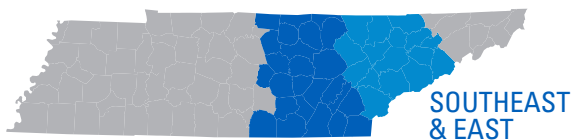


2023 Summary of Benefits

A MEDICARE ADVANTAGE PLAN WITH
PART D PRESCRIPTION DRUG COVERAGE



Sapphire

BlueAdvantage (PPO)SM





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 **1-800-292-5146**, TTY **711**.

Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [bcbstmedicare.com](https://www.bcbstmedicare.com) or call **1-800-292-5146**, 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.
- Review the formulary to make sure your drugs are covered.

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/coinsurance may change on January 1, 2024.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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 you can call us and ask for the “**Evidence of Coverage.**”

Sections in this booklet

- **Things to Know About BlueAdvantage Sapphire**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Part D 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 **1-800-831-2583**, TTY 711.

Things to Know About BlueAdvantage Sapphire

Hours of Operation & Contact Information

- From **Oct. 1 to March 31**, we’re open 8 a.m. – 9 p.m. ET, seven days a week.
- From **April 1 to Sept. 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 **1-800-831-2583**, TTY 711.
- If you are not a member of this plan, call us at **1-800-292-5146**, TTY 711.
- Our website: bcbstmedicare.com

Who can join?

To join **BlueAdvantage Sapphire**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area.

Southeast region counties in Tennessee:

Bledsoe, Bradley, Cannon, Clay, Cumberland, DeKalb, Fentress, Franklin, Grundy, Hamilton, Jackson, Macon, Marion, McMinn, Meigs, Overton, Pickett, Polk, Putnam, Rhea, Sequatchie, Smith, Van Buren, Warren and White

East region counties in Tennessee:

Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate which tier your drug is in 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
BlueCross BlueShield of Tennessee.**

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

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 East Tennessee	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$5,500 for services you receive from in-network providers • \$8,950 for services you receive from in- and out-of-network providers
Maximum Out-of-Pocket Responsibility Southeast Tennessee	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$5,500 for services you receive from in-network providers • \$8,950 for services you receive from in- and out-of-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 monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS

<p>Inpatient Hospital and Inpatient Mental Health Hospitalization</p> <p>Prior authorization is required.</p>	<p><u>In-Network:</u> Days 1-5: \$300 copay per day Days 6+: \$0 copay per day</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount per stay</p> <p>The amounts above apply per benefit period.</p> <p>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.</p> <p>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.</p>
<p>Outpatient Surgical Services</p> <p>Prior authorization may be required.</p>	<p><u>In-Network:</u> Ambulatory Surgical Center: \$275 copay Outpatient hospital facility: \$325 copay</p>

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

	<p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
<p>Doctor's Office Visits</p>	<p><u>In-Network:</u> Primary Care Provider visit: \$10 copay Specialist visit: \$35 copay <u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
<p>Preventive Care <i>Our plan covers many preventive services, including:</i></p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse screenings & counseling • Bone mass measurements (bone density) • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • Cervical & vaginal cancer screening • Colorectal cancer screenings <ul style="list-style-type: none"> * Multi-target stool DNA tests * Screening barium enemas * Screening colonoscopies * Screening fecal occult blood tests * Screening flexible sigmoidoscopies • Depression screenings • Diabetes screenings • Diabetes self-management training 	<p>Additional preventive services approved by Original Medicare will be covered for dates of service on or after approval by Original Medicare.</p> <p><u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p> <p>Additional preventive services approved by Original Medicare will be covered for dates of service on or after approval by Original Medicare.</p> <p><u>In-Network:</u></p>

