BlueMedicare Value (PPO) offered by Florida Blue Medicare

Annual Notice of Changes for 2022

You are currently enrolled as a member of BlueMedicare Value. Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes.*

- **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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1, 1.2 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit **go.medicare.gov/drugprices**, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at **www.medicare.gov/plan-compare** website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ 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, 2021, you will be enrolled in BlueMedicare Value.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in BlueMedicare Value.
- If you join another plan by **December 7, 2021,** your new coverage will start on **January 1, 2022.** You will be automatically disenrolled from your current plan.

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 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 booklet says "we," "us," or "our," it means Florida Blue Medicare. When it says "plan" or "our plan," it means BlueMedicare Value.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for BlueMedicare Value in several important areas. **Please note this is only a summary of changes**. 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*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $4,900 From network and out-of-network providers combined: $10,000	From network providers: $4,900 From network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network:** Primary care visits: $10 copay per visit Specialist visits: $45 copay per visit **Out-of-Network:** Primary care visits: 50% of the total cost per visit Specialist visits: 50% of the total cost per visit	**In-Network:** Primary care visits: Level 1 - $0 copay per visit Level 2 - $10 copay per visit Specialist visits: Level 1 - $35 copay per visit Level 2 - $48 copay per visit **Out-of-Network:** Primary care visits: Level 1 and Level 2 - 50% of the total cost per visit Specialist visits: Level 1 and 2 - 50% of the total cost per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts	**In-Network** Days 1-6: $325 copay per day (per Medicare-covered stay) After the 6th day, the plan pays 100% of the covered expenses.	**In-Network** Days 1-6: $275 copay per day (per Medicare-covered stay) After the 6th day, the plan pays 100% of the covered expenses.

Cost	2021 (this year)	2022 (next year)
the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**Out-of-Network** 50% of the total cost	**Out-of-Network** 50% of the total cost
Part D prescription drug coverage (See Section 1.6 for details.) To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by referencing the "Blood Glucose Regulators" category Tier 3 drugs on the Drug List. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet.)	Deductible: $150 Applies to Tiers 3, 4, and 5 only. Copay/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Standard Cost Sharing: $0 copay • Drug Tier 2: Standard Cost Sharing: $8 copay • Drug Tier 3: Standard Cost Sharing: $47 copay • Drug Tier 4: Standard Cost Sharing: $100 copay • Drug Tier 5: Standard Cost Sharing: 30% of the total cost • Drug Tier 6: Standard Cost Sharing: $0 copay	Deductible: $150 Applies to Tiers 3, 4, and 5 only. Copay/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Standard Cost Sharing: $0 copay • Drug Tier 2: Standard Cost Sharing: $8 copay • Drug Tier 3: Standard Cost Sharing: $47 copay • Drug Tier 4: Standard Cost Sharing: $100 copay • Drug Tier 5: Standard Cost Sharing: 30% of the total cost • Drug Tier 6: Standard Cost Sharing: $0 copay

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,900	$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.

Cost	2021 (this year)	2022 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is 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*. **Please review the 2022 *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. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is 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 *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Convenient Care Center	**In- and Out-of-Network** You pay a $50 copay for convenient care center services	**In- and Out-of-Network** You pay a $30 copay for convenient care center services
Dental Services (Medicare-Covered Dental Services Non-Routine)	**In-Network** You pay a $50 copay for non-routine dental care	**In-Network** You pay a $35 copay for Level 1 non-routine dental care You pay a $48 copay for Level 2 (all other) non-routine dental care
Diabetes self-management training, diabetic services and supplies	Prior Authorization is required for certain diabetic supplies and services. Please call Member Services for additional information.	No Authorization Required
Health Education	Health Education is not covered	**In- and Out-of-Network** meQuilibrium's digital coaching platform delivers clinically validated and highly personalized resilience solutions to help people improve their ability to manage stress and successfully cope with life's challenges. To get started go to FloridaBlue.com/Medicare log in, click

