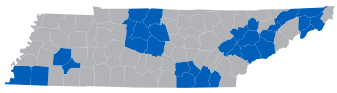
2021 Summary of Benefits

A MEDICARE ADVANTAGE PLAN WITH PART D PRESCRIPTION DRUG COVERAGE



BlueEssential (HMO SNP)℠

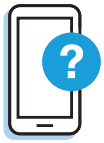
of Tennessee

H2120_21SB_M (9/20)

of Tennessee

ENROLLING

Pre-Enrollment Checklist



Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-888-665-5678**, TTY **711**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **bcbstmedicare.com** or call **1-888-665-5678,** TTY **711** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

H2120_21PEC_C (08/20)

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, go to **bcbstmedicare.com** or call us and ask for the "**Evidence of Coverage**."

Sections in this booklet

- **Things to Know About BlueEssential**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats.

This document may be available in a non-English language. For additional information, call us at **1-888-851-2583** TTY **711**.

Things to Know About BlueEssential

Hours of Operation & Contact Information

- From **October 1 to March 31** we're open 8 a.m. – 9 p.m. ET, 7 days a week.
- From **April 1 to September 30**, we're open 8 a.m. – 9 p.m. ET, Monday through Friday.
- If you are a member of this plan, call us at 1-888-851-2583, TTY 711.
- If you are not a member of this plan, call us at 1-888-665-5678, TTY 711.
- Our website: **bcbstmedicare.com**

Who can join?

To join **BlueEssential**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area and have diabetes mellitus and/or cardiovascular disease. Our service area includes these Tennessee counties:

West Tennessee: Chester, Fayette, Madison and Shelby

Middle Tennessee: Cheatham, Davidson, Robertson, Rutherford, Sumner, Williamson and Wilson

Southeast Tennessee: Anderson, Blount, Bradley, Grundy, Hamblen, Hamilton, Jefferson, Knox, Loudon, Marion, Roane, Sequatchie, Sevier and Union

Northeast Tennessee: Carter, Hawkins, Sullivan, Unicoi and Washington

What do we cover?

Like all Medicare Advantage health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **bcbstmedicare.com.**
- Or, call us and we will send you a copy of the formulary.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." 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. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact BlueEssential.

SECTION II - SUMMARY OF BENEFITS BlueEssential	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	**$0** per month. You must keep paying your Medicare Part B premium.
Deductible	Medical Deductible: **No deductible** Prescription Drug Deductible: **No deductible**
Maximum Out-of-Pocket Responsibility	Your yearly limit in this plan : • **$6,700** for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your cost-sharing for your Part D prescription drugs.
Out-of-Network Benefit	This plan has no out-of-network benefits except for emergency care, urgently needed services.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital **Prior Authorization is required.**	**In-Network:** Days 1-6: **$325** copay per day Days 7+: **$0** copay per day The amounts above apply per benefit period. A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins. Our plan covers an unlimited number of days for an inpatient hospital stay. You may only receive 190 days in a psychiatric hospital in a lifetime. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.
Inpatient Mental Health Hospitalization **Prior Authorization is required.**	**In-Network:** Days 1-5: **$325** copay per day Days 6+: **$0** copay per day The amounts above apply per benefit period. A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins. Our plan covers an unlimited number of days for an inpatient hospital stay.

SECTION II - SUMMARY OF BENEFITS BlueEssential	
	You may only receive 190 days in a psychiatric hospital in a lifetime. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.
Outpatient Hospital Services **Prior authorization may be required.**	**<u>In-Network:</u>** Ambulatory Surgical Center: **$275** copay Outpatient Hospital: **$325** copay
Doctor's Office Visits	**<u>In-Network:</u>** Primary Care Provider, Endocrinologist or Cardiologist visit: **$10** copay Other Specialist visit: **$35** copay
Preventive Care ***Our plan covers many preventive services, including:*** • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings	**<u>In-Network:</u>** **$0** copay Additional preventive services approved by Original Medicare will be covered for dates of service on or after approval by Original Medicare.

