Florida Blue | MEDICARE

2027 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

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BlueMedicare Group PPO (Employer PPO)

Elite PPO w DHV + Elite Rx

City of Tallahassee #45380



Our service area includes:
Nationwide

This is a summary of what our plan covers and what you pay. For a complete list of covered services, limitations and exclusions, you may view the **"Evidence of Coverage"**. To get a complete list of the drugs we cover, call us and ask for the List of Covered Drugs "**Formulary"**. You may also contact your former employer's benefits administrator for the "Evidence of Coverage" and "Formulary".

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

You and your dependent(s) can join this plan if you are a retired employee of the group, and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and enrolled in Medicare Part B
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer

Our service area is nationwide. It includes all fifty states, the District of Columbia and the United States territories.

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 to receive medical services, you may pay more for these services. If you use pharmacies that are not in our network to fill your covered Part D drugs, the plan will generally not cover your drugs.

- You can see our plan's provider and pharmacy directory on our website (https://providersearch.floridablue.com/). 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: 711.
- If you are not a member of this plan, call us at 844-BLUE-MED (844-258-3633), TTY: 711.
    - 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**.

Important Information

- Our plan groups each medication into a tier. The number of tiers may vary based on the plan you choose. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached.

- Throughout 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 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

Monthly Plan Premium	$357.67 You must continue to pay your Medicare Part B premium.
Annual Deductible	▪ **$0** for In-Network health care services ▪ **$1,500** for Out-of-Network health care services ▪ **$200** for Part D prescription drugs applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier). ▪ There is no deductible for insulins.
Maximum Out-of-Pocket Responsibility (MOOP) (does not include prescription drugs)	▪ **$3,500** This 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** This is the most you pay for Medicare-covered medical services you receive from in- and out-of-network providers. ▪ Once you reach the maximum out-of-pocket (MOOP), our plan pays 100% of covered medical services. ▪ Premium and prescription drug costs do not count toward your MOOP.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Coverage ◊ (Authorization applies to in-network services only) (Covers an unlimited number of days for	▪ **$250** copay per day, for days 1-7 ▪ **$0** copay per day, after day 7	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

	In-Network	Out-of-Network
an inpatient hospital stay)		
Outpatient Hospital Coverage	▪ Observation Services: **$100** copay ▪ All Other Services ◊: **$200** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Ambulatory Surgical Center (ASC) Services	▪ Surgery Services◊ : **$150** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Doctor Visits	▪ Provider of Choice: **$15** copay ▪ Specialist: **$30** copay	▪ Provider of Choice: **$15** copay ▪ Specialist: **30%** of the total cost after you reach your $1,500 out-of-network deductible

Preventive Care
 	
(Medicare-covered Services)
	Medicare-covered Services: **$0** copay
	
	• Abdominal aortic aneurysm screenings
	• Alcohol misuse screenings & counseling
	• Bone mass measurements
	• Cardiovascular disease screenings
	• Cardiovascular disease (behavioral therapy)
	• Cervical & vaginal cancer screenings
	• Colorectal cancer screenings
	  o Blood-based biomarker tests
	  o Colonoscopies
	  o Computed tomography (CT) colonography
	  o Fecal occult blood tests
	  o Flexible sigmoidoscopies
	  o Multi-target stool DNA tests
	• Counseling to prevent tobacco use & tobacco-caused disease
	• Depression screenings
	• Diabetes screenings
	• Diabetes self-management training
		▪ **30%** of the total cost

	In-Network	Out-of-Network

	• Glaucoma screenings
	• Hepatitis B shots
	• Hepatitis B Virus (HBV) infection screenings
	• Hepatitis C screening tests
	• HIV screenings
	• Lung cancer screenings
	• Mammograms (screening)
	• Medical nutrition therapy services
	• Medicare Diabetes Prevention Program
	• Obesity behavioral therapy
	• One-time "Welcome to Medicare" preventive visit
	• Pre-exposure prophylaxis (PrEP) for HIV prevention
	• Prostate cancer screenings
	• Sexually transmitted infections screenings & counseling
	• Shots:
	  o COVID-19 vaccines
	  o Flu shots
	  o Hepatitis B shots
	  o Pneumococcal shots
	• Yearly "Wellness" visit
	• Any additional preventive services approved by Medicare during the contract year will be covered	

Emergency Care	▪ **$100** copay Copay waived if admitted to the same hospital within 48 hours of an emergency room visit.	
Worldwide Emergency Care (does not include emergency transportation) **If you have an emergency outside**	▪ **$100** copay ▪ Worldwide emergency and worldwide urgently needed services have a combined $25,000 coverage limit. The copay for worldwide emergency care is waived if admitted to the same hospital.	

