

## 2022 Summary of Benefits

### Medicare Advantage Plans with Part D Prescription Drug Coverage

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BlueMedicare Complete (HMO D-SNP) H1035-027

BlueMedicare Complete (HMO D-SNP) H1035-028

1/1/2022 – 12/31/2022



The plans' service area includes:

**Broward, Miami-Dade, Palm Beach and St. Lucie Counties**

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the “**Evidence of Coverage.**” You may also view the “Evidence of Coverage” for this plan on our website, [www.floridablue.com/medicare](http://www.floridablue.com/medicare).

If you want to know more about the coverage and costs of Original Medicare, look in your current 2022 “*Medicare & You*” handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy 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.

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## Who Can Join?

To join, you must:

- be entitled to Medicare Part A; and
- be enrolled in Medicare Part B; and
- receive any level of assistance from the Florida Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual-eligible. BlueMedicare Complete (HMO D-SNP) may enroll dual-eligibles who are in the SMLB, SLMB Plus, QMB, QMB Plus, FBDE, QI and QDWI programs; and
- live in **our service area.**

Our H1035-027 service area includes the following county in Florida: Miami-Dade

Our H1035-028 service area includes the following counties in Florida: Broward, Palm Beach and St. Lucie

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## Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

- You can see our plan's provider and pharmacy directory on our website ([www.floridablue.com/medicare](http://www.floridablue.com/medicare)). Or call us and we will send you a copy of the provider and pharmacy directories.
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## Have Questions? Call Us

- If you are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
  - If you are not a member of this plan, call us at 1-855-601-9465, TTY: 1-800-955-8770.
    - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
    - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
  - Or visit our website at [www.floridablue.com/medicare](http://www.floridablue.com/medicare).
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## Important Information

Through this document you will see the symbols below.

- \* Services with this symbol may require approval in advance (a referral) from your Primary Care Doctor (PCP) in order for the plan to cover them.
- ◇ Services with this symbol may require prior authorization from the plan before you receive services.

If you do not get a referral or prior authorization when required, you may have to pay the full cost of the services. Please contact your PCP or refer to the Evidence of Coverage (EOC) for more information about services that require a referral and/or prior authorization from the plan.

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## Monthly Premium, Deductible and Limits

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
<b>Monthly Plan Premium</b>	<b>\$0 or up to \$34.30</b> There may be some situations in which your premium increases. You will never pay more than a premium of <b>\$34.30</b> . You must continue to pay your Medicare Part B premium.	<b>\$0 or up to \$34.30</b> There may be some situations in which your premium increases. You will never pay more than a premium of <b>\$34.30</b> . You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	<b>\$0</b> per year for health care services <b>\$0 or up to \$480</b> per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic))	<b>\$0</b> per year for health care services <b>\$0 or up to \$480</b> per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic))
<b>Maximum Out-of-Pocket Responsibility</b>	<b>\$500</b> is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year	<b>\$2,500</b> is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year

## Medical and Hospital Benefits

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
<b>Inpatient Hospital Care</b> ◇	<u>This Plan</u> ▪ <b>\$0</b> copay  <u>Medicaid</u> ▪ <b>\$3</b> copay, per visit, if not exempt from cost-sharing	<u>This Plan</u> ▪ <b>\$0</b> copay  <u>Medicaid</u> ▪ <b>\$3</b> copay, per visit, if not exempt from cost-sharing
<b>Outpatient Hospital Care</b>	<u>This Plan</u> ▪ <b>\$0</b> copay, per visit, for Medicare covered services ◇ ▪ <b>\$0</b> copay, per visit for observation services  <u>Medicaid</u> ▪ <b>\$3</b> copay, per visit, if not exempt from cost-sharing	<u>This Plan</u> ▪ <b>\$0</b> copay, per visit, for Medicare covered services ◇ ▪ <b>\$0</b> copay, per visit for observation services  <u>Medicaid</u> ▪ <b>\$3</b> copay, per visit, if not exempt from cost-sharing
<b>Ambulatory Surgery Center</b> ◇	<u>This Plan</u> ▪ <b>\$0</b> copay	<u>This Plan</u> ▪ <b>\$0</b> copay

