

2027 Member Rights & Responsibilities

BlueCare Plus (HMO D-SNP)SM

BlueCare Plus Choice (HMO D-SNP)SM

BlueCare Plus Select (HMO D-SNP)SM

Here's some important info about your rights.

Table of Contents

Legal Resources	1
Making Important Health Decisions	2
Fight Fraud	3
Forms You May Need	4
Nondiscrimination Notice	15

Legal Resources

Do you have a complaint?

If you have a concern about the way we or one of your providers treated you, you can file a complaint. This is also called a grievance. Your coverage won't change because you file a complaint. Call us at **800-332-5762**, TTY **711** to file a complaint. You can also mail or fax us the grievance form. You can find the form at **bluecareplus.bcbst.com/documents** under Grievances.

Mail

BlueCare Plus Tennessee Grievance
1 Cameron Hill Circle, Suite 43
Chattanooga, TN 37402-0043

Fax

888-416-3026

Do you think we made a mistake?

You can file an appeal if you don't agree with a claim or service denial. We'll review our decision and tell you your next steps. You can file an appeal within 65 days of the written denial we send you. If you appeal after 65 days, you have to show good cause for why it's late. You can use the appeal form on our website or write your appeal on plain paper.

Then send it to us by mail or fax.

Mail

BlueCare Plus Tennessee Appeals
1 Cameron Hill Circle, Suite 42
Chattanooga, TN 37402-0042

Fax

888-416-3026

Someone else can file your appeal for you if they're your designated representative. Fill out the Appointment of Representative form on page 5 of this booklet or provide other written documentation. You and your representative will need to sign and date it. Be sure to include this documentation when you file your appeal if you don't already have a representative on file.

When you appoint a representative, they can:

- Get info about your claims.
- Appeal on your behalf.
- Make requests as if they were you.
- Give and get info about your appeals.

Learn more about appeals and grievances in your Evidence of Coverage online at **bluecareplus.bcbst.com/documents**.

Making Important Health Decisions

Thinking about what care you want if you're sick or in an accident can be hard. But an advance care plan or advance directive lets you make decisions for yourself ahead of time. It tells your family or provider what care you want if you're not able to speak for yourself later.

Call us if you want to fill out an advance directive. We can send you the paperwork. Or talk with your primary care provider.

Fight Fraud

We know you're concerned about fraud. Here are some simple ways to help protect yourself:

- Don't share personal info with people you don't know.
- Be sure the online pharmacies you use are in our network.
- Don't click suspicious links or popups.
- Write down and report any suspicious phone numbers.
- Call our Compliance Hotline at **888-343-4221** to report suspicious activity 24/7.

Remember, you don't have to give your Member ID or Medicare number to anyone for free services.

Forms You May Need

If you have someone who represents you, fill out both forms to let us work with them.

Appointment of Representative – pg. 5

Use this form or other written notice to tell us you want someone to act on your behalf. Your representative can see all your info and file grievances and appeals for you. If you want to keep your representative, you'll need to fill out this form every year.

HIPAA Authorization Form – pg. 7

This form lets us share your health info in the ways you tell us.

Mail your completed forms to:

BlueCross BlueShield of Tennessee
BlueCare Plus Correspondence
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37402

Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative

This section must be completed by the patient, provider or other person appointing a representative.

Name	Medicare Number or National Provider Identifier	
Mailing address	Phone number (with area code) () -	
City	State 	ZIP code
Email (optional)	Fax (optional) () -	
Signature	Date signed (mm/dd/yyyy) / /	

Section 2: Information about the representative

This section must be completed by the representative.

Representative name		
Professional status or relationship to the person in Section 1 (attorney, relative, etc.)		
Mailing address	Phone number (with area code) () -	
City	State 	ZIP code
Email (optional)	Fax (optional) () -	

By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.

Signature	Date signed (mm/dd/yyyy) / /
-----------	---------------------------------

Representative must complete the sections below, if applicable (go to instructions on page 2)

Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.

Signature	Date signed (mm/dd/yyyy) / /
-----------	---------------------------------

Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

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

Signature	Date signed (mm/dd/yyyy) / /
-----------	---------------------------------

Instructions and Regulation Requirements

Instructions

All fields in Sections 1 and 2 are required unless marked “optional.” If the person or entity appointing a representative doesn’t have a Medicare number or National Provider Identifier, fill in “not applicable.” Go to the regulation at 42 CFR 405.910: [ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910)

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it’s valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants 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 have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, “Petition to Obtain Approval of a Fee for Representing a Beneficiary” and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval 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 approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: [HHS.gov/sites/default/files/OMHA-118.pdf](https://www.hhs.gov/sites/default/files/OMHA-118.pdf)

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are 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, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

Conflict of interest

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

Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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 [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE for more information.