	BlueEssential
(colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Flu vaccine, hepatitis B vaccine, and pneuomococcal vaccine • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit	**In-Network:** **$0** copay Additional preventive services approved by Original Medicare will be covered for dates of service on or after approval by Original Medicare.

SECTION II - SUMMARY OF BENEFITS BlueEssential	
Emergency Care	**<u>In and Out-of-Network</u>** Medicare-covered: **$90** copay per visit Worldwide Coverage: **$90** copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	**<u>In and Out-of-Network</u>** Medicare-covered: **$65** copay per visit Worldwide Coverage: **$90** copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
Diagnostic Services / Labs/ Imaging **Prior Authorization may be required.** **Refer to your EOC for details about prior authorization requirements for these services.**	**<u>In-Network:</u>** **Diagnostic tests and procedures:** **$10** copay at a Primary Care Provider's, Endocrinologist's or Cardiologist's office **$35** copay at a Specialist's office **$40** copay at a Free Standing Facility **$100** copay at an Outpatient Hospital **Lab services:** **$0** copay at a Primary Care Provider's, Endocrinologist's or Cardiologist's office **$0** copay at a Specialist's office **$0** copay at a Free Standing Facility **$40** copay at an Outpatient Hospital **X-rays:** **$10** copay at a Primary Care Provider's, Endocrinologist's or Cardiologist's office **$35** copay at a Specialist's office **$40** copay at a Free Standing Facility **$50** copay at an Outpatient Hospital **Genetic Testing:** **20%** of the plan-allowed amount **Coumadin Services:** **$0** copay at a Primary Care Provider's, Endocrinologist's or Cardiologist's office **$0** copay at a Specialist's office **$0** copay at a Free Standing Facility **$10** copay at an Outpatient Hospital

SECTION II - SUMMARY OF BENEFITS BlueEssential	
	Sleep Studies: **$10** copay for in-home **$40** copay at an Outpatient Hospital **Therapeutic Radiology:** **$60** copay **Advanced Imaging (such as MRI, CT scans):** **$225** copay
Hearing Services **Cost-sharing for hearing aids does not count toward the out-of-pocket amount.**	**In-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine Hearing Exam (1 per year): **$0** copay at TruHearing® provider Hearing Aid: **$599 or $899** copay depending on model Limited to one per ear per year. Benefit is limited to TruHearing Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit.
Dental Services **Comprehensive and preventive dental benefits do not count toward the out-of-pocket amount.** (Service limits and other restrictions may apply to the comprehensive dental benefits.)	**In-Network:** Medicare-covered : **$40** copay Our plan pays up to **$1,000** per year for combined preventive and comprehensive dental services. Included as covered benefits with service limits in this plan, but not limited to: • Standard diagnostic exam (limited to 2 per year) • Emergency diagnostic exam (limited to 1 per year) • Cleaning (limited to 2 per year) • Bitewing x-ray (limited to 1 per year) • Panoramic x-ray (limited to 1 per 36 months) • Fillings (limited to 1 per tooth surface per year) • Crowns (limited to 1 per tooth per 5 years) • Extractions • Bridges (limited to 1 per 5 years) • Removable dentures; complete, immediate, and partial (limited to 1 in any 5 year period) If the total covered cost for dental services is more than **$1,000** or if you exceed a service limit, you are required to pay the difference.
Vision Services **Members are encouraged to use the defined vision care network to obtain routine eye**	**In-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$35** copay Routine eye exam (1 per year): **$35** copay Eyeglasses or contact lenses after cataract surgery: **$0** copay