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	<u>Medicaid</u> ▪ <b>\$3</b> copay for Medicaid-covered services.	<u>Medicaid</u> ▪ <b>\$3</b> copay for Medicaid-covered services.
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<b>Doctor’s Office Visits</b>	<u>This Plan</u> ▪ <b>\$0</b> copay per primary care visit ▪ <b>\$0</b> copay per specialist* visit	<u>This Plan</u> ▪ <b>\$0</b> copay per primary care visit ▪ <b>\$0</b> copay per specialist* visit
	<u>Medicaid</u> ▪ <b>\$2</b> copay per provider or group provider, per day, if not exempt from cost-sharing ▪ <b>\$3</b> copay for practitioner services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing	<u>Medicaid</u> ▪ <b>\$2</b> copay per provider or group provider, per day, if not exempt from cost-sharing ▪ <b>\$3</b> copay for practitioner services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing

<b>Preventive Care</b>	<u>This Plan</u> <b>\$0</b> copay for Medicare-covered services	<u>This Plan</u> <b>\$0</b> copay for Medicare-covered services
	<ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Annual wellness visit</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammograms)</li> <li>▪ Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</li> <li>▪ Cardiovascular disease testing</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screening</li> <li>▪ Depression screening</li> <li>▪ Diabetes screening</li> <li>▪ Diabetes self-management training, diabetic services and supplies</li> <li>▪ Health and wellness education programs</li> <li>▪ Hepatitis C Screening</li> <li>▪ HIV screening</li> <li>▪ Immunizations</li> <li>▪ Medical nutrition therapy</li> <li>▪ Medicare Diabetes Prevention Program (MDPP)</li> <li>▪ Obesity screening and therapy to promote sustained weight loss</li> <li>▪ Prostate cancer screening exams</li> <li>▪ Screening and counseling to reduce</li> </ul>	<ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Annual wellness visit</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammograms)</li> <li>▪ Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</li> <li>▪ Cardiovascular disease testing</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screening</li> <li>▪ Depression screening</li> <li>▪ Diabetes screening</li> <li>▪ Diabetes self-management training, diabetic services and supplies</li> <li>▪ Health and wellness education programs</li> <li>▪ Hepatitis C Screening</li> <li>▪ HIV screening</li> <li>▪ Immunizations</li> <li>▪ Medical nutrition therapy</li> <li>▪ Medicare Diabetes Prevention Program (MDPP)</li> <li>▪ Obesity screening and therapy to promote sustained weight loss</li> <li>▪ Prostate cancer screening exams</li> <li>▪ Screening and counseling to reduce</li> </ul>

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- alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Vision care: Glaucoma screening
- “Welcome to Medicare” preventive visit

Medicaid

**\$3** copay for covered preventive screenings provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing.

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- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Vision care: Glaucoma screening
- “Welcome to Medicare” preventive visit

Medicaid

**\$3** copay for covered preventive screenings provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing.

**Emergency Care**

This Plan

- **\$0** copay per visit, in- or out-of-network

Medicaid

- **\$3** copay, per visit, if not exempt from cost-sharing
- **5%** coinsurance up to the first \$300 of Medicaid payment for each visit in the emergency room for non-emergency services, not to exceed \$15

This Plan

- **\$0** copay per visit, in- or out-of-network

Medicaid

- **\$3** copay, per visit, if not exempt from cost-sharing
- **5%** coinsurance up to the first \$300 of Medicaid payment for each visit in the emergency room for non-emergency services, not to exceed \$15

**Urgently Needed Services**

This Plan

- **\$0** copay at an Urgent Care Center or Convenient Care Center, in- or out-of-network