	In-Network	Out-of-Network
of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.	▪ There is no coverage for care outside of the emergency room or emergency hospital admission.	
Urgently Needed Services **Worldwide Urgently Needed Services** (does not include emergency transportation) **If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.**	▪ Urgent Care Center: **$50** copay ▪ Convenient Care Center: **$50** copay ▪ **$100** copay ▪ Worldwide emergency and worldwide urgently needed services have a combined $25,000 coverage limit. The copay for worldwide urgently needed services is not waived if admitted to the hospital.	
Diagnostic Services/ Labs/Imaging ◊ (Authorization applies to in-network services only) **Tests and Procedures**	▪ Independent Diagnostic Testing Facility (IDTF): **$10** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

	In-Network	Out-of-Network
	▪ Outpatient Hospital Facility: **$30** copay ▪ Allergy Testing: **$0** copay	
Laboratory Services	▪ Independent Clinical Laboratory: **$0** copay ▪ Outpatient Hospital Facility: **$15** copay	
X-Rays	▪ Physician's Office **$25** copay ▪ IDTF: **$25** copay ▪ Outpatient Hospital Facility: **$100** copay	
Advanced Imaging Services (MRI, MRA, PET, CT scan, Nuclear Medicine Testing)	▪ Physician's Office: **$50** copay ▪ IDTF: **$75** copay ▪ Outpatient Hospital Facility: **$100** copay	
Radiation Therapy	▪ **20%** coinsurance	
Hearing Services Medicare-Covered	▪ Physician's Office: **$30** copay ▪ Specialist: **$30** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Additional Hearing Services	▪ Routine hearing exam: **$0** copay ▪ Evaluation and fitting: **$0** copay	▪ Member must submit receipts for reimbursement at 50% of maximum allowed for one routine hearing exam per year.

	In-Network	Out-of-Network
	▪ **$350 per ear.** You pay a **$0** copay for up to 2 hearing aids every year with a maximum benefit allowance of **$350** per ear. ▪ To receive in-network benefits and access the hearing aid benefit, hearing aids must be purchased through our participating provider. ▪ Member is responsible for any amount after the benefit allowance has been applied. Subject to benefit maximum. **NOTE:** Hearing aids must be purchased through our participating provider to receive in-network benefits.	▪ Member must submit receipts for reimbursement at 50% of maximum allowed for evaluation and fitting of hearing aids. ▪ Member must submit receipts for reimbursement at 50% of maximum allowed for up to 2 hearing aids every year. Subject to benefit maximum.
Dental Services **Medicare-Covered** ◊ (Authorization applies to in-network services only)	▪ **$30** copay for non-routine dental care (dental services that are covered when medically necessary (e.g., jaw surgery, tooth extraction before radiation, or dental exam prior to kidney transplant).	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Additional Dental Services	▪ **Preventive Dental:** You pay **$0** per service. Your preventive dental services include routine exams, cleanings, and X-rays per calendar year. ▪ **Comprehensive Dental:** You pay **$0** per service. Your comprehensive dental services include a denture adjustment and an extraction per calendar year. ▪ *See the Evidence of Coverage for full details, including frequency limits and provider network information.*	▪ **Preventive Dental:** You will pay up front and will be reimbursed 50% of non-participating rates for covered preventive dental services, which include routine exams, cleanings, and X-rays per calendar year.