Paperwork Reduction Act: 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.



Please return completed form to:
BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402

General HIPAA Authorization Form

This form tells us with whom we can share your health information. You can also choose which information to share and for how long. This form does not give anyone permission to make decisions for you.

Member's Information

Please fill out your information.

First Name: _____ Phone number: _____
Last Name: _____ Date of birth: _____
MM DD YYYY
Address: _____

Member ID number: _____
City: _____ State: _____
ZIP: _____

Person or Organization That Will Receive Your Information

BlueCross can share your information with this person/organization (include address):

☐ Person ☐ Organization

Organization _____ Address: _____
First name: _____
Last name: _____ City: _____ State: _____
Date of birth: _____
MM DD YYYY
ZIP: _____ Phone: _____
Gender: _____
Email: _____
☐ Male ☐ Female ☐ Other ☐ Prefer not to say

What Information Is Being Used or Shared

Select the information you want BlueCross to share with the person or organization listed on this form. You can give us a date range for the information you want us to share. Otherwise, we will share all the information we have about you from the selected categories.

☐ Option 1 - All Information

☐ **Specific dates (optional)** - please specify _____ (If answer is all dates, leave blank.)

☐ Option 2 - Limited Information - select which boxes apply.

Check the type of information you are authorizing to be used or shared:

- | | |
|--|--|
| ☐ Family planning information | ☐ Mental health, behavioral health, and intellectual and developmental disabilities information |
| ☐ General account information (eligibility, benefits, enrollment status, payments, appointments, phone and email address) | ☐ Information about sexually transmitted or other communicable diseases |
| ☐ General medical information | ☐ Substance use disorder information |
| ☐ Genetic testing information | ☐ Other _____ |
| ☐ HIV/AIDS information | |

☐ **Specific dates (optional)** - please specify _____ (If answer is all dates, leave blank.)

☐ Option 3 - Psychotherapy Notes or Substance Use Disorder Counseling Notes – select which boxes apply. Federal law requires a separate authorization to use or share psychotherapy or substance use disorder counseling notes. If you want to check either of these boxes in Option 3, and you've already checked a box in Option 1 or Option 2, please complete a separate form to select these boxes.

Check the type of information you are authorizing to be used or shared:

- ☐ Psychotherapy notes
- ☐ Substance use disorder counseling notes
- ☐ **Specific dates (optional)** - please specify _____ (If answer is all dates, leave blank.)

Reasons the Information is Being Used or Shared

Select One:

- ☐ Member request
- ☐ State the reason the information is being used or shared:

Special Information about SUD Records

If you are asking us to share substance use disorder records (SUD Records), special information applies:

- › Your SUD Records might be shared for TPO Purposes: If you are asking us to share SUD Records with a health plan, another third-party payer, one of your treating health care providers, or one of their service providers or vendors, we are sharing SUD Records with them for treatment, payment, and health care operations purposes (TPO Purposes).
- › Your SUD Records might be treated like other health information: Certain SUD Records are protected by both the HIPAA Privacy Rule and a law called the Confidentiality of Substance Use Disorder Patient Records Rule (Part 2 Rule). HIPAA regulates health plans, certain health care providers and some of their service providers or vendors. If we share those SUD Records with an entity that HIPAA regulates, the SUD Records can be reshared if allowed by the HIPAA Privacy Rule, except that the SUD Records cannot be used against you in a civil, administrative, or legislative proceeding.
- › 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

Expiration or Cancellation

This General HIPAA Authorization Form will continue until one of the following events happen:

1. You tell us in writing that you want to cancel it, or
2. Either: (a) Three years from the date you sign this form
if you are at least 18 years old when you sign this form, or
(b) You turn 18 years old, if you are between
12-17 years old when you sign this form.
3. (Optional) The following date or event that you list happens: _____
(Leave blank if not applicable.)

You understand that canceling this form will not affect anything BlueCross did based on this form before we receive your cancellation.



Signature

Signing this form is voluntary. BlueCross will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this form.

If you don't sign this form, BlueCross won't send the person or organization listed on this form the information unless BlueCross is required or allowed to send it by law.