Medicaid

- **\$2** copay for services in a practitioner office setting, per provider or group provider, per day, if not exempt from cost-sharing
- Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. Urgently needed services are provided to treat a non-

This Plan

- **\$0** copay at an Urgent Care Center or Convenient Care Center, in- or out-of-network

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- Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. Urgently needed services are provided to treat a non-

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	emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.
<b>Diagnostic Services/ Labs/Imaging</b> ◇*	<p><u>This Plan</u></p> <p><b>Laboratory Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><b>X-Rays</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><b>Advanced Imaging Services</b></p> <p>Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan</p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><b>Radiation Therapy</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$1</b> copay for independent laboratory services per provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$1</b> copay for portable X-Ray services per provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$2</b> copay per provider or group provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> </ul>	<p><u>This Plan</u></p> <p><b>Laboratory Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><b>X-Rays</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><b>Advanced Imaging Services</b></p> <p>Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan</p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><b>Radiation Therapy</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$1</b> copay for independent laboratory services per provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$1</b> copay for portable X-Ray services per provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$2</b> copay per provider or group provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> </ul>
	<b>Hearing Services</b>	<p><u>This Plan</u></p> <p><b>Medicare-Covered Hearing Services*</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for exams to diagnose and treat hearing and balance issues</li> </ul> <p><b>Additional Hearing Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for one routine hearing exam per year</li> <li>▪ <b>\$0</b> copay for evaluation and fitting of hearing aids</li> <li>▪ <b>\$1,500 per ear.</b> You pay a \$0 copay for up to 2 hearing aids every year with a</li> </ul>

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<p>maximum benefit allowance of \$1,500 per ear.</p> <p>NOTE: Hearing aids must be purchased through our participating provider to have access to the benefit.</p> <ul style="list-style-type: none"> <li>Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.</li> </ul>	<p>maximum benefit allowance of \$2,000 per ear.</p> <p>NOTE: Hearing aids must be purchased through our participating provider to have access to the benefit.</p> <ul style="list-style-type: none"> <li>Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum.</li> </ul>
<p><u>Medicaid</u></p> <p><b>\$0</b> copay for recipients who have moderate hearing loss or greater, including the following services:</p> <ul style="list-style-type: none"> <li>One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient</li> <li>Up to three pairs of ear molds per year, per recipient</li> <li>One fitting and dispensing service per ear, every three years, per recipient</li> </ul>	<p><u>Medicaid</u></p> <p><b>\$0</b> copay for recipients who have moderate hearing loss or greater, including the following services:</p> <ul style="list-style-type: none"> <li>One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient</li> <li>Up to three pairs of ear molds per year, per recipient</li> <li>One fitting and dispensing service per ear, every three years, per recipient</li> </ul>

**Dental Services**

This Plan

**Medicare-Covered Dental Services** ◇

- **\$0** copay for non-routine dental care

**Additional Dental Services**

- **\$0** copay for covered preventive dental services
- **\$0** copay for covered comprehensive dental services

Medicaid

- **\$2** copay for oral and maxillofacial surgery services per practitioner office visit, per day
- **\$3** copay for dental services provided at a Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing

**Covered Adult Services (Ages 21 and Over)**

- One comprehensive evaluation every three years, per recipient. For recipients age 21 years and older, a comprehensive evaluation is reimbursed for determining the need for

This Plan

**Medicare-Covered Dental Services** ◇

- **\$0** copay for non-routine dental care

**Additional Dental Services**

- **\$0** copay for covered preventive dental services
- **\$0** copay for covered comprehensive dental services

Medicaid

- **\$2** copay for oral and maxillofacial surgery services per practitioner office visit, per day
- **\$3** copay for dental services provided at a Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing

**Covered Adult Services (Ages 21 and Over)**

- One comprehensive evaluation every three years, per recipient. For recipients age 21 years and older, a comprehensive evaluation is reimbursed for determining the need