	In-Network	Out-of-Network
		▪ **Comprehensive Dental:** You will pay up front and will be reimbursed 50% of non-participating rates for covered comprehensive dental services, which include a denture adjustment and an extraction per calendar year. ▪ *See the Evidence of Coverage for full details, including frequency limits and provider network information.*
Vision Services **Medicare-Covered**	▪ Physician Services: **$30** copay ▪ Glaucoma Screening: **$0** copay ▪ Diabetic Retinal Exam: **$0** copay ▪ Eyeglasses or Contact Lenses: **$0** copay One pair after cataract surgery	▪ Physician Services: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Glaucoma Screening: **30%** of the total cost ▪ Diabetic Retinal Exam: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Eyeglasses or Contact Lenses: **30%** of the total cost after you reach your $1,500 out-of-network deductible One pair after cataract surgery.
Additional Vision Services (subject to annual maximum benefit allowance)	▪ **Routine Eye Exam: $0** copay ▪ **Lenses, frames, contacts or upgrades: $0** copay ▪ Member responsible for any amounts in excess of the annual maximum plan benefit allowance. ▪ **$250** maximum allowance per year towards the purchase of lenses, frames or contacts.	▪ **Routine Eye Exam:** Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount. ▪ **Lenses, frames, contacts or upgrades:** Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the submitted amount.

	In-Network	Out-of-Network
		Member is responsible for all amounts in excess of the 50% submitted amount and/or any amounts in excess of the annual maximum plan benefit allowance. Total reimbursement is subject to the annual maximum plan benefit allowance.
Mental Health Services ◊ (Authorization applies to in-network services only) **Inpatient Psychiatric Hospital**	▪ **$200** copay per day for days 1-7 ▪ **$0** copay per day for days 8 - 90 90 days maximum per stay with a lifetime maximum of 190 days	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible 90 days maximum per stay with a lifetime maximum of 190 days
Outpatient Mental Health Therapy	<u>Individual Sessions</u> ▪ **$30** copay <u>Group Sessions</u> ▪ **$30** copay	<u>Individual Sessions</u> ▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible <u>Group Sessions</u> ▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Skilled Nursing Facility (SNF) ◊ (Authorization applies to	▪ **$0** copay per day for days 1-20 ▪ **$100** copay per day for days 21-100	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

	In-Network	Out-of-Network
in-network services only) (Covers up to 100 days per benefit period)		
Physical Therapy ◊ (Authorization applies to in-network services only)	▪ Physician's Office: **$25** copay ▪ Specialist Office: **$25** copay ▪ Outpatient Rehab Facility: **$25** copay ▪ Outpatient Hospital: **$25** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Speech Therapy ◊ (Authorization applies to in-network services only)	▪ Physician's Office: **$25** copay ▪ Specialist Office: **$25** copay ▪ Outpatient Rehab Facility: **$25** copay ▪ Outpatient Hospital: **$25** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Occupational Therapy ◊ (Authorization applies to in-network services only)	▪ Physician's Office: **$25** copay ▪ Specialist Office: **$25** copay ▪ Outpatient Rehab Facility: **$25** copay ▪ Outpatient Hospital: **$25** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Lymphedema Therapy ◊ (Authorization applies to in-network services only)	▪ **$0** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Ambulance ◊ (Authorization applies to in-network services only) (one-way trip)	▪ Ground: **$200** copay ▪ Facility-to-facility transfers: **$0** copay for transfer via ground ambulance ▪ Air: **20%** coinsurance	▪ Ground: **$200** copay ▪ Facility-to-facility transfers: **$200** copay for transfer via ground ambulance ▪ Air: **20%** coinsurance

	In-Network	Out-of-Network
Medicare Part B Drugs	▪ Allergy Injections: **$0** copay ▪ Chemotherapy drugs◊: Up to **20%** coinsurance ▪ Other Part B drugs: **20%** coinsurance ▪ Part B Insulin◊: **20% up to $35 per month** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

Part D Prescription Drug Benefits

Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage.
You will pay a yearly deductible of **$200** which applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand) and Tier 5 (Specialty Tier) drugs. You must pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand) and Tier 5 (Specialty Tier) drugs until you reach the plan's deductible amount. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. For all other drugs, you will not have to pay any deductible. The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid **$200** which applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand) and Tier 5 (Specialty Tier) drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

Initial Coverage Stage

You begin in this stage after you meet your deductible (if applicable). During this stage, the plan pays its share of the total cost of your drugs and you pay your share of the total cost. You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,400**. You then move on to the Catastrophic Coverage Stage. You may get your drugs at network retail and mail order pharmacies.

