Florida Blue

2020 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

BlueMedicare Value (PPO) H5434-026

BlueMedicare Value (PPO) H5434-032

BlueMedicare Value (PPO) H5434-033

BlueMedicare Value (PPO) H5434-034

1/1/2020 – 12/31/2020

The plans' service area includes:

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

Y0011_34948_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
- live in **our service area.**

Our service area includes the following counties in Florida: Broward, Miami-Dade, Orange, Palm Beach, Polk 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 the providers that are not in our network, you may pay more 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 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.
    - 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 "◊" symbol. Services with this symbol may require prior authorization from the plan before you receive the services from network providers. If you do not get a prior authorization when required, you may have to pay out-of-network cost-sharing, even though you received services from a network provider. Please contact your doctor or refer to the Evidence of Coverage (EOC) for more information about services that require a prior authorization from the plan.

Monthly Premium, Deductible and Limits

	BlueMedicare Value (PPO) Broward, Palm Beach, St. Lucie H5434-026 Miami-Dade H5434-032	**BlueMedicare Value (PPO)** Orange H5434-033 Polk H5434-034
Monthly Plan Premium	▪ **$0** You must continue to pay your Medicare Part B premium.	▪ **$0** You must continue to pay your Medicare Part B premium.
Deductible	▪ **$1,000** Out-of-Network (OON) Deductible ▪ **$0** per year for Part D prescription drugs	▪ **$1,000** Out-of-Network (OON) Deductible ▪ **$150** per year for Part D prescription drugs (does not apply to Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 6 (Select Care Drugs))
Maximum Out-of-Pocket Responsibility	▪ **$4,500** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$10,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in and out-of-network providers combined.	▪ **$4,500** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$10,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in and out-of-network providers combined.

Medical and Hospital Benefits

	BlueMedicare Value (PPO) Broward, Palm Beach, St. Lucie H5434-026 Miami-Dade H5434-032	**BlueMedicare Value (PPO)** Orange H5434-033 Polk H5434-034
Inpatient Hospital Care	In-Network ◊ ▪ **$325** copay per day, days 1-6 ▪ **$0** copay per day, after day 6 Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **$325** copay per day, days 1-6 ▪ **$0** copay per day, after day 6 Out-of-Network **50%** coinsurance after OON deductible
Outpatient Hospital Care	In-Network ▪ **$90** copay per visit for Medicare-covered observation services ▪ **$250** copay for all other services ◊ Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ▪ **$90** copay per visit for Medicare-covered observation services ▪ **$250** copay for all other services ◊ Out-of-Network ▪ **50%** coinsurance after OON deductible

	BlueMedicare Value (PPO) Broward, Palm Beach, St. Lucie H5434-026 Miami-Dade H5434-032	**BlueMedicare Value (PPO)** Orange H5434-033 Polk H5434-034
Ambulatory Surgery Center	In-Network ◊ ▪ **$125** copay for surgery services provided at an Ambulatory Surgery Center Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **$125** copay for surgery services provided at an Ambulatory Surgery Center Out-of-Network ▪ **50%** coinsurance after OON deductible
Doctor's Office Visits	In-Network ▪ **$0** copay per Level 1 primary care visit ▪ **$10** copay all other primary care visit ▪ **$35** copay per Level 1 specialist visit ▪ **$45** copay all other specialist visit Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ▪ **$0** copay per Level 1 primary care visit ▪ **$10** copay all other primary care visit ▪ **$35** copay per Level 1 specialist visit ▪ **$45** copay all other specialist visit Out-of-Network ▪ **50%** coinsurance after OON deductible
Preventive Care	In-Network ▪ **$0** copay Out-of-Network ▪ **50%** coinsurance ▪ 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	In-Network ▪ **$0** copay Out-of-Network ▪ **50%** coinsurance

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	covered.	
Emergency Care	**Medicare Covered Emergency Care** ▪ **$90** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$125** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	**Medicare Covered Emergency Care** ▪ **$90** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$125** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.
Urgently Needed Services	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$50** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$0** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$125** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$50** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$0** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$125** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.