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<p>full or partial dentures, or problem focused services</p> <ul style="list-style-type: none"> <li>▪ Limited evaluations, as medically indicated</li> <li>▪ One complete series of intraoral radiographs every three years, per recipient</li> <li>▪ One panoramic radiograph every three years, per recipient</li> <li>▪ Prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows: <ul style="list-style-type: none"> <li>✓ One upper, lower, or complete set of full or removable partial dentures per recipient</li> <li>✓ One reline, per denture, per 366 days, per recipient</li> </ul> </li> </ul> <p>Traditional Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.</p>	<p>for full or partial dentures, or problem focused services</p> <ul style="list-style-type: none"> <li>▪ Limited evaluations, as medically indicated</li> <li>▪ One complete series of intraoral radiographs every three years, per recipient</li> <li>▪ One panoramic radiograph every three years, per recipient</li> <li>▪ Prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows: <ul style="list-style-type: none"> <li>✓ One upper, lower, or complete set of full or removable partial dentures per recipient</li> <li>✓ One reline, per denture, per 366 days, per recipient</li> </ul> </li> </ul> <p>Traditional Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.</p>

**Vision Services**

This Plan

**Medicare-Covered Vision Services**

- **\$0** copay for physician services to diagnose and treat eye diseases and conditions \*
- **\$0** copay for glaucoma screening (once per year for members at high risk of glaucoma)
- **\$0** copay for one diabetic retinal exam per year
- **\$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery

**Additional Vision Services**

- **\$0** copay for an annual routine eye examination.
- **\$500** maximum allowance per year towards the purchase of lenses, frames or contact lenses
- Member responsible for costs exceeding the annual maximum plan benefit allowance.

This Plan

**Medicare-Covered Vision Services**

- **\$0** copay for physician services to diagnose and treat eye diseases and conditions \*
- **\$0** copay for glaucoma screening (once per year for members at high risk of glaucoma)
- **\$0** copay for one diabetic retinal exam per year
- **\$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery

**Additional Vision Services**

- **\$0** copay for an annual routine eye examination
- **\$500** maximum allowance per year towards the purchase of lenses, frames or contact lenses
- Member responsible for costs exceeding the annual maximum plan benefit allowance.



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	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for visual aid services</li> <li>▪ <b>\$3</b> copay for optometrist services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day</li> </ul>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for visual aid services</li> <li>▪ <b>\$3</b> copay for optometrist services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day</li> </ul>
<b>Mental Health Services</b> ◇	<p><u>This Plan</u></p> <p><b>Inpatient Mental Health Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> <li>▪ 190-day lifetime benefit maximum in a psychiatric hospital</li> </ul> <p><b>Outpatient Mental Health Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$2</b> copay per provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for outpatient mental health services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> </ul>	<p><u>This Plan</u></p> <p><b>Inpatient Mental Health Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> <li>▪ 190-day lifetime benefit maximum in a psychiatric hospital</li> </ul> <p><b>Outpatient Mental Health Services</b></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$2</b> copay per provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for outpatient mental health services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> </ul>
<b>Skilled Nursing Facility (SNF)</b> ◇	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p>Once Medicare services for each benefit period are exhausted, coverage will continue for days 101 through 120 under your eligibility for Medicaid.</p>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p>Once Medicare services for each benefit period are exhausted, coverage will continue for days 101 through 120 under your eligibility for Medicaid.</p>
<b>Physical Therapy</b> ◇*	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <p>Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services.</p>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <p>Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services.</p>