SECTION II - SUMMARY OF BENEFITS BlueEssential	
exam and eyewear benefit coverage. Routine eye exam and eyewear copays and coinsurance do not apply to the maximum out-of-pocket.	Our plan pays up to **$150** per year for eyewear. There is no copay for contact lenses or eyeglasses (frames and lenses). But if your total eyewear cost is more than **$150**, you will be required to pay the difference. For example: If your total cost for eyewear is **$300**, your plan will pay **$150** and you will pay **$150**.
Mental Health Services **Prior authorization is required.**	**In-Network:** Individual therapy visit: **$30** copay Outpatient group therapy visit: **$20** copay
Skilled Nursing Facility (SNF) **Prior authorization is required.**	**In-Network:** Days 1-20: **$0** copay per day Days 21-100: **$184** copay per day The amounts above apply per benefit period. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you go into a SNF. The benefit period will accumulate one day for each day you are inpatient at a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Physical Therapy **Prior authorization is required.**	**In-Network:** Occupational therapy visit: **$35** copay Physical therapy and speech and language therapy visit: **$35** copay
Ambulance **Prior authorization is required for all non-emergency ambulance transport.**	**In and Out-of-Network (Domestic)** Ground Ambulance: **$275** copay per trip Air Ambulance: **20%** of the Medicare-allowed amount per trip See the EOC for details regarding worldwide emergency transportation.

SECTION II - SUMMARY OF BENEFITS BlueEssential	
Transportation Prior authorization is required.	**In-Network:** **24** one-way trips per year, not to exceed 25 miles per trip **$0** cost share
Medicare Part B Drugs **Prior authorization may be required.**	**In-Network:** For Part B drugs such as chemotherapy drugs: **20%** of the plan-allowed amount Other Part B drugs: **20%** of the plan-allowed amount

Part D Prescription Drug Benefits

1. Deductible Stage

This plan does not have a deductible for drug benefits. Prescription drug copays and coinsurance do not apply to the maximum out-of-pocket.

2. Initial Coverage Stage

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail Pharmacy

You pay the following until total yearly drug cost (including what our plan paid and what you have paid) reaches **$4,130**.

Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at preferred retail pharmacies and through the preferred mail order pharmacy program managed by Express Scripts®. Or you can get your drugs from standard retail pharmacies. Your prescription drug copay will typically be less at a preferred network pharmacy because it has an agreement with BlueEssential. Some medications may require prior authorization, step therapy and/or quantity limits. Please see the formulary (drug list).

PRESCRIPTION DRUG BENEFITS		
Initial Coverage Stage	**Preferred Retail and Mail Order Pharmacy** **30 / 90 Day Supply**	**Standard Retail and Mail Order Pharmacy** **30 / 90 Day Supply**
Tier 1: Preferred Generic	**$1 / $1**	**$6 / $6**
Tier 2: Generic	**$10 / $10**	**$15 / $15**

Tier 3: Preferred Brand - Select Insulin(s)	**$27 / $81**	**$35 / $105**
Tier 3: Preferred Brand	**$42 / $105**	**$47 / $110**
Tier 4: Non-Preferred Drugs	**$92 / $225**	**$97 / $230**
Tier 5: Specialty Drugs	**33%** coinsurance – Specialty medications are limited to a 30-day supply	
Tier 6: Select Care Drugs	**$6 / $6**	**$11 / $11**

3. Coverage Gap Stage (Donut Hole)

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail Pharmacy

The coverage gap begins after the total yearly cost of your drugs (including what our plan has paid and what you have paid) reaches **$4,130**.

After you enter the coverage gap, you pay **25%** of the plan's cost for covered brand name and generic drugs until your costs total **$6,550**, which is the end of the coverage gap. With this plan you may pay less than **25%** of the cost of some preferred generic drugs and diabetic select care drugs through the gap.

PRESCRIPTION DRUG BENEFITS		
Coverage Gap Stage	**Preferred Retail and Mail Order Pharmacy** **30 / 90 Day Supply**	**Standard Retail and Mail Order Pharmacy** **30 / 90 Day Supply**
Tier 1: Preferred Generic	**$1 / $1**	**$6 / $6**
Tier 3: Preferred Brand - Select Insulin(s)	**$27 / $81**	**$35 / $105**

4. Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, until 12/31/21, you pay the greater of:

5% of the cost, or
$3.70 copay for generic (including brand drugs treated as generic) and a **$9.20** copay for all other drugs.

