



BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association

BlueCare Plus (HMO SNP)SM offered by BlueCare Plus Tennessee

Annual Notice of Changes for 2018

You are currently enrolled as a member of BlueCare Plus (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Section 1.5 for information about benefit and cost changes for our plan.
 - Check the changes in the booklet to our prescription drug coverage to see if they affect you.
 - Will your drugs be covered?
 - Are your drugs in a different tier, with different cost sharing?
 - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
 - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
 - Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.
 - Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 1.3 for information about our Provider Directory.
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Form CMS 10260-ANOC/EOC
(Approved 05/2017)

OMB Approval 0938-1051
(Expires May 31, 2020)

Cost	2017 (this year)	2018 (next year)
<p>Part D prescription drug coverage (See Section 1.6 for details.)</p>	<p>Deductible: \$0, \$82 or \$400</p> <p>Copayments/ Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0.00, \$1.20 or \$3.30 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 2: \$0.00, \$1.20 or \$3.30 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 3: \$0.00, \$1.20, \$3.30, \$3.70 or \$8.25 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 4: \$0.00, \$1.20, \$3.30, \$3.70 or \$8.25 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 5: \$0.00, \$1.20, \$3.30, \$3.70 or \$8.25 copay; or 15% of the total cost (or for no extra help: 25% of the cost) 	<p>Deductible: \$0, \$83 or \$405</p> <p>Copayments/ Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0.00, \$1.25 or \$3.35 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 2: \$0.00, \$1.25 or \$3.35 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 3: \$0.00, \$1.25, \$3.35, \$3.70 or \$8.35 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 4: \$0.00, \$1.25, \$3.35, \$3.70 or \$8.35 copay; or 15% of the total cost (or for no extra help: 25% of the cost) • Drug Tier 5: \$0.00, \$1.25, \$3.35, \$3.70 or \$8.35 copay; or 15% of the total cost (or for no extra help: 25% of the cost)
<p>Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	<p>\$6,700</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>	<p>\$6,700</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by TennCare SM (Medicaid).)	\$32 (Note: Because you receive Extra Help, your premium is \$0 .)	\$30.60 (Note: Because you receive Extra Help, your premium is \$0 .)

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

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$6,700	\$6,700 Once you have paid \$6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at bluecareplus.bcbst.com. You may also call Member Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

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

Section 1.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at bluecareplus.bcbst.com. You may also call Member Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* only tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage*. A copy of the *Evidence of Coverage* was included in this envelope.

Cost	2017 (this year)	2018 (next year)
Dental Services (Preventive)	\$250 Quarterly Allowance.	\$1,000 Annual Allowance.
Health Information Audio Library Index	Covered.	Health Information Audio Library Index is <u>not</u> covered.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	Not offered	You pay a \$0 copay
Over-the-Counter Benefit	The maximum coverage amount is \$120 every three months. Any unused credits will expire at the end of each quarter.	The maximum coverage amount is \$192 every three months. Any unused credits will expire at the end of each quarter.
Transportation – Non-Emergent	20 one-way trips to plan-approved locations every year.	40 one-way trips to plan-approved locations every year.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is in this envelope.

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

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

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

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

Your current formulary exceptions will still be covered in 2018 if you are still active as a member and the prior authorization is still active.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. Because you receive “Extra Help” and haven’t received this insert by 10/15/2017, please call Member Service and ask for the “LIS Rider.” Phone numbers for Member Service are in Section 6.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
<p>Stage 1: Yearly Deductible Stage</p> <p>During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible.</p>	<p>Your deductible amount is either \$0 or \$82 or \$400, depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)</p>	<p>Your deductible amount is either \$0 or \$83 or \$405, depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)</p>

Changes to Your Cost-sharing in the Initial Coverage Stage

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

	2017 (this year)	2018 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Preferred Generic Drugs: You pay \$0.00, \$1.20 or \$3.30 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <p>Generic Drugs: You pay \$0.00, \$1.20 or \$3.30 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Preferred Generic Drugs: You pay \$0.00, \$1.25 or \$3.35 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <p>Generic Drugs: You pay \$0.00, \$1.25 or \$3.35 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p>