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
	<ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for respiratory system services</li> <li>▪ <b>\$0</b> copay for physical therapy services</li> <li>▪ <b>\$2</b> copay per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay, per visit to an outpatient hospital, if not exempt from cost-sharing</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for respiratory system services</li> <li>▪ <b>\$0</b> copay for physical therapy services</li> <li>▪ <b>\$2</b> copay per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay, per visit to an outpatient hospital, if not exempt from cost-sharing</li> </ul>
<b>Ambulance</b> ◇	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for each Medicare-covered trip (one-way)</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for Medicaid-covered services</li> </ul>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for each Medicare-covered trip (one-way)</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for Medicaid-covered services</li> </ul>
<b>Transportation</b>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for unlimited one-way trips for rides to your doctor, hospital or pharmacy</li> <li>▪ These services can accommodate wheelchairs, walkers, oxygen tanks and service animals</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$1</b> copay per one-way trip.</li> <li>▪ Non-Emergency Medical Transportation (NEMT) services are available only to eligible beneficiaries who cannot obtain transportation through any other means (such as family, friends or community resources).</li> </ul>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for unlimited one-way trips for rides to your doctor, hospital or pharmacy</li> <li>▪ These services can accommodate wheelchairs, walkers, oxygen tanks and service animals</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$1</b> copay per one-way trip.</li> <li>▪ Non-Emergency Medical Transportation (NEMT) services are available only to eligible beneficiaries who cannot obtain transportation through any other means (such as family, friends or community resources).</li> </ul>

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
<b>Medicare Part B Drugs</b>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>0%</b> coinsurance for allergy injections</li> <li>▪ <b>0%</b> coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs ◇</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for prescription drugs obtained through the Prescription Drug Services program</li> <li>▪ <b>\$2</b> copay for practitioner services, per provider or group provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for Part B prescription drug administration provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> </ul>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>0%</b> coinsurance for allergy injections</li> <li>▪ <b>0%</b> coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs ◇</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for prescription drugs obtained through the Prescription Drug Services program</li> <li>▪ <b>\$2</b> copay for practitioner services, per provider or group provider, per day, if not exempt from cost-sharing</li> <li>▪ <b>\$3</b> copay for Part B prescription drug administration provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing</li> </ul>

## Part D Prescription Drug Benefits

Most of our members qualify for and are getting “Extra Help” from Medicare to pay for their prescription drug plan costs. If you are in the “Extra Help” program, this information about the 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 known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage.

### Deductible Stage

The deductible does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic). **In most cases you will pay \$0 or \$99.** The deductible for those who do not qualify for “Extra Help” is \$480.

### Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **\$4,430**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost-sharing below applies to a one-month (31-day) supply.

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	<b>Preferred Retail/Mail Order/LTC (31-day supply)</b>	<b>Standard Retail/Mail Order (31-day supply)</b>	<b>Preferred Retail/Mail Order/LTC (31-day supply)</b>	<b>Standard Retail/Mail Order (31-day supply)</b>
Tier 1 - Preferred Generic	<b>\$0</b>	<b>\$0 or \$10 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0</b>	<b>\$0 or \$10 copay</b> depending on the level of "Extra Help" you receive.
Tier 2 - Generic	<b>\$0</b>	<b>\$0 or \$11</b> depending on the level of "Extra Help" you receive.	<b>\$0</b>	<b>\$0 or \$11 copay</b> depending on the level of "Extra Help" you receive.
Tier 3 - Preferred Brand	<b>\$0 or \$40 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0 or \$47 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0 or \$40 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0 or \$47 copay</b> depending on the level of "Extra Help" you receive.
Tier 4 - Non-Preferred Drug	<b>\$0 or \$92 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0 or \$99 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0 or \$92 copay</b> depending on the level of "Extra Help" you receive.	<b>\$0 or \$99 copay</b> depending on the level of "Extra Help" you receive.
Tier 5 - Specialty Tier	<b>\$0 copay or up to 25%</b> , depending on the level of "Extra Help" you receive.	<b>\$0 copay or up to 25%</b> , depending on the level of "Extra Help" you receive.	<b>\$0 copay or up to 25%</b> , depending on the level of "Extra Help" you receive.	<b>\$0 copay or up to 25%</b> , depending on the level of "Extra Help" you receive.

### Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including total drug costs paid by you *and* any Part D plan) reaches **\$4,430**. You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **\$7,050**.