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

<ul style="list-style-type: none">• Glaucoma tests• Hepatitis B Virus (HBV) infection screening• Hepatitis C screening test• HIV screening• Lung cancer screening• Mammograms (screening)• Nutrition therapy services• Obesity screenings & counseling• One-time "Welcome to Medicare" preventive visit• Prostate cancer screenings• Sexually transmitted infections screening & counseling• Tobacco use cessation counseling• Vaccines:<ul style="list-style-type: none">* COVID-19* Flu* Hepatitis B* Pneumococcal• Yearly "Wellness" visit	<p>\$0 copay</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p>
<p>Emergency Care</p>	<p><u>In- and Out-of-Network:</u></p> <p>Medicare-covered: \$90 copay per visit</p> <p>Worldwide Coverage: \$90 copay per visit</p> <p>If you are admitted to the hospital within 24 hours, you do not pay your share of the cost for emergency care.</p>
<p>Urgently Needed Services</p>	<p><u>In- and Out-of-Network:</u></p> <p>Medicare-covered: \$45 copay per visit</p> <p>Worldwide Coverage: \$90 copay per visit</p> <p>If you are admitted to the hospital within 24 hours, you do not pay your share of the cost for urgently needed services.</p>

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

<p>Diagnostic Services / Labs / Imaging</p> <p>Prior authorization may be required.</p> <p>Refer to your EOC for details about prior authorization requirements for these services.</p>	<p><u>In-Network:</u></p> <p>Diagnostic tests and procedures: \$10 copay at a Primary Care Provider’s office \$35 copay at a Specialist’s office \$40 copay at a Free Standing Facility \$100 copay at an Outpatient Hospital</p> <p>Lab services: \$0 copay at a Primary Care Provider’s office \$0 copay at a Specialist’s office \$0 copay at a Free Standing lab \$40 copay at an Outpatient Hospital</p> <p>X-rays: \$10 copay at a Primary Care Provider’s office \$35 copay at a Specialist’s office \$40 copay at a Free Standing Facility \$50 copay at an Outpatient Hospital</p> <p>Genetic Testing: 20% of the plan-allowed amount</p> <p>Coumadin Services: \$0 copay at a Primary Care Provider’s office \$0 copay at a Specialist’s office \$0 copay at a Free Standing Facility \$10 copay at an Outpatient Hospital</p> <p>Sleep Studies: \$10 copay for In-Home \$40 copay at an Outpatient Facility</p> <p>Therapeutic Radiology Services: \$60 copay</p> <p>Advanced Imaging (such as MRI, CT scans): \$225 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
<p>Hearing Services</p> <p>Cost-sharing for hearing aids does not count toward the</p>	<p><u>In-Network:</u></p> <p>Medicare-covered exam to diagnose and treat hearing and balance issues: \$10 copay</p> <p>Routine hearing exam (1 per year): \$0 copay at TruHearing® provider</p> <p>Hearing Aid: \$399 (Standard), \$599 (Advanced) or \$899 (Premium) copay depending on model Limited to one per ear per year. Benefit is limited to</p>

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

<p>maximum out-of-pocket amount.</p>	<p>TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit.</p> <p><u>Out-of-Network:</u></p> <p>Medicare-covered exam to diagnose and treat hearing and balance issues: \$10 copay</p> <p>Routine hearing exam: Not covered</p> <p>Hearing Aids: Not covered</p>
<p>Dental Services</p> <p>Comprehensive and preventive dental benefits do not count toward the maximum out-of-pocket amount.</p> <p>(Service limits and other restrictions may apply to the comprehensive dental benefits.)</p> <p>Included as covered benefits with service limits in this plan, but not limited to:</p> <ul style="list-style-type: none"> • 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) 	<p><u>In-Network:</u></p> <p>Medicare-covered: \$35 copay</p> <p>Our plan pays up to \$2,000 per year for combined preventive and comprehensive dental services.</p> <p>If the total covered cost for dental services is more than \$2,000 or if you exceed a service limit, you are required to pay the difference.</p> <p><u>Out-of-Network:</u></p> <p>Medicare-covered: 50% of the Medicare-allowed amount</p> <p>Our plan pays 50% of billed charges up to \$2,000. You pay 100% of any charges over \$2,000.</p>