	Standard Retail (31-day supply)	Standard Retail (90 to 100-day supply)	Mail Order (90 to 100-day supply)
Tier 1 - Preferred Generic	**$0** copay	**$0** copay	**$0** copay
Tier 2 - Generic	**$0** copay	**$0** copay	**$0** copay
Tier 3 - Preferred Brand	**$30** copay	**$90** copay	**$90** copay
Tier 4 - Non-Preferred Drug	**$75** copay	**$225** copay	**$225** copay
Tier 5 - Specialty Tier	**33%** of the total cost	**N/A**	**N/A**
Tier 6 - Select Care Drugs	**$0** copay	**$0** copay	**$0** copay

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the drug tier, even if you haven't paid your deductible.

Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$2,400** limit for the calendar year. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You will stay in this payment stage until the end of the calendar year.

Additional Information About Drug Coverage

- For a complete list of the drugs we cover see the plan's "**Formulary**" and to see information about the cost of drugs see the plan's **"Evidence of Coverage**". These documents are available upon request. If you request a formulary exception, and the plan approves it, 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, an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.
- Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.

Medicare Prescription Payment Plan

- The Medicare Prescription Payment Plan is a payment option to help Medicare beneficiaries spread out their out-of-pocket drug costs across the calendar year (January to December). Participation is voluntary and there is no cost to enroll. You can enroll in the payment plan by speaking with your Agent of Record (AOR) or by calling our dedicated Election support line at 1-800-926-6565 or 1-833-696-2087, (TTY – 711) 8am — 8pm ET Mon – Fri, (voicemails monitored on weekends), 8am — 8pm ET 7 days a week (during Annual Enrollment Period (AEP)).
- For more information about the payment plan, speak with agent or visit our website at https://www.floridablue.com/medicare/member/prescription-drug-payments.

Additional Medical Benefits

	In-Network	Out-of-Network
Podiatry **Medicare-covered**	▪ **$25** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible
Chiropractic (manual manipulation of the spine to correct subluxation)	▪ **$20** copay	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

	In-Network	Out-of-Network
Telehealth ◊ (Authorization applies to in-network services only)	▪ Urgently Needed Services: **$50** copay ▪ Provider of Choice: **$15** copay ▪ Occupational Therapy: **$25** copay ▪ Physical Therapy: **$25** copay ▪ Speech Therapy: **$25** copay ▪ Dermatology Services: **$30** copay ▪ Mental Health Specialty Services: **$30** copay ▪ Psychiatry Specialty Services: **$30** copay ▪ Opioid Treatment: **$30** copay ▪ Substance Use Disorder Services: **$30** copay ▪ Diabetes Self-Management Training: **$0** copay ▪ Dietician Services: **$0** copay	▪ Urgently Needed Services: **$50** copay ▪ Provider of Choice: **$15** copay ▪ Occupational Therapy: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Physical Therapy: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Speech Therapy: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Dermatology Services: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Mental Health Specialty Services: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Psychiatry Specialty Services: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Opioid Treatment: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Substance Use Disorder Services: **30%** of the total cost after you reach your $1,500 out-of-network deductible ▪ Diabetes Self-Management Training: **30%** of the total cost ▪ Dietician Services: **30%** of the total cost after you reach your $1,500 out-of-network deductible
Diabetic Supplies	Available at Florida Blue Medicare contracted retail or mail-order pharmacies. **Preferred Brands:**	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

	In-Network	Out-of-Network
	• **0%** coinsurance Abbott (eg. Freestyle Lite) and Ascensia (Contour®) glucose meters, test strips, and lancets. • **0%** coinsurance Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies (other brands require prior authorization) **Non-Preferred Brands:** • 20% coinsurance Glucose meters, test strips, lancets, and continuous glucose monitors. All others, for example LifeScan (OneTouch), MiniMed CGM require prior authorization. **Insulin, alcohol swabs, insulin syringes, and needles for self-administration in the home are covered under Medicare Part D pharmacy benefit, with applicable co-pays and deductibles.** Please note: Medical supplies (e.g. alcohol swabs, gauze, syringes) are not covered under Part D unless used for insulin administration. Glucose meters and test strips can also be obtained through our participating DME network. Initial fill of a CGM with an insulin pump can be obtained through our participating DME provider.	
Medicare Diabetes Prevention Program (MDPP)	▪ **$0** copay for Medicare-covered services	▪ **30%** of the total cost