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
<b>During the Coverage Gap Stage:</b>	<ul style="list-style-type: none"> <li>▪ You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 2 (Generic) – or <b>25%</b> of the cost, whichever is lower</li> <li>▪ For generic drugs in all other tiers, you pay <b>25%</b> of the cost</li> <li>▪ For brand-name drugs, you pay <b>25%</b> of the cost (plus a portion of the dispensing fee)</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 2 (Generic) – or <b>25%</b> of the cost, whichever is lower</li> <li>▪ For generic drugs in all other tiers, you pay <b>25%</b> of the cost</li> <li>▪ For brand-name drugs, you pay <b>25%</b> of the cost (plus a portion of the dispensing fee)</li> </ul>

## Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach **\$7,050**, you pay the *greater* of:

- **\$3.95** copay for generic drugs in all tiers (including brand drugs treated as generic) and a **\$9.85** copay for all other drugs in all tiers, or **5%** of the cost.

## Additional Drug Coverage

- Please call us or see the plan’s “Evidence of Coverage” on our website ([www.floridablue.com/medicare](http://www.floridablue.com/medicare)) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (Non-Preferred Drug) cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

## Additional Benefits

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
<b>At Home Care</b>	<p>We offer this benefit through our partnership with our participating provider who connects college students to older adults who require assistance with transportation, companionship, household chores, use of electronic devices, and exercise and activity.</p> <p>Benefits include the following:</p> <p><b>At Home Care, 60 hours per year.</b> Services include support with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).</p>	<p>We offer this benefit through our partnership with our participating provider who connects college students to older adults who require assistance with transportation, companionship, household chores, use of electronic devices, and exercise and activity.</p> <p>Benefits include the following:</p> <p><b>At Home Care, 60 hours per year.</b> Services include support with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).</p>
<b>Caregiver Support for Member</b>	<p>Provides coverage for coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits include:</p> <ul style="list-style-type: none"> <li>▪ A web-based tool that contains educational content covering topics on health, wealth, senior living, in-home care and lifestyle</li> <li>▪ Access for caregivers and family members to post updates and videos; tools to manage documents, stay organized and on top of upcoming tasks and appointments. Search tools</li> </ul>	<p>Provides coverage for coaching, education and support services such as counseling and training courses for caregivers of enrollees. Benefits include:</p> <ul style="list-style-type: none"> <li>▪ A web-based tool that contains educational content covering topics on health, wealth, senior living, in-home care and lifestyle</li> <li>▪ Access for caregivers and family members to post updates and videos; tools to manage documents, stay organized and on top of upcoming tasks and appointments. Search tools</li> </ul>

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	(i.e., senior housing search and in-home care search).	(i.e., senior housing search and in-home care search).
	See the “Evidence of Coverage” for benefit details.	See the “Evidence of Coverage” for benefit details.
<b>Diabetic Supplies</b>	<ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: <ul style="list-style-type: none"> <li>• Lifescan (One Touch®) Glucose Meters</li> <li>• Lancets</li> <li>• Test Strips</li> </ul> </li> </ul> <p><b>Important Note: Insulin, insulin syringes and needles for self-administration in the home are obtained from a retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.</b> Applicable Part D co-pays and deductibles apply.</p>	<ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: <ul style="list-style-type: none"> <li>• Lifescan (One Touch®) Glucose Meters</li> <li>• Lancets</li> <li>• Test Strips</li> </ul> </li> </ul> <p><b>Important Note: Insulin, insulin syringes and needles for self-administration in the home are obtained from a retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.</b> Applicable Part D co-pays and deductibles apply.</p>
<b>Medicare Diabetes Prevention Program</b>	<ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for Medicare-covered services</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for Medicare-covered services</li> </ul>
<b>Podiatry</b>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$2</b> copay per provider, per day</li> </ul>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$2</b> copay per provider, per day</li> </ul>
<b>Chiropractic</b>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$1</b> copay per provider/group, per day</li> </ul>	<p><u>This Plan</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>▪ <b>\$1</b> copay per provider/group, per day</li> </ul>