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

<ul style="list-style-type: none"> • 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) 	
<p>Vision Services</p> <p>Members are encouraged to use the defined vision care network to obtain routine eye exam and eyewear benefit coverage. Routine eye exam and eyewear copays and coinsurance do not apply to the maximum out-of-pocket.</p>	<p><u>In- and Out-of-Network:</u></p> <p>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: \$35 copay</p> <p>Routine eye exam (1 per year): \$35 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay</p> <p>Our plan pays up to \$150 per year for eyewear (in- and out-of-network).</p> <p>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.</p> <p>For example: If your total cost for eyewear is \$300, your plan will pay \$150 and you will pay \$150.</p>
<p>Mental Health Services</p> <p>Prior authorization is required.</p>	<p><u>In-Network:</u></p> <p>Individual therapy visit: \$30 copay</p> <p>Outpatient group therapy visit: \$20 copay</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p>

SECTION II - SUMMARY OF BENEFITS

BlueAdvantage Sapphire

<p>Skilled Nursing Facility (SNF)</p> <p>Prior authorization is required.</p>	<p><u>In-Network:</u> Days 1-20: \$0 copay per day Days 21-100: \$196 copay per day</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount per stay</p> <p>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.</p>
<p>Physical Therapy</p> <p>Prior authorization is required.</p>	<p><u>In-Network:</u> Occupational therapy visit: \$35 copay</p> <p>Physical therapy and speech and language therapy visit: \$35 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
<p>Ambulance</p> <p>Prior authorization is required for all non-emergency ambulance transport. See the EOC for details regarding worldwide emergency transportation.</p>	<p><u>In- and Out-of-Network:</u></p> <p>Ground Ambulance: \$295 copay per trip</p> <p>Air Ambulance: 20% of the Medicare-allowed amount per trip.</p>
<p>Prior authorization is required for all non-emergency ambulance transport. See the EOC for details regarding worldwide emergency transportation.</p>	
<p>Transportation</p>	<p>Not covered</p>
<p>Medicare Part B Drugs</p> <p>Prior authorization may be required.</p>	<p><u>In-Network:</u> Part B chemotherapy drugs: 20% of the plan-allowed amount</p> <p>Other Part B drugs: 20% of the plan-allowed amount</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>

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 **\$4,660**.

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 mail order pharmacy. Or you can get your drugs from standard retail pharmacies. Your prescription drug copay will typically be less at a preferred network pharmacy. 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 / 100 Day Supply	Standard Retail Pharmacy 30 / 100 Day Supply
Tier 1: Preferred Generic	\$0 / \$0	\$6 / \$15
	Preferred Retail and Mail Order Pharmacy 30 / 90 Day Supply	Standard Retail Pharmacy 30 / 90 Day Supply
Tier 2: Generic	\$10 / \$10	\$15 / \$35
Tier 3: Select Insulin(s)	\$30 / \$90	\$35 / \$105
Tier 3: Preferred Brand	\$42 / \$105	\$47 / \$135
Tier 4: Non-Preferred Drugs	\$94 / \$230	\$99 / \$290
Tier 5: Specialty Drugs	33% coinsurance – Specialty medications are limited to a 30-day supply	

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 **\$4,660**.

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 **\$7,400**, 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 through the gap.

PRESCRIPTION DRUG BENEFITS		
Coverage Gap Stage	Preferred Retail and Mail Order Pharmacy 30 / 100 Day Supply	Standard Retail Pharmacy 30 / 100 Day Supply
Tier 1: Preferred Generic	\$0 / \$0	\$6 / \$15
	Preferred Retail and Mail Order Pharmacy 30 / 90 Day Supply	Standard Retail Pharmacy 30 / 90 Day Supply
Tier 3: Select Insulin(s)	\$30 / \$90	\$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 **\$7,400**, until 12/31/23, you pay the greater of: **5%** of the cost, or **\$4.15** copay for generic (including brand drugs treated as generic) and a **\$10.35** copay for all other drugs.

