BlueCare Plus (HMO D-SNP)℠
BlueCare Plus Choice (HMO D-SNP)℠
BlueCare Plus Select (HMO D-SNP)℠

2024 Info You May Need

Hello!

This booklet has some important info and materials you may need this year. If you have questions about any of it, give us a call. We'll walk you through the details.

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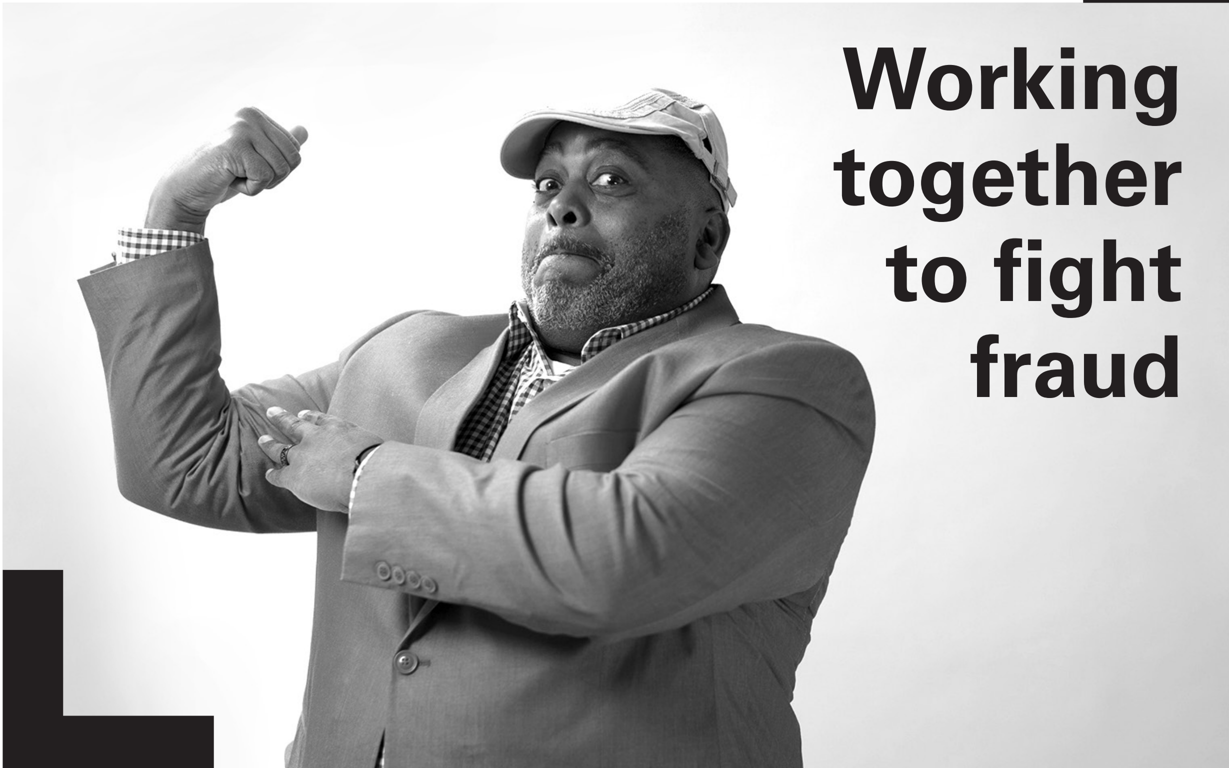
Questions? Please call us.
1-800-332-5762, TTY **711**



When it comes to caring for you, we're in this together. And that means working together to help protect you from fraud. Here are some ways to help keep your information safe:

- Share your information only with people you know.
- Remember you don't have to give your Member ID or Medicare number to anyone for free services (like at a community health fair).
- If you order your prescription drugs online, be sure to use our mail-order delivery program. Don't order from online pharmacies outside our network.
- Be careful what links you click in emails or pop-up ads online.
- Write down suspicious phone numbers and report them.

1-888-343-4221
You can report fraud to us by calling our Fraud/Compliance Hotline.

Legal resources

Do you have a complaint?

Do you have a complaint about the way you've been treated by us or one of your doctors or providers? If so, you can file a complaint. (This is also called filing a grievance.) You can't be dropped from your health plan for filing a complaint.