	<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
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**Medical Equipment and Supplies** ◇

This Plan

- **\$0** copay for all plan approved, Medicare-covered motorized wheelchairs and electric scooters
- **\$0** copay for all other plan approved, Medicare-covered durable medical equipment

Medicaid

- **\$0** copay

This Plan

- **\$0** copay for all plan approved, Medicare-covered motorized wheelchairs and electric scooters
- **\$0** copay for all other plan approved, Medicare-covered durable medical equipment

Medicaid

- **\$0** copay

**Outpatient Occupational and Speech Therapy** ◇\*

This Plan

- **\$0** copay

Medicaid

Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services.

- **\$0** copay for respiratory system services
- **\$0** copay for physical therapy services
- **\$2** copay per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost-sharing
- **\$3** copay for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing
- **\$3** copay, per visit to an outpatient hospital, if not exempt from cost-sharing

This Plan

- **\$0** copay

Medicaid

Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech-Language Pathology services.

- **\$0** copay for respiratory system services
- **\$0** copay for physical therapy services
- **\$2** copay per provider, per day, for outpatient rehabilitation services provided in an office setting, if not exempt from cost-sharing
- **\$3** copay for outpatient rehabilitation services provided at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) only, per clinic, per day, if not exempt from cost-sharing
- **\$3** copay, per visit to an outpatient hospital, if not exempt from cost-sharing

**Telehealth** ◇\*

This Plan

- **\$0** copay for Urgently Needed Services
- **\$0** copay for Primary Care Services
- **\$0** copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location
- **\$0** copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital
- **\$0** copay for Dermatology Services
- **\$0** copay for individual sessions for

This Plan

- **\$0** copay for Urgently Needed Services
- **\$0** copay for Primary Care Services
- **\$0** copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location
- **\$0** copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital
- **\$0** copay for Dermatology Services
- **\$0** copay for individual sessions for

<b>BlueMedicare Complete (HMO D-SNP)</b> Miami-Dade H1035-027	<b>BlueMedicare Complete (HMO D-SNP)</b> Broward, Palm Beach and St. Lucie H1035-028
<p>outpatient Mental Health Specialty Services</p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for individual sessions for outpatient Psychiatry Specialty Services</li> <li>▪ <b>\$0</b> copay for Opioid Treatment Program Services</li> <li>▪ <b>\$0</b> copay for individual sessions for outpatient Substance Abuse Specialty Services</li> <li>▪ <b>\$0</b> copay for Diabetes Self-Management Training</li> <li>▪ <b>\$0</b> copay for Dietician Services</li> </ul>	<p>outpatient Mental Health Specialty Services</p> <ul style="list-style-type: none"> <li>▪ <b>\$0</b> copay for individual sessions for outpatient Psychiatry Specialty Services</li> <li>▪ <b>\$0</b> copay for Opioid Treatment Program Services</li> <li>▪ <b>\$0</b> copay for individual sessions for outpatient Substance Abuse Specialty Services</li> <li>▪ <b>\$0</b> copay for Diabetes Self-Management Training</li> <li>▪ <b>\$0</b> copay for Dietician Services</li> </ul>
<u>Medicaid</u> <b>\$0</b> copay	<u>Medicaid</u> <b>\$0</b> copay

**Special Supplemental Benefits for the Chronically Ill (SSBCI) ◇**

Members diagnosed as having one or a combination of Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and/or Diabetes may receive the following additional benefit:

**Healthy Food Benefit - \$50 per month to your Blue Dollars card to purchase healthy food and produce at a plan approved location.** Any unused amount does not roll over to the next month.

See the “Evidence of Coverage” for full eligibility requirements.

Members diagnosed as having one or a combination of Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and/or Diabetes may receive the following additional benefit:

**Healthy Food Benefit - \$50 per month to your Blue Dollars card to purchase healthy food and produce at a plan approved location.** Any unused amount does not roll over to the next month.

