Florida Blue

2020 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

BlueMedicare Complete (HMO D-SNP) H1035-029

BlueMedicare Complete (HMO D-SNP) H1035-030

BlueMedicare Complete (HMO D-SNP) H1035-031

BlueMedicare Complete (HMO D-SNP) H1035-032

1/1/2020 – 12/31/2020

The plans' service area includes:
Clay, Duval, Hillsborough, Orange, Osceola, Pinellas, and Polk Counties
Y0011_34934_M 0819 CMS Accepted

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.**

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **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.

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 H1035-029 service area includes the following counties in Florida: Orange and Osceola
Our H1035-030 service area includes the following counties in Florida: Hillsborough and Polk
Our H1035-031 service area includes the following counties in Florida: Clay and Duval
Our H1035-032 service area includes the following county in Florida: Pinellas

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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 the 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 at our website **(www.floridablue.com/medicare**). Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- If you are a member of one of these plans, call us at 1-800-926-6565, TTY: 1-800-955-8770.
- If you are not a member of one of these plans, call us at 1-855-601-9465, TTY: 1-800-955-8770.
    - We are available October 1 to March 31, 7 days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
    - From April 1 to September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time.
- Or visit our website at **www.floridablue.com/medicare.**

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.

Monthly Premium, Deductible and Limits

	BlueMedicare Complete (HMO D-SNP) Orange and Osceola H1035-029 Hillsborough and Polk H1035-030	**BlueMedicare Complete (HMO D-SNP)** Clay and Duval H1035-031 Pinellas H1035-032
Monthly Plan Premium	**$28.50** You may pay a lower premium or no premium based on your level of assistance. You must continue to pay your Medicare Part B premium.	**$28.50** You may pay a lower premium or no premium based on your level of assistance. You must continue to pay your Medicare Part B premium.
Deductible	**$435** per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic))	**$435** per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic) and Tier 2 (Generic))
Maximum Out-of-Pocket Responsibility	**$3,200** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year	**$3,200** 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

	BlueMedicare Complete (HMO D-SNP) Orange and Osceola H1035-029 Hillsborough and Polk H1035-030	**BlueMedicare Complete (HMO D-SNP)** Clay and Duval H1035-031 Pinellas H1035-032
Inpatient Hospital Care◊	This Plan ▪ **$0** copay Medicaid ▪ **$3** copay, per visit, if not exempt from cost-sharing	This Plan ▪ **$0** copay
Outpatient Hospital Care◊	This Plan ▪ **$0** copay Medicaid ▪ **$3** copay, per visit, if not exempt from cost sharing	This Plan ▪ **$0** copay
Ambulatory Surgery Center ◊	This Plan ▪ **$0** copay Medicaid ▪ **$3** copay for Medicaid-covered services	This Plan ▪ **$0** copay

	BlueMedicare Complete (HMO D-SNP) Orange and Osceola H1035-029 Hillsborough and Polk H1035-030	**BlueMedicare Complete (HMO D-SNP)** Clay and Duval H1035-031 Pinellas H1035-032
Doctor's Office Visits	This Plan ▪ **$0** copay per primary care visit ▪ **$0** copay per specialist* visit	This Plan ▪ **$0** copay per primary care visit ▪ **$0** copay per specialist* visit
	Medicaid ▪ **$2** copay per provider or group provider, per day, if not exempt from cost-sharing ▪ **$3** 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	
Preventive Care	This Plan ▪ **$0** copay for Medicare-covered services	This Plan ▪ **$0** copay for Medicare-covered services
	▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse screening and counseling ▪ Annual Wellness Visit ▪ Bone mass measurements ▪ Breast cancer screening (mammograms) ▪ Cardiovascular disease screening and intensive behavioral therapy ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening ▪ Depression screening ▪ Diabetes screening and self-management training ▪ Glaucoma screening ▪ Hepatitis B and C screening ▪ HIV screening ▪ Intensive Behavioral Therapy for Obesity ▪ Lung cancer screening ▪ Medical nutrition therapy ▪ Prostate cancer screening ▪ Sexually transmitted infections - screening and high-intensity behavioral counseling to prevent them ▪ Smoking and tobacco use cessation counseling ▪ Vaccines for influenza, pneumonia and Hepatitis B ▪ Welcome to Medicare preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.	
	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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Emergency Care	This Plan ▪ **$0** copay per visit, in- or out-of-network	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	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-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	
Diagnostic Services/ Labs/Imaging*◊	This Plan **Laboratory Services** ▪ **$0** Copay **X-Rays** ▪ **$0** copay **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$0** copay **Radiation Therapy** ▪ **$0** copay	This Plan **Laboratory Services** ▪ **$0** Copay **X-Rays** ▪ **$0** copay **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$0** copay **Radiation Therapy** ▪ **$0** copay
	Medicaid ▪ **$1** copay for independent laboratory services per provider, per day, if not exempt from cost sharing ▪ **$1** copay for portable X-Ray services per provider, per day, if not exempt from cost sharing ▪ **$2** copay per provider or group provider, per day, if not exempt from cost sharing. ▪ **$3** 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	