How to file a grievance

Just give us a call at **1-800-332-5762**, TTY **711**. Or you can complete our grievance form. You can find it online at **bluecareplus.bcbst.com/documents** under **Grievances & Appeals**. Once you print it and fill it out, you can send it to us by mail or fax at:

- **Mail:**
  BlueCare Plus Grievance
  1 Cameron Hill Circle Suite 42
  Chattanooga, TN 37402
- **Fax: 1-888-416-3026**

Do you think we've made a mistake?

If you disagree with a decision we made, you can file an appeal. An appeal is for when we've denied a claim or request for services. It asks us to look at our decision again and change it. We might still say no. But if we do, we'll walk you through your next steps.

How to file an appeal

You have 60 days from the date on the written notice we send you. If you send an appeal after 60 days, you have to show good cause for why it's late. We have an appeal form on our website you can use. It has all the details we'll need from you. But you don't have to use that form. You can also write an appeal on plain paper and send it to us by mail or fax at:

- **Mail:**
  BlueCare Plus Member Appeals
  1 Cameron Hill Circle Suite 42
  Chattanooga, TN 37402
- **Fax: 1-888-416-3026**

If you want someone else to file your appeal for you, you can appoint them as your representative. You just need to fill out the Appointment of Representative (AOR) form we've included on page 7. You and your representative will both need to sign and date it. Then you can send it to us with your appeal.

Remember that when you appoint a representative, they'll be able to:

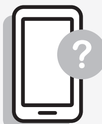
- **Get information about your claims**
- **Tell us what you want us to know about your appeal**
- **Make requests as if they were you**
- **Give and get information about your appeal**

There are more details about appeals and grievances in your plan's Evidence of Coverage. You can find it online at **bluecareplus.bcbst.com/documents**. But if you have questions, we're here to help answer them. Just give us a call at **1-800-332-5762**, TTY **711**.

Make important health decisions ahead of time

Many of us have an idea of what we would want done for us in case of an accident or illness. But it's a good idea to make sure your family or health care providers know, too. That's exactly what an advance care plan or advance directive does. It's a list of written decisions you get to make yourself ahead of time.

If you want to fill out an advance care plan or advance directive, call us. We can send you the paperwork and answer any questions you have. Or talk to your Primary Care Provider. They can help, too.



Questions? Please call us.
1-800-332-5762, TTY **711**

Forms you may need:

If you have someone who represents you, these forms will make it easier for them to work with us. You'll need to fill out both forms.

1. **Appointment of Representative (AOR) — pg. 7**

   This form tells us if you want someone to act on your behalf. They'll be able to see all your information and file a grievance or an appeal for you. You'll have to update this info each year.

2. **HIPAA Authorization Form — pg. 9**

   This form lets us use or disclose protected health information as stated.

Mail completed form to:
BlueCare Plus Correspondence
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37402

Questions? Please call us.
1-800-332-5762, TTY **711**

Form CMS-1696 Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the “Act”) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, ______________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ______________________________
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing ______________________ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, “not applicable”.

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at 42 CFR 405.910.

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, “Petition to Obtain Approval of a Fee for Representing a Beneficiary” elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative’s fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: https://www.hhs.gov/sites/default/files/OMHA-118.pdf

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

BlueCare Plus Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-0001

bluecareplus.bcbst.com

Authorization (Health Plan)

Purpose: This form is used to authorize us to use or disclose protected health information or for another person to disclose protected health information to us for the purpose stated.

SECTION A: Psychotherapy notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Identification Number: ______________________ Social Security Number (optional): ______________________

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

____

____

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above:

______________________ ______________________

______________________ ______________________

Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

______________________ ______________________

______________________ ______________________

Purpose of this Authorization:

☐ At request of individual
☐ For the following purposes:

____

____

H3259_21HIPPA_C (08/20)

AUTHORIZATION

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On ___ / ___ / ___

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402

INDIVIDUAL'S SIGNATURE.

I, ______________________________ , have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: ____ Date: ____________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Please return completed form to:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402

BlueCare Plus Tennessee

Notice of Privacy Practices (NOPP)

This notice describes how information we have about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

LEGAL OBLIGATIONS

The law requires Volunteer State Health Plan, Inc. dba BlueCare Plus Tennessee and certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

The law requires us to keep private all of the information we have about you, including your name, address, other demographic information, claims information, financial information, (including Social Security number), diagnosis information, other health information, and other information that can identify you ("nonpublic personal information" or "health plan information"). The law requires us to follow all the privacy practices in this notice from the date on the cover until we change or replace it.