See the “Evidence of Coverage” for full eligibility requirements.



## You Get More with BlueMedicare

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<b>Health Education</b>	<ul style="list-style-type: none"> <li>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 <a href="https://FloridaBlue.com/Medicare">FloridaBlue.com/Medicare</a> log in, click on My Health and select HealthyBlue Rewards.</li> </ul>	<ul style="list-style-type: none"> <li>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 <a href="https://FloridaBlue.com/Medicare">FloridaBlue.com/Medicare</a> log in, click on My Health and select HealthyBlue Rewards.</li> </ul>
<b>Over-the-Counter Items</b>	<ul style="list-style-type: none"> <li><b>\$100</b> monthly allowance for the purchase of non-prescription items such as vitamins and aspirin</li> <li>Any balance not used for a month will not carry over to the next month</li> </ul>	<ul style="list-style-type: none"> <li><b>\$100</b> monthly allowance for the purchase of non-prescription items such as vitamins and aspirin</li> <li>Any balance not used for a month will not carry over to the next month</li> </ul>
<b>Healthy Blue Rewards</b>	<ul style="list-style-type: none"> <li>Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.</li> </ul>	<ul style="list-style-type: none"> <li>Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.</li> </ul>
<b>SilverSneakers® Fitness Program</b>	<ul style="list-style-type: none"> <li>Gym membership and classes available at fitness locations across the country, including national chains and local gyms</li> <li>Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more</li> </ul>	<ul style="list-style-type: none"> <li>Gym membership and classes available at fitness locations across the country, including national chains and local gyms</li> <li>Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more</li> </ul>
<b>Meal Benefit</b>	<ul style="list-style-type: none"> <li><b>10</b> meals after each hospital discharge</li> </ul>	<ul style="list-style-type: none"> <li><b>10</b> meals after each hospital discharge</li> </ul>

## **Disclaimers**

Florida Blue Medicare is an HMO plan with a Medicare contract. Enrollment in Florida Blue Medicare depends on contract renewal.

If you have any questions, please contact our Member Services at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Our 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.

HMO coverage is offered by Florida Blue Medicare, Inc., dba Florida Blue Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

Sponsored by Florida Blue Medicare, Inc., d/b/a Florida Blue Medicare, and the State of Florida, Agency for Health Care Administration.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

SSBCI benefits are part of special supplemental benefits and not all members will qualify.

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## **Section 1557 Notification: Discrimination is Against the Law**

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

### **Health and vision coverage (including FEP members):**

Section 1557 Coordinator  
4800 Deerwood Campus Parkway, DCC 1-7  
Jacksonville, FL 32246  
1-800-477-3736 x29070  
1-800-955-8770 (TTY)  
Fax: 1-904-301-1580  
[section1557coordinator@floridablue.com](mailto:section1557coordinator@floridablue.com)

### **Dental, life, and disability coverage:**

Civil Rights Coordinator  
17500 Chenal Parkway  
Little Rock, AR 72223  
1-800-260-0331  
1-800-955-8770 (TTY)  
[civilrightscoordinator@fclife.com](mailto:civilrightscoordinator@fclife.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), by mail or phone at:

### **U.S. Department of Health and Human Services**

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019  
1-800-537-7697 (TDD)  
Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

**ATANSYON:** Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

**ATENÇÃO:** Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583 (TTY: 1-800-955-8770)。FEP: 請致電1-800-333-2227

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). اتصل برقم 1-800-333-2227.

**ATTENZIONE:** Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

**주의:** 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

**सुचना:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

**ફોન કરો** 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรศัพท์ **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ FEP โทรศัพท์ **1-800-333-2227**

**注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583 (TTY: 1-800-955-8770) まで、お電話にてご連絡ください。FEP: 1-800-333-2227

**توجه:** اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود. با شماره 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojí' hodíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojí' hodíłnih 1-800-333-2227.