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Diagnostic Services/ Labs/Imaging	In-Network ◊ **Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$40** copay at an outpatient hospital facility **X-Rays** ▪ **$15** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$150** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a specialist's office or at an IDTF ▪ **$150** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ **Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$40** copay at an outpatient hospital facility **X-Rays** ▪ **$15** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$150** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a specialist's office or at an IDTF ▪ **$150** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount Out-of-Network ▪ **50%** coinsurance after OON deductible

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Hearing Services	**Medicare-Covered Hearing Services** In-Network ◊ ▪ **$45** copay for exams to diagnose and treat hearing and balance issues Out-of-Network ▪ **50%** coinsurance after OON deductible **Additional Hearing Services** In-Network ▪ **$0** copay for one routine hearing exam per year in- or out-of-network ▪ **$0** copay for evaluation and fitting of hearing aids in- or out-of-network Out-of-Network ▪ **50%** coinsurance for one routine hearing exam per year ▪ **50%** coinsurance for evaluation and fitting of hearing aids In- and Out-of-Network **$1000** maximum allowance per year for up to two hearing aids	**Medicare-Covered Hearing Services** In-Network ◊ ▪ **$45** copay for exams to diagnose and treat hearing and balance issues Out-of-Network ▪ **50%** coinsurance after OON deductible **Additional Hearing Services** In-Network ▪ **$0** copay for one routine hearing exam per year in- or out-of-network ▪ **$0** copay for evaluation and fitting of hearing aids in- or out-of-network Out-of-Network ▪ **50%** coinsurance for one routine hearing exam per year ▪ **50%** coinsurance for evaluation and fitting of hearing aids In- and Out-of-Network **$1000** maximum allowance per year for up to two hearing aids
Dental Services	**Medicare-Covered Dental Services** In-Network ◊ ▪ **$45** copay for non-routine dental care Out-of-Network ▪ **50%** coinsurance after OON deductible **Additional Dental Services** In-Network ▪ **$0** copay for covered preventive dental services ▪ **$0** copay for covered comprehensive dental services Out-of-Network ▪ **50%** coinsurance	**Medicare-Covered Dental Services** In-Network ◊ ▪ **$45** copay for non-routine dental care Out-of-Network ▪ **50%** coinsurance after OON deductible **Additional Dental Services** In-Network ▪ **$0** copay for covered preventive dental services ▪ **$0** copay for covered comprehensive dental services Out-of-Network ▪ **50%** coinsurance

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Vision Services 	**Medicare-Covered Vision Services** In-Network ▪ **$45** 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 Out-of-Network ▪ **50%** coinsurance after OON deductible **Additional Vision Services** In-Network ▪ **$0** copay for an annual routine eye examination Out-of-Network ▪ **50%** coinsurance for an annual routine eye examination **$200** maximum allowance per year towards the purchase of lenses, frames or contact lenses in- or out -of network	**Medicare-Covered Vision Services** In-Network ▪ **$45** 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 Out-of-Network ▪ **50%** coinsurance after OON deductible **Additional Vision Services** In-Network ▪ **$0** copay for an annual routine eye examination Out-of-Network ▪ **50%** coinsurance for an annual routine eye examination **$200** maximum allowance per year towards the purchase of lenses, frames or contact lenses in- or out -of network
Mental Health Care	**Inpatient Mental Health Services** In-Network ◊ ▪ **$318** copay per day, days 1-5 ▪ **$0** copay per day, days 6-90 ▪ 190-day lifetime benefit maximum in a psychiatric hospital Out-of-Network ▪ **50%** coinsurance after OON deductible **Outpatient Mental Health Services** In-Network ◊ ▪ **$40** copay Out-of-Network ▪ **50%** coinsurance after OON deductible	**Inpatient Mental Health Services** In-Network ◊ ▪ **$318** copay per day, days 1-5 ▪ **$0** copay per day, days 6-90 ▪ 190-day lifetime benefit maximum in a psychiatric hospital Out-of-Network ▪ **50%** coinsurance after OON deductible **Outpatient Mental Health Services** In-Network ◊ ▪ **$40** copay Out-of-Network ▪ **50%** coinsurance after OON deductible
Skilled Nursing Facility (SNF)	In-Network ◊ ▪ **$0** copay per day for days 1-20 ▪ **$160** copay per day, days 21-100	In-Network ◊ ▪ **$0** copay per day for days 1-20 ▪ **$160** copay per day, days 21-100