Cost	2021 (this year)	2022 (next year)
		on My Health and select HealthyBlue Rewards.
Hearing Services (Medicare-Covered Hearing Services Non-Routine)	**In-Network** You pay a $50 copay for exams to diagnose and treat hearing and balance issues	**In-Network** You pay a $35 copay for Level 1 exams to diagnose and treat hearing and balance issues You pay a $48 copay for Level 2 (all other) exams to diagnose and treat hearing and balance issues
Hearing Services (Additional Hearing Services)	**In-Network** You pay a $0 copay for up to 2 hearing aids every year with a maximum benefit allowance of **$500** per ear **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits. Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum	**In-Network** You pay a $0 copay for up to 2 hearing aids every year with a maximum benefit allowance of **$750** per ear **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits. Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum
Inpatient Hospital Care	**In-Network** You pay a $325 copay per day for days 1-6 (per Medicare-covered stay) You pay a $0 copay after day 6. The plan pays 100% of the covered expenses.	**In-Network** You pay a $275 copay per day for days 1-6 (per Medicare-covered stay) You pay a $0 copay after day 5. The plan pays 100% of the covered expenses.
Mental Health Specialty Non-Physician	**In-Network** You pay a $40 copay for Medicare-Covered Group Sessions You pay a $40 copay for Medicare-Covered Individual Sessions	**In-Network** You pay a $20 copay for Medicare-Covered Group Sessions You pay a $20 copay for Medicare-Covered Individual Sessions
Opioid Treatment Programs	**In-Network** You pay a $40 copay for Opioid Treatment Programs	**In-Network** You pay a $20 copay for Opioid Treatment Programs

Cost	2021 (this year)	2022 (next year)
Outpatient Substance Abuse Services	**In-Network** You pay a $40 copay for Medicare-Covered Group Sessions You pay a $40 copay for Medicare-Covered Individual Sessions	**In-Network** You pay a $20 copay for Medicare-Covered Group Sessions You pay a $20 copay for Medicare-Covered Individual Sessions
Over-the-Counter	**In-Network** $50 each quarter. Balance does not roll over to next quarter. You must use your full quarterly benefit amount in one order.	**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.
Partial Hospitalization (Outpatient Mental Health Sessions)	**In-Network** You pay a $40 copay for Partial Hospitalization (Outpatient Mental Health Sessions)	**In-Network** You pay a $20 copay for Partial Hospitalization (Outpatient Mental Health Sessions)
Physician Specialist	**In-Network** You pay a $45 copay for per visit	**In-Network** You pay a $35 copay per visit at Level 1 Physician Specialist You pay a $48 copay per visit for Level 2 (all other) Physician Specialist
Primary Care Physician (PCP)	**In-Network** You pay a $10 copay for Primary Care Physician services	**In-Network** You pay a $0 copay for Level 1 Primary Care Physician services You pay a $10 copay for Level 2 (all other) Primary Care Physician services
Psychiatric Services	**In-Network** You pay a $40 copay Medicare-Covered Group Sessions You pay a $40 copay Medicare-Covered Individual Sessions	**In-Network** You pay a $20 copay Medicare-Covered Group Sessions You pay a $20 copay Medicare-Covered Individual Sessions
Telehealth	**In-Network** • You pay a $50 copay for Urgently Needed Services • You pay a $10 copay for Primary	**In-Network** • You pay a $30 copay for Urgently Needed Services • You pay a Level 1 $0 copay, Level

Cost	2021 (this year)	2022 (next year)
	Care Services • You pay a $40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location • You pay a $40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital • You pay a $45 copay for Dermatology Services • You pay a $40 copay for individual sessions for outpatient Mental Health Specialty Services • You pay a $40 copay for individual sessions for outpatient Psychiatry Specialty Services • You pay a $40 copay for Opioid Treatment Program Services • You pay a $40 copay for individual sessions for outpatient Substance Abuse Specialty Services • You pay a $0 copay for Diabetes Self-Management Training • You pay a $0 copay for Dietician Services	2 $10 copay for Primary Care Services • You pay a $40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location • You pay a $40 copay for Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital • You pay a Level 1 $35 copay, Level 2 $48 copay for Dermatology Services • You pay a $20 copay for individual sessions for outpatient Mental Health Specialty Services • You pay a $20 copay for individual sessions for outpatient Psychiatry Specialty Services • You pay a $20 copay for Opioid Treatment Program Services • You pay a $20 copay for individual sessions for outpatient Substance Abuse Specialty Services • You pay a $0 copay for Diabetes Self-Management Training • You pay a $0 copay for Dietician Services
Urgent Care Center	**In- and Out-of-Network** You pay a $50 copay for urgent care center services	**In- and Out-of-Network** You pay a $30 copay for urgent care center services
Vision Services (Medicare-Covered Vision Services Non-Routine)	**In-Network** You pay a $50 copay for physician services to diagnose and treat eye diseases and conditions	**In-Network** You pay a $35 copay for Level 1 physician services to diagnose and treat eye diseases and conditions You pay a $48 copay for Level 2 (all other) services to diagnose and treat eye diseases and conditions