ADDITIONAL HEALTH BENEFITS	
24/7 Nurseline	**In-Network:** You can speak with a Registered Nurse (RN) 24 hours a day, 7 days a week. **$0** copay
Acupuncture **Prior authorization is required.**	**In-Network:** **$20** copay
Chiropractic **Prior authorization is required.**	**In-Network:** Chiropractic visit: **$20** copay Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)
Diabetes Supplies and Services **Prior authorization may be required.** **Refer to your EOC for details about prior authorization requirements for these services.**	**In-Network:** Diabetes self-management training: **$0** copay Diabetes **preferred** monitoring supplies: **$0** copay Diabetes **non-preferred** monitoring supplies: Not covered Therapeutic shoes or inserts: **$10** copay
Durable Medical Equipment (DME) **Prior authorization may be required.**	**In-Network:** Continuous Glucose Monitors (CGMs) and Insulin Pumps: **15%** of the plan-allowed amount All other DME: **20%** of the plan-allowed amount
Foot Care ***(podiatry services)***	**In-Network:** Medicare-covered Foot Exams: **$35** copay Routine Foot Care: **$0** copay (limited to 6 visits per year)

Home Health Care **Prior Authorization is required.**	**In-Network:** **$0** copay
Outpatient Rehabilitation **Prior Authorization is required.**	**In-Network:** **Cardiac (heart) rehab services** **$20** copay **Pulmonary (lung) rehab services** **$20** copay
Over-the-Counter (OTC) Items	**In-Network:** The plan pays **$25 per quarter** for OTC items such as vitamins, cough/cold/allergy medicines, dental products and skin care items.
Prosthetic Devices ***(braces, artificial limbs, etc.)*** **Prior authorization may be required.**	**In-Network:** Prosthetic devices: **20%** of the plan-allowed amount Related medical supplies: **20%** of the plan-allowed amount
Renal Dialysis	**In-Network:** **20%** of the plan-allowed amount
Wellness Program – Fitness Membership	The plan includes a Fitness Membership: **You pay nothing**

DISCLAIMERS

This document is available in other formats.

BlueEssential is a HMO SNP plan with a Medicare contract. Enrollment in BlueEssential depends on contract renewal.

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

This is a summary of drugs and health services covered by BlueEssential Health Maintenance Organization Special Needs Plan (HMO SNP) health plan January 1, 2021 through December 31, 2021.

of 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 **1-888-851-2583**, 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 **1-888-851-2583**, 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.

H2120_21NDMLI_C (08/20)

Multi Language Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-888-851-2583, TTY 711.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان.
اتصل برقم 1-888-851-2583, TTY 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 1-888-851-2583, TTY 711。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-888-851-2583, TTY 711.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-851-2583, TTY 711 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-851-2583, ATS 711.

ເອົາໃຈໃส่: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ
1-888-851-2583, TTY 711.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-851-2583, (መስማት ለተሳናቸው 711.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1-888-851-2583, TTY 711.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-888-851-2583, 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。
1-888-851-2583, 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 1-888-851-2583, TTY 711.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-888-851-2583, TTY 711 पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните
1-888-851-2583, телетайп 711.

توجه: اگر به زبان فارسی صحبت می کنید خدمات زبان و ترجمه به صورت رایگان برایتان فراهم
می گردد. با 1-888-851-2583, TTY 711 تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-888-851-2583, TTY 711.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-888-851-2583, TTY 711

ATENÇÃO: se fala português, encontram-se disponíveis serviços linguísticos grátis.
Ligue para 1-888-851-2583, TTY 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza
linguistica gratuiti. Chiamare il numero 1-888-851-2583, TTY 711.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'd66', t'áá jiik'eh, éí ná hól=,
koj8' hód77lnih 1-888-851-2583, TTY 711.

Notes

We're right here when you need us.

bcbstmedicare.com

If you are a member, call toll-free
1-888-851-2583 TTY **711**.

If you are not a member, call toll-free
1-888-665-5678 TTY **711**.

OCT. 1 TO MARCH 31, SEVEN DAYS A WEEK FROM 8 A.M. TO 9 P.M. ET. FROM **APRIL 1 TO SEPT. 30**, M-F FROM 8 A.M. TO 9 P.M. ET.

of Tennessee