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	Out-of-Network ▪ **50%** coinsurance after OON deductible Our plan covers up to 100 days in a SNF per benefit period.	Out-of-Network ▪ **50%** coinsurance after OON deductible Our plan covers up to 100 days in a SNF per benefit period.
Physical Therapy	In-Network ◊ ▪ **$40** copay per visit Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **$40** copay per visit Out-of-Network ▪ **50%** coinsurance after OON deductible
Ambulance	▪ **$250** copay for each Medicare-covered trip (one-way) in-network ◊ or out-of-network	▪ **$250** copay for each Medicare-covered trip (one-way) in- network ◊ or out-of-network
Transportation	▪ Not covered	▪ Not covered
Medicare Part B Drugs	In-Network ◊ ▪ **$5** copay for allergy injections ▪ **20%** coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **$5** copay for allergy injections ▪ **20%** coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs Out-of-Network ▪ **50%** coinsurance after OON deductible

Part D Prescription Drug Benefits

	BlueMedicare Value (PPO) Broward, Palm Beach, St. Lucie H5434-026 Miami-Dade H5434-032	**BlueMedicare Value (PPO)** Orange H5434-033 Polk H5434-034
During the Deductible Stage:	This plan does not have a deductible	▪ This plan has a **$150** deductible. ▪ The deductible does not apply to Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 6 (Select Care Drugs)

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.

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.

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	Standard Retail	**Mail Order**	**Standard Retail**	**Mail Order**
Tier 1 - Preferred Generic	**$2** copay	**$2** copay	**$3** copay	**$3** copay
Tier 2 - Generic	**$10** copay	**$10** copay	**$12** copay	**$12** copay
Tier 3 - Preferred Brand	**$47** copay	**$47** copay	**$47** copay	**$47** copay
Tier 4 - Non- Preferred Brand/Drug	**$100** copay	**$100** copay	**$100** copay	**$100** copay
Tier 5 - Specialty Tier	**33%** of the cost	**33%** of the cost	**30% of the cost**	**30% of the cost**
Tier 6 – Select Care Drugs	**$0** copay	**$0** copay	**$0** copay	**$0** copay

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**.

<u>During the Coverage Gap Stage:</u>

- You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 6 (Select Care Drugs) – 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 an **$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 Value (PPO) Broward, Palm Beach, St. Lucie H5434-026 Miami-Dade H5434-032	**BlueMedicare Value (PPO)** Orange H5434-033 Polk H5434-034
Diabetic Supplies	In-Network ◊ ▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips Out-of-Network ▪ **50%** coinsurance after OON deductible

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 Prevention Program	**$0** copay for Medicare-covered services	**$0** copay for Medicare-covered services
Podiatry	In-Network ▪ **$35** copay for each Medicare-covered podiatry visit Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ▪ **$35** copay for each Medicare-covered podiatry visit Out-of-Network ▪ **50%** coinsurance after OON deductible
Chiropractic	In-Network ▪ **$20** copay for each Medicare-covered chiropractic visit Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ▪ **$20** copay for each Medicare-covered chiropractic visit Out-of-Network ▪ **50%** coinsurance after OON deductible
Medical Equipment and Supplies	In-Network ◊ ▪ **20%** coinsurance for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** coinsurance for all other plan approved, Medicare-covered durable medical equipment Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **20%** coinsurance for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** coinsurance for all other plan approved, Medicare-covered durable medical equipment Out-of-Network ▪ **50%** coinsurance after OON deductible

Outpatient Occupational and Speech Therapy	In-Network ◊ ▪ **$40** copay per visit Out-of-Network ▪ **50%** coinsurance after OON deductible	In-Network ◊ ▪ **$40** copay per visit Out-of-Network ▪ **50%** coinsurance after OON deductible

You Get More with BlueMedicare

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Over-the-Counter Items	▪ **$50** 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	▪ **$50** 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	

Disclaimers

Florida Blue is a PPO plan with a Medicare contract. Enrollment in Florida Blue 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.

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions please contact our Member Services number 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).

Health coverage is offered by Blue Cross and Blue Shield of Florida, Inc., dba Florida Blue, 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.