Section 1.6 – 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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Any existing formulary, tiering or utilization management exception authorization you may have will not automatically renew for the 2022 plan year. In order to ensure your current exception authorization does not expire, please contact our Member Services number for assistance. If your exception authorization does expire, you will be eligible for a transitionary fill of your currently approved medication according to the transition policy. Your doctor may have to submit a new request for continued authorization of the exception. See Chapter 5, Section 5 of the *Evidence of Coverage* for more information about exception requests.

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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

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. Because you receive "Extra Help" if you haven't received this insert by September 30, 2021 please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in 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*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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 is $150. During this stage, you pay $0 cost-sharing for drugs on Tier 1 (Preferred Generic); $8 cost-sharing for drugs on Tier 2 (Generic); $0 cost-sharing for drugs on Tier 6 (Select Care Drugs) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	The deductible is $150. During this stage, you pay $0 cost-sharing for drugs on Tier 1 (Preferred Generic); $8 cost-sharing for drugs on Tier 2 (Generic); $0 cost-sharing for drugs on Tier 6 (Select Care Drugs) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.

Changes to Your Cost-Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (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.** 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:** *Standard cost-sharing:* You pay $0 per prescription. **Tier 2-Generic:** You pay $8 per prescription. **Tier 3-Preferred Brand:** You pay $47 per prescription. **Tier 4-Non-Preferred Drug:** You pay $100 per prescription. **Tier 5-Specialty Tier:** You pay 30% of the total cost. **Tier 6-Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy standard cost sharing: **Tier 1-Preferred Generic:** *Standard cost-sharing:* You pay $0 per prescription. **Tier 2-Generic:** You pay $8 per prescription. **Tier 3-Preferred Brand:** You pay $47 per prescription. **Tier 4-Non-Preferred Drug:** You pay $100 per prescription. **Tier 5-Specialty Tier:** You pay 30% of the total cost. **Tier 6-Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $4,430, 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**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Automatic Payment Option (APO)	Instead of paying by check, you can have your Part D late enrollment penalty automatically	You can have your Part D late enrollment penalty automatically withdrawn from your checking or savings account; or

Description	2021 (this year)	2022 (next year)
	withdrawn from your bank account. Your payments will be withdrawn monthly. Deductions are made on the third day of the month. To enroll in the Automatic Payment Option (APO), you will need to mail us a completed authorization form with a voided check attached to it. Please allow up to four weeks for your enrollment to become effective. You may revoke the APO by notifying us and your financial institution 15 days prior to your premium due date. If you have questions about the APO or would like an authorization form, please call Member Services (phone numbers are printed on the back cover of this booklet), or visit our plan website at **www.floridablue.com/medicare.**	credit/debit card. Your payments will be withdrawn monthly. Deductions are made on the third day of the month. You can enroll in the Automatic Payment Option (APO) in one of three ways: 1. Visit **www.floridablue.com/medicare** to log in to My Health Link™, your member portal then select "Pay my Bill" 2. Call Member Services (phone numbers are printed on the back cover of this booklet) 3. Mail us a completed authorization form. Withholding from a checking/savings account will require a voided check attached to the form. If you have questions about the APO or would like an authorization form, please call Member Services (phone numbers are printed on the back cover of this booklet) or visit our plan website at **www.floridablue.com/medicare**. Please allow up to four weeks for your enrollment to become effective. You may revoke the APO by notifying us and your financial institution 15 days prior to your penalty payment due date.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BlueMedicare Value

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

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *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, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to **www.medicare.gov/plan-compare. Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

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 this (phone numbers are in Section 7.1 of this booklet).
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 – Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

SHINE is independent (not connected with any insurance company or health plan). 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 only, call 1-800-955-8770. You can learn more about SHINE by visiting their website (**www.floridashine.org**).

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. 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 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); 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 7 Questions?

Section 7.1 – Getting Help from BlueMedicare Value

Questions? We're here to help. Please call Member Services at 1-800-926-6565. (TTY only, call 1-800-955-8770. We are available for phone calls 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays. Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **www.medicare.gov/plan-compare**).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website (**www.medicare.gov**) 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.