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Hearing Services	This Plan **Medicare-Covered Hearing Services*** ▪ **$0** copay for exams to diagnose and treat hearing and balance issues **Additional Hearing Services** ▪ **$0** copay for one routine hearing exam per year ▪ **$0** copay for evaluation and fitting of hearing aids ▪ **$1,500** maximum allowance per year for up to two hearing aids	This Plan **Medicare-Covered Hearing Services*** ▪ **$0** copay for exams to diagnose and treat hearing and balance issues **Additional Hearing Services** ▪ **$0** copay for one routine hearing exam per year ▪ **$0** copay for evaluation and fitting of hearing aids ▪ **$1,500** maximum allowance per year for up to two hearing aids
	Medicaid **$0** copay for recipients who have moderate hearing loss or greater, including the following services: ▪ One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient ▪ Up to three pairs of ear molds per year, per recipient ▪ One fitting and dispensing service per ear, every three years, per recipient	
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	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 full or partial dentures, or problem focused services ▪ Limited evaluations, as medically indicated ▪ One complete series of intraoral radiographs every three years, per recipient. ▪ One panoramic radiograph every three years, per recipient ▪ Prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows: ✓ One upper, lower, or complete set of full or removable partial dentures per recipient	

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	✓ One reline, per denture, per 366 days, per recipient 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.	
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. ▪ **$400** maximum allowance per year towards the purchase of lenses, frames or contact lenses	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 ▪ **$300** maximum allowance per year towards the purchase of lenses, frames or contact lenses
	Medicaid ▪ **$0** copay for visual aid services ▪ **$2** copay for optometrist services, per provider or group provider, per day, if not exempt from cost sharing ▪ **$3** copay for optometrist 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 Florida Medicaid covers one frame every two years and two lenses every 365 days.	
Mental Health Care ◊	This Plan **Inpatient Mental Health Services** ▪ **$0** copay ▪ 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **$0** copay	This Plan **Inpatient Mental Health Services** ▪ **$0** copay ▪ 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **$0** copay

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	Medicaid ▪ **$2** copay per provider, per day, if not exempt from cost sharing ▪ **$3** 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	
Skilled Nursing Facility (SNF) ◊	This Plan ▪ **$0** copay Our plan covers up to 100 days in a SNF per benefit period. Medicaid ▪ **$0** copay	This Plan ▪ **$0** copay Our plan covers up to 100 days in a SNF per benefit period.
Physical 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
Ambulance ◊	This Plan ▪ **$0** copay for each Medicare-covered trip (one-way) Medicaid **$0** copay for Medicaid-covered services	This Plan ▪ **$0** copay for each Medicare-covered trip (one-way)
Transportation	This Plan ▪ **$0** copay for unlimited one-way trips for rides to your doctor, hospital or pharmacy ▪ These services can accommodate wheelchairs, walkers, oxygen tanks and service animals	This Plan ▪ **$0** copay for unlimited one-way trips for rides to your doctor, hospital or pharmacy ▪ These services can accommodate wheelchairs, walkers, oxygen tanks and service animals

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	Medicaid ▪ **$1** copay per one way trip. 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).	
Medicare Part B Drugs ◊	This Plan ▪ **$0** Copay for allergy injections ▪ **$0** copay for chemotherapy drugs and other Medicare Part B-covered drugs	This Plan ▪ **$0** Copay for allergy injections ▪ **$0** copay for chemotherapy drugs and other Medicare Part B-covered drugs
	Medicaid ▪ **$0** copay for prescription drugs obtained through the Prescription Drug Services program ▪ **$2** copay for practitioner services, per provider or group provider, per day, if not exempt from cost sharing ▪ **$3** 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	

Part D Prescription Drug Benefits

Deductible Stage
These plans have a **$435** deductible. The deductible does not apply to Tiers 1 (Preferred Generic) and 2 (Generic.)

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 **$4,020**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost sharing below applies to a one-month (31 day) supply.