	In-Network	Out-of-Network
Durable Medical Equipment (DME) and Supplies ◊ (Authorization applies to in-network services only)	▪ Motorized Wheelchairs/Electric Scooters: **20%** coinsurance ▪ All Other DME: **0%** coinsurance	▪ **30%** of the total cost after you reach your $1,500 out-of-network deductible

Additional Benefits

	In-Network	Out-of-Network
SilverSneakers® Fitness Program	▪ Included in your plan you get a basic membership to any SilverSneakers® participating fitness facility at no additional cost. Gym membership and classes are available at 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.	▪ If you do not use a SilverSneakers participating fitness facility, you must pay 100% billed charges and submit an itemized receipt for reimbursement of 10% billed charges. The plan allows members to utilize their fitness benefit out of network under limited conditions. These conditions include: access to the lowest-cost tier of membership at established gyms and fitness centers, as well as live instructor-led group fitness classes designed for seniors. ▪ You are responsible for all amounts in excess of the reimbursable benefit amount.
HealthyBlue Rewards	▪ Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars Benefits MasterCard® Prepaid Card for completing and/or reporting certain preventive care and screenings. ▪ Rewards are available after opting in to the program.	▪ Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars Benefits MasterCard® Prepaid Card for completing and/or reporting certain preventive care and screenings. ▪ Rewards are available after opting in to the program.

Disclaimers

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

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 711). 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.

PPO 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.

The Benefits Mastercard® Prepaid Card, is issued by The Bancorp Bank, N.A., pursuant to license by Mastercard International Incorporated and Card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated. Valid only in the U.S. No cash access. Eligible allowance and rewards amounts cannot be combined. Additional limitations or restrictions may apply. Subscription type services like Walmart+, Instacart, Shipt, Amazon are not eligible.

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Participation in HealthyBlue Rewards is voluntary and offered at no additional cost to you.

HealthyBlue Rewards Program (HealthyBlue) restrictions and limitations may apply. Eligible members who opt in to participate in HealthyBlue Rewards must complete the activity and redeem rewards no later than December 31st of the benefit year. Unredeemed rewards will expire by December 31st of the benefit year or if you disenroll from the plan. If you need help with your HealthyBlue Rewards account or for full details on current program rules, visit FloridaBlue.com/HealthyBlue or call 1-800-926-6565 (TTY: 711).

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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, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, 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
711 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
711 (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 or Civil Rights 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, or 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

Visit www.floridablue.com/disclaimer/ndnotice to view an electronic version of this notice.
87768 0625R

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-800-352-2583, a FEP al 1-800-333-2227, a Medicare al 1-800-926-6565, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòma ki disponib gratis. Rele nan 1-800-352-2583, FEP 1-800-333-2227, oswa rele Medicare nan 1-800-926-6565 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-800-352-2583 联邦雇员计划(FEP)1-800-333-2227 医疗保险 (Medicare)1-800-926-6565 听障专线 (TTY)711.

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-800-352-2583, le FEP au 1-800-333-2227, le Medicare au 1-800-926-6565 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على:

1-800-352-2583 برنامج FEP: 1-800-333-2227 برنامج Medicare: 1-800-926-6565 (لذوي الإعاقة السمعية TTY: 711)

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-800-352-2583, FEP: 1-800-333-2227, Medicare: 1-800-926-6565, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-800-352-2583, FEP 1-800-333-2227, 메디케어 1-800-926-6565, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે.

1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565, (TTY 711) પર કૉલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-800-352-2583, FEP 1-800-333-2227, Medicare 1-800-926-6565 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-800-352-2583、FEP 1-800-333-2227、メディケア 1-800-926-6565 (TTY 711) までお電話ください。

خدمات رایگان زبانی، کمک‌های جانبی، و قالب‌های جایگزین در دسترس هستند. با شماره 1-800-352-2583 تماس بگیرید (TTY: 711). با Medicare 1-800-926-6565 و با 1-800-333-2227 برای FEP تماس بگیرید.

T’áá free yíníłta’go saad bee áká anilyeedígíí, ałk’ida’áníígíí, dóó t’áá ajiłii hane’ bee áká anilyeedígíí t’éiyá éí hołne’. 1-800-352-2583 bich’į’ náhodoonih, FEP bich’į’ 1-800-333-2227 bich’į’ náhodoonih, Medicare bich’į’ 1-800-926-6565 bich’į’ náhodoonih, (TTY 711).