	2017 (this year)	2018 (next year)
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	<p>Preferred Brand Drugs: You pay \$0.00, \$1.20, \$3.30, \$3.70 or \$8.25 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <p>Non-Preferred Brand Drugs: You pay \$0.00, \$1.20, \$3.30, \$3.70 or \$8.25 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <p>Specialty Tier Drugs: You pay \$0.00, \$1.20, \$3.30, \$3.70 or \$8.25 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <hr/> <p>Once you have paid \$4,950 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>Preferred Brand Drugs: You pay \$0.00, \$1.25, \$3.35, \$3.70 or \$8.35 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <p>Non-Preferred Drugs: You pay \$0.00, \$1.25, \$3.35, \$3.70 or \$8.35 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <p>Specialty Tier Drugs: You pay \$0.00, \$1.25, \$3.35, \$3.70 or \$8.35 per prescription <i>OR</i> 15% of the total cost (or for no extra help: 25% of the total cost).</p> <hr/> <p>Once you have paid \$5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in BlueCare Plus (HMO SNP)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2018.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan at any time,
- -- *OR*-- You can change to Original Medicare at any time.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <https://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from BlueCare Plus (HMO SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BlueCare Plus (HMO SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Member Service if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Deadline for Changing Plans

Because you are eligible for Medicare and TennCare (Medicaid) or eligible for Medicare cost-sharing assistance under TennCare (Medicaid), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Tennessee, the SHIP is called the Tennessee State Health Insurance Assistance Program.

The Tennessee State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The Tennessee State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call the Tennessee State Health Insurance Assistance Program at 1-877-801-0044 (Toll-Free). You can learn more about the Tennessee State Health Insurance Assistance Program by visiting their website (www.tn.gov/aging/topic/ship).

For questions about your TennCare (Tennessee's Medicaid Program) benefits, contact TennCare (Medicaid) at 1-866-311-4287, Monday - Friday, 8 a.m. to 5 p.m., all time zones. Closed on state holidays. TTY users should call 1-877-779-3103. Ask how joining another plan or returning to Original Medicare affects how you get your TennCare coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** Because you have Medicaid, you are already enrolled in “Extra Help”, also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
 - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Ryan White Program (Tennessee's AIDS Drug Assistance program). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Ryan White Program (Tennessee's AIDS Drug Assistance Program): 615-741-7500.

SECTION 6 Questions?

Section 6.1 – Getting Help from BlueCare Plus (HMO SNP)

Questions? We're here to help. Please call Member Service at **1-800-332-5762**. (TTY: **711**). We are available for phone calls from Oct. 1 to Feb. 14, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From Feb. 15 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays. Calls to these numbers are free.

Read your 2018 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for BlueCare Plus (HMO SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at bluecareplus.bcbst.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (<https://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <https://www.medicare.gov> and click on "Find health & drug plans.")

Read *Medicare & You 2018*

You can read *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from TennCareSM (Medicaid)

To get information from Medicaid, you can call TennCare (Medicaid) at 1-866-311-4287. TTY users should call 1-877-779-3103.



Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries Security Care, Inc., and Volunteer State Health Plan, Inc., dba BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact member service at the number on the back of your Member ID card or call 1-800-332-5762 (TTY: 711). From Oct. 1 to Feb. 14, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From Feb. 15 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact member service at the number on the back of your Member ID card or call 1-800-332-5762 (TTY: 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi Language Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-5762 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-332-5762 (رقم هاتف الصم والبكم: 711).

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 1-800-332-5762 (TTY:711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-5762 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-5762 (TTY: 711) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-5762 (ATS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ່ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-332-5762 (TTY: 711).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-332-5762 (መስማት ለተሳናቸው: 711)።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-5762 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-332-5762 (TTY:711)

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。1-800-332-5762 (TTY: 711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-5762 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-332-5762 (TTY: 711) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-5762 (телетайп: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-5762 (TTY:711) تماس بگیرید .