ADDITIONAL HEALTH BENEFITS	
24/7 Nurseline	<p><u>In-Network:</u> You can speak with a Registered Nurse (RN) 24 hours a day, 7 days a week. \$0 copay</p> <p><u>Out-of-Network:</u> Not covered</p>
Acupuncture	<p><u>In-Network:</u> \$20 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>

<p>Chiropractic Care</p> <p>Prior authorization is required.</p>	<p>Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).</p> <p><u>In-Network:</u></p> <p>\$20 copay</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p>
<p>Diabetic Supplies and Services</p> <p>Prior authorization may be required.</p>	<p>Diabetes self-management training</p> <p><u>In-Network:</u></p> <p>\$0 copay</p> <p><u>Out-of-Network:</u></p> <p>20% of the Medicare-allowed amount</p> <p>Diabetes monitoring supplies</p> <p><u>In-Network:</u></p> <p>Preferred: \$0 copay Non-Preferred: 20% of the plan-allowed amount</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p> <p>Therapeutic shoes/inserts</p> <p><u>In-Network:</u></p> <p>\$10 copay</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p>
<p>Durable Medical Equipment</p> <p>Prior authorization may be required.</p>	<p><u>In-Network:</u></p> <p>20% of the plan-allowed amount</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p>
<p>Home Health Care</p> <p>Prior authorization is required</p>	<p><u>In-Network:</u></p> <p>\$0 copay</p> <p><u>Out-of-Network:</u></p> <p>50% of the Medicare-allowed amount</p>

Meal Benefit	<p><u>In-Network:</u> \$0 copay</p> <p>Meal benefit includes 14 meals following an acute inpatient, SNF discharge, or observation stay to a home setting. There is not a limit to the number of discharges for meals. Must use designated vendor.</p> <p><u>Out-of-Network:</u> Not covered</p>
Outpatient Rehabilitation Prior authorization is required	<p>Cardiac (heart) rehab services</p> <p><u>In-Network:</u> \$20 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p> <p>Pulmonary (lung) rehab services</p> <p><u>In-Network:</u> \$20 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
Over-the-Counter (OTC) items	<p><u>In-Network:</u> The plan pays \$115 per quarter (no roll-over) for certain OTC items such as vitamins, cough/cold/allergy medicines, dental products and skin care items. Must use designated vendor.</p> <p><u>Out-of-Network:</u> Not covered</p>
Prosthetic Devices Prior authorization may be required	<p><u>In-Network:</u> Prosthetic devices: 20% of the plan-allowed amount</p> <p>Related medical supplies: 20% of the plan-allowed amount</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
Renal Dialysis	<p><u>In-Network:</u> 20% of the plan-allowed amount</p> <p><u>Out-of-Network:</u> 20% of the Medicare-allowed amount</p>
Fitness Program	<p><u>In-Network:</u> You pay nothing This plan includes a free standard fitness center membership, tools and online resources.</p> <p><u>Out-of-Network:</u> Not covered</p>

DISCLAIMERS

This document is available in other formats.

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

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

This is a summary of drugs and health services covered by BlueAdvantage Preferred Provider Organization (PPO) Sapphire East & Southeast health plans January 1, 2023 through December 31, 2023.



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 **1-800-831-2583**, 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 **1-800-831-2583**, 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 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.

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 1-800-831-2583, 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 1-800-831-2583, 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 1-800-831-2583, 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 1-800-831-2583, 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 pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-800-831-2583, 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 1-800-831-2583, 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 quý vị cần thông dịch viên xin gọi 1-800-831-2583, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-831-2583, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-831-2583, 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 1-800-831-2583, 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 1-800-831-2583, 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 1-800-831-2583, 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 1-800-831-2583, TTY 711. Un nostro incaricato che parla Italiano 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 1-800-831-2583, 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 1-800-831-2583, 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 1-800-831-2583, 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。通訳をご用命になるには、1-800-831-2583, TTY 711 にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

We're right here when you need us.



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If you are a member, call toll-free
1-800-831-2583 TTY 711.

If you are not a member, call toll-free
1-800-292-5146 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.**