We have the right to make changes to our privacy practices and this notice at any time, but we will send you a new notice any time we do. Any changes we make to this notice will apply to all information we keep, including information created or received before we made changes.

Please review this notice carefully and keep it on file for reference. You may ask us for a copy of this notice at any time. To get one, please contact us at:

CONNECT WITH US

Privacy Office
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Chattanooga, TN 37402
Phone: 888-455-3824 | Fax: 423-535-1976
E-mail: privacy_office@bcbst.com

For additional information, including TTY/TDD users, please call the Privacy Office at **1-888-455-3824**.
Para obtener ayuda en español, llame al **1-888-455-3824**.

You may reach out to us at this address or phone number to ask questions or make a complaint about this notice or how we've handled your privacy rights. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Just ask us for their address, and we will give it to you.

We support your right to protect the privacy of the information we have about you. We won't retaliate against you if you file a complaint with HHS or us.

ORGANIZATIONS THIS NOTICE COVERS

This notice applies to Volunteer State Health Plan, Inc. dba BlueCare Plus Tennessee. We may share our members' information with any of the following subsidiaries and affiliates as set out in this notice and as permitted by law: Group Insurance Services, Inc., Golden Security Insurance Co., SecurityCare of Tennessee, Inc., Shared Health Mississippi and BlueCross BlueShield of Tennessee, Inc.

These entities support us in providing health insurance and related products and services. If we buy or create new affiliates or subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

HOW WE MAY USE AND SHARE YOUR INFORMATION

We typically use your information for treatment, payment, or health care operations. Sometimes we are allowed, and sometimes we are required, to use or disclose your information in other ways. This is usually to contribute to the public good, such as public health and research.

Some states may have more stringent laws. When those laws apply to your information, we follow the more stringent law. Specifically, Tennessee law and other state and federal laws require us to obtain your consent for most uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Health Plan information about members and former members may be used and disclosed for treatment, payment, and health care operations.

We restrict access to health plan information about you to those employees or contractors who need to know that information to run our business. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your health plan information.

SOURCES OF INFORMATION WE COLLECT AND SHARE

We collect health plan information about you from the following sources:

1. **Information we receive from you:** We collect health plan information directly from you. For example, we collect information like your name, address, and Social Security number when you apply for insurance or complete other forms, and we collect information like your name and contact information when you contact us for customer service requests.

2. **Information about your transactions with us and our affiliates:** We collect health plan information about your relationship with us and with our affiliates. For example, we collect information about the claims we process like when you received health care, what services are covered and how much we've paid. We sometimes use affiliates and related entities to provide administrative services to process those claims, and they provide us with the same type of health plan information about you.

3. **Information about your transactions with non-affiliated third-parties:** We collect health plan information about your relationship with non-affiliated third-parties such as healthcare providers. For example, when your healthcare provider submits claims to us, it includes health plan information about your encounter like diagnostic information, procedures you've had and the date of service

As permitted by law and this notice, we may use and disclose all of the health plan information we have about you as described above.

WAYS WE MAY USE AND SHARE YOUR INFORMATION

We share health plan information with our affiliates and non-affiliated third-parties in the way described in this notice. We do not disclose any health plan information about our members or former members to anyone, except as permitted by law. The following are examples of how we may use or disclose your information in accordance with federal and state laws.

For your treatment: We may use or share your information with health care professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional care for you from other health care providers.

To make payments: We may use or share your information to pay claims for your care or to coordinate benefits covered under your health care coverage. For example, we may share your information with your dental provider to coordinate payment for dental services.

For health care operations: We may use or share your information to run our organization. For example, we may use or share it to measure quality, provide you with care management or wellness programs, and to conduct audit and other oversight activities.

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. For example, we may use or share your information to help verify your identity or to give you more information about your health insurance options. Please see your plan documents for all ways a plan sponsor may use this information.

For underwriting: We may use or share your health plan information for underwriting, premium rating or other activities relating to the creation, renewal, or replacement of a health plan contract. We're not allowed to use or disclose genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes. For example, we may disclose your health plan information as part of a limited data set given to a researcher for clinical research.

In the event of your death: If you die, we may share your health plan information with a coroner, medical examiner, funeral director, or organ procurement organization.

To help with public health and safety issues: We can share information about you in certain situations, such as:

› Preventing disease

› Assisting public health authorities in controlling the spread of disease such as during pandemics

› Helping with product recalls

› Reporting negative reactions to medications

› Reporting suspected abuse, neglect, or domestic violence

› Preventing or reducing a serious threat to anyone's health or safety

As required by law: We may use or share your information as required by state or federal law.

