Out-of-Network** Member must submit receipts for reimbursement at 53% of maximum allowed.	**Out-of-Network** Member must submit receipts for reimbursement at 55% of maximum allowed
Home Health Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Inpatient Hospital - Acute	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Inpatient Hospital - Psychiatric	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Intensive Cardiac Rehabilitation	Prior Authorization may be required for services, in-network only. **In-Network** You pay a $50 copay for intensive cardiac rehabilitation **Out-of-Network** You pay 47% of the total cost	Prior authorization is not required for intensive cardiac rehabilitation. **In-Network** You pay a $65 copay for intensive cardiac rehabilitation **Out-of-Network** You pay 45% of the total cost
Kidney Disease Education Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Laboratory	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Medicare Covered Dental (Non-Routine)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Medicare Covered Eye Examination (Non-Routine)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Medicare Covered Eye Wear (Non-Routine)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost

Cost	2023 (this year)	2024 (next year)
Medicare Covered Hearing Examination (Non-Routine)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Medicare Part B Drugs (including insulin via DME)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Mental Health Specialty-Non Physician	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Occupational Therapy Rehabilitation	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Opioid Treatment Programs	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Other Health Care Professional	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Outpatient Hospital Observation	**In-Network** You pay a $90 copay for outpatient hospital observation **Out-of-Network** You pay 47% of the total cost	**In-Network** You pay a $120 copay for outpatient hospital observation **Out-of-Network** You pay 45% of the total cost
Outpatient Hospital Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Outpatient Substance Abuse Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Over-the-Counter Items	**In-Network** $50 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** $65 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.

Cost	2023 (this year)	2024 (next year)
Partial Hospitalization (Outpatient Mental Health Sessions)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Physical and Speech Therapy Rehabilitation	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Physician Specialist	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Podiatry	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Preventive Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Primary Care Physician (PCP)	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Prosthetics, Orthotics and Related Supplies	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Psychiatric Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Pulmonary Rehabilitation Services	Prior Authorization may be required for services, in-network only. **In-Network** You pay a $20 copay for pulmonary rehabilitation services **Out-of-Network** You pay 47% of the total cost	Prior Authorization is not required for Pulmonary Rehabilitation Services **In-Network** You pay a $15 copay for pulmonary rehabilitation services **Out-of-Network** You pay 45% of the total cost
Skilled Nursing Facility	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost

Cost	2023 (this year)	2024 (next year)
Supervised Exercise Therapy (SET)	**In-Network** You pay a $20 copay for supervised exercise therapy (SET) **Out-of-Network** You pay 47% of the total cost	**In-Network** You pay a $25 copay for supervised exercise therapy (SET) **Out-of-Network** You pay 45% of the total cost
Telehealth Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% of the total cost
Therapeutic Radiological Services	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% 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 53% 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 55% of the in-network allowed amount.
Worldwide Emergency/Urgent Services	**In- and Out-of-Network** You pay a $125 copay for worldwide emergency/urgent services.	**In- and Out-of-Network** You pay a $120 copay for worldwide emergency/urgent services.
X-Rays	**Out-of-Network** You pay 47% of the total cost	**Out-of-Network** You pay 45% 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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

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.

Changes to Prescription Drug 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, 2023 please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (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	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	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

Stage	2023 (this year)	2024 (next year)
most adult Part D vaccines, including shingles, tetanus and travel vaccines.	on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	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	2023 (this year)	2024 (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.** Most adult Part D vaccines are covered at no cost to you. The costs in this row 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 $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	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 $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

Stage	2023 (this year)	2024 (next year)
	have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – 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 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, 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 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 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 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).
- **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. 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, or how to enroll in the program, 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.

SECTION 6 Questions?

Section 6.1 – 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 *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 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. 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 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 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)

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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。