	BlueMedicare Complete (HMO D-SNP) Orange and Osceola H1035-029 Hillsborough and Polk H1035-030		BlueMedicare Complete (HMO D-SNP) Clay and Duval H1035-031 Pinellas H1035-032	
	Preferred Retail/Mail Order	**Standard Retail/Mail Order**	**Preferred Retail/Mail Order**	**Standard Retail/Mail Order**
Tier 1 - Preferred Generic	**$0** copay	**$10** copay	**$0** copay	**$10** copay
Tier 2 - Generic	**$0** copay	**$11** copay	**$0** copay	**$11** copay
Tier 3 - Preferred Brand	**$40** copay	**$47** copay	**$40** copay	**$47** copay
Tier 4 - Non-Preferred Brand/Drug	**$92** copay	**$99** copay	**$92** copay	**$99** copay
Tier 5 - Specialty Tier	**25%** of the cost	**25%** of the cost	**25%** of the cost	**25%** of the cost

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 what our plan has paid and what you have paid) reaches **$4,020**. You stay in this stage until your year-to-date "out-of-pocket" costs reach a total of **$6,350**.

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During the Coverage Gap Stage:	▪ 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 **25%** of the cost, whichever is lower ▪ For generic drugs in all other tiers, you pay **25%** of the cost ▪ For brand-name drugs, you pay **25%** of the cost (plus a portion of the dispensing fee)	▪ 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 **25%** of the cost, whichever is lower ▪ For generic drugs in all other tiers, you pay **25%** of the cost ▪ For brand-name drugs, you pay **25%** of the cost (plus a portion of the dispensing fee)

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach **$6,350**, you pay the greater of:

- **$3.60** copay for generic drugs in all tiers (including brand drugs treated as generic) and a **$8.95** 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**) 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 Brand/Drug) cost sharing.
- Your cost-sharing may be different if you use a Long-Term Care 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

	BlueMedicare Complete (HMO D-SNP) Orange and Osceola H1035-029 Hillsborough and Polk H1035-030	**BlueMedicare Complete (HMO D-SNP)** Clay and Duval H1035-031 Pinellas H1035-032
Diabetic Supplies ◊	▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips **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 you Medicare Part D pharmacy benefit.** Applicable co-pays and deductibles apply.	
Medicare Diabetes Program	▪ **$0** copay for Medicare-covered services	▪ **$0** copay for Medicare-covered services
Podiatry	This Plan ▪ **$0** copay Medicaid **$2** copay per provider, per day	This Plan ▪ **$0** copay
Chiropractic	This Plan ▪ **$0** copay Medicaid ▪ **$1** copay per provider/group, per day	This Plan ▪ **$0** copay
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	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

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	Medicaid **$0** copay	
Outpatient Occupational and Speech Therapy*◊	This Plan ▪ **$0** copay	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	

You Get More with BlueMedicare

	BlueMedicare Complete **(HMO D-SNP)** Orange and Osceola H1035-029 Hillsborough and Polk H1035-030	BlueMedicare Complete **(HMO D-SNP)** Clay and Duval H1035-031 Pinellas H1035-032
Over-the-Counter Items	▪ **$150** quarterly allowance for the purchase of non-prescription items, such as vitamins and aspirin ▪ Any balance not used for a quarter will not carry over to the next quarter	▪ **$150** quarterly allowance for the purchase of non-prescription items, such as vitamins and aspirin ▪ Any balance not used for a quarter will not carry over to the next quarter
HealthyBlue Rewards	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings	

SilverSneakers® Fitness Program 	▪ College Save: As a SilverSneakers member, you can accumulate tuition discount points for savings on college tuition (up to one year off full tuition) for students that you designate ▪ Gym membership and classes available at 16,000+ fitness locations across the country, including national chains and local gyms ▪ Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more ▪ Classes such as line dance and Latin-style dance, indoor and outdoor boot camp, walking groups, and many more	
Meal Benefit	▪ 10 meals after each hospital discharge	▪ 10 meals after each hospital discharge

Disclaimers

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

This information is not a complete description of benefits. Call 1-855-601-9465 (TTY: 1-800-955-8770) for more information.

If you have any questions please contact our Member Services at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week, from October 1 – March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday – Friday, 8:00 a.m. – 8:00 p.m. local time.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-926-6565 (TTY: 1-800-955-8770). ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-926-6565 (TTY: 1-877-955-8773).

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

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

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

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, 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 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 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-008-1.

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.

સુચના: 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 โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **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 (TTY: 1-800-955-8770) 1-800-352-2583 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. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.