To comply with a court or administrative order: Under certain circumstances, we may share your information in response to a court or administrative order, subpoena, discovery request or other lawful process.

To address workers' compensation, law enforcement and other government requests: We can use or share information about you:

› For workers' compensation claims

› For law enforcement purposes, or with a law enforcement official

› With health oversight agencies for legal activities

› To comply with requests from the military or other authorized federal officials

With your permission: Some uses and disclosures of information require your written authorization, including certain instances if you want us to share your information with anyone. You may cancel your authorization in writing at any time, but doing so won't affect use or disclosure that happened while your authorization was valid.

For example, we would need your written authorization for:

› Most uses and disclosures of psychotherapy notes

› Uses and disclosures of your health plan information for marketing

› Sale of your health plan information

› Other uses and disclosures not described in this notice

We will let you know if any of these circumstances arise. We cannot use or disclose health plan information except as described in this notice without your written authorization.

YOUR INDIVIDUAL RIGHTS

To access your records: You have the right to view and get copies of your information that we maintain, with some exceptions. You must make a written request, using a form available from the Privacy Office, to get access to your information.

If you ask for copies of your information, we may charge you a reasonable, cost-based fee for staff time and postage if you want us to mail the copies to you. If you ask for this information in another format, this charge will reflect the cost of giving you the information in that format. If you prefer, you may request a summary or explanation of your information, which may also result in a fee. For details about fees we may charge, please contact the Privacy Office.

To see who we've disclosed your information to: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information, other than for the purpose of treatment, payment, or health care operations, within the past six years. This list will include the date of the disclosure, what information was disclosed, the name of the person or entity it was disclosed to, the reason for the disclosure and some other information.

If you ask for this list of disclosures more than once in a 12-month period, we may charge you based on the cost of responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of these charges.

To ask for restrictions: You have the right to ask for restrictions on how we use or disclose your health plan information. We're not required to agree to these requests except in limited circumstances. If we agree to a restriction, you and we will agree to the restriction in writing. Please contact the Privacy Office for more information.

To get notified of a breach: The law requires us to notify you after the unauthorized acquisition, access, use or disclosure of your unsecured information that compromises the security or privacy of the information. This notice must include various data points, such as:

- The date of the breach
- The type of data disclosed
- Who accessed, used, or disclosed the information without permission
- Who received your information, if known
- What we did or will do to prevent future breaches

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums.

If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

To ask for changes to your personal information: You have the right to request in writing that we revise your information. Your request must be in writing and explain why the information should be revised. We may deny your request, for example, if we

received (but didn't create) the information you want to amend. If we deny your request, we will write to let you know why. If you disagree with our denial, you may send us a written statement that we will include with your information.

If we grant your request, we will make reasonable efforts to notify people you name about this change. Any future disclosures of that information will be revised.

To request another copy of this notice: You can ask for a paper copy of this notice at any time, even if you got this notice by email or from our website. Please contact the Privacy Office at the address on page 1.

To choose a personal representative: You may choose someone to exercise your rights on your behalf, such as a power of attorney. You may also have a legal guardian exercise your rights. We will work with you if you'd like to make this effective.

BlueCare Plus
Tennessee

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, Inc. also doing business as 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 March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 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 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 hhs.gov/ocr/office/file/index.html.

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-332-5762, TTY 711. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-332-5762, TTY 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-332-5762, TTY 711。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-332-5762, TTY 711。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-332-5762, TTY 711. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-332-5762, TTY 711. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-332-5762, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-332-5762, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-332-5762, TTY 711 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-332-5762, TTY 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-332-5762, TTY 711. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-332-5762, TTY 711 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-332-5762, TTY 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-332-5762, TTY 711. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-332-5762, TTY 711. Yon moun ki pale Kreyòl kapab ede w.
Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-332-5762, TTY 711. Ta usługa jest bezpłatna.

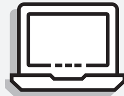
Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-332-5762, TTY 711 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Notes

Notes

For you. With you. We’re right here.

Questions? Please call us.
1-800-332-5762, TTY **711**



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1 Cameron Hill Circle | Chattanooga, TN 37402

From **Oct. 1 to March 31**, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.

BlueCare Plus Tennessee, Independent Licensee of the Blue Cross Blue Shield Association

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