If you sign this form, you are confirming all of the following:

- › You understand this form. You have read this form, and you are giving us your permission to use and share your health information as described in this form.
- › You may cancel at any time. You may cancel the permission to use and share your information by telling us in writing. Send your written cancellation to BlueCross BlueShield of Tennessee, Inc., 1 Cameron Hill Circle, Chattanooga, Tennessee 37402.
- › Your information may be shared again. If we share your information (including SUD Records) with a person or organization that is not subject to federal health privacy laws, they may reshare your health information, and it may not be protected by federal privacy laws anymore.
- › Your legal representative can tell us to share your information. If you are under 18 and you sign this form to give your legal representative access to your highly sensitive information, they will be able to access all of your highly sensitive information that we have. Even if you don't sign this form, they already can know account and medical information about you that is not highly sensitive.
- › You may have a copy of this form. You have the right to receive a copy of this form after you sign it. Send us a request in writing at the address above if you did not keep a copy.

Member Signature

The member **MUST** sign this form if they are 12 or older, unless they are legally incompetent. For members between age 12-17, a Legal Representative must also sign below.

X

Signature of member

MM

DD

YYYY

Legal Representative Signature

A legal representative, such as a parent, guardian, executor of an estate, or a healthcare power of attorney, must sign this form if:

- › The member is under 18, or
- › The member is legally incompetent, or
- › The member is deceased.

X

Signature of legal representative

MM

DD

YYYY

Relationship to individual

If you are signing this form as the member's legal representative, we must have legal documentation that shows that you can make health care decisions for the member for this form to be valid. Please call Member Service at the number on the back of the Member ID card for information on how to submit legal documentation if you are not sure if we have it. If we do not have that legal documentation, BlueCross cannot share the member's information.

Notice of Privacy Practices (NOPP)

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

LEGAL OBLIGATIONS

The law requires Volunteer State Health Plan, Inc. d/b/a 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 (your "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 or tell you about the changes and where you can find the notice. 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 your information with any of the following subsidiaries and affiliates as set forth below: Shared Health, Inc., Group Insurance Services, Inc., Volunteer State Health Plan, Inc., Golden Security Insurance Co., Shared Health Mississippi, Inc., Shared Health Insurance Company and BlueCross BlueShield of Tennessee, Inc. as outlined in this notice.

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 share your information in other ways. This is usually to contribute to the public good, such as public health and research. Information that has been shared may be shared again and no longer protected by federal or state law.

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 may require us to obtain your consent for uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Information about members and former members may be used and shared for treatment, payment, and health care operations.

We restrict access to 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 information.

SOURCES OF INFORMATION WE COLLECT AND SHARE

We collect 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 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 information about you.

3. Information about your transactions with non-affiliated third-parties: We collect information about your relationship with non-affiliated third-parties such as health care providers. For example, when your health care provider submits claims to us, it includes 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 share all of the information we have about you as described above.

WAYS WE MAY USE AND SHARE YOUR INFORMATION

We may use and share any of the information we have about you, including to nonaffiliated third-parties, in accordance with federal and state laws. The following are examples of how we may use or share your information — and the types of third-parties to whom we may share your information.

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 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 share genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes. For example, we may share your 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 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 any 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 information for marketing
- › Sale of your information
- › Other uses and disclosures not described in this notice

Substance Use Disorder Information: We may receive substance use disorder treatment information about you from certain providers that are subject to federal regulations governing the confidentiality of such information. We may not use or share such information in any civil, criminal, administrative, or legislative proceedings against you unless (1) you consent in writing, or (2) a court order is issued after notice and an opportunity to be heard is provided and is accompanied by a subpoena or similar legal mandate compelling disclosure.

We will let you know if any of these circumstances arise. We cannot use or share 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 shared 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 within the last six years, other than those made for the purpose of treatment, payment, or health care operations, and certain other disclosures. This list will include the date of the disclosure, what information was shared, the name of the person or entity it was shared 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 share your 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: We will notify you after an unauthorized acquisition, access, use or disclosure of your unsecured health information that compromises the security or privacy of the information.

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.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee, Inc. (BlueCross), including its subsidiary 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 sex¹. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **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 **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 Grievance; 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, 800-368-1019, 800-537-7697 (TDD), Monday through Friday, 8:00am to 6:00 pm, ET. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (phone), Nondiscrimination_CoordinatorGM@bcbst.com (email), or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bluecareplus.bcbst.com

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

¹ Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-332-5762 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-332-5762 (TTY: 711) o hable con su proveedor.

LUU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-332-5762 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-332-5762 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 800-332-5762 (文本电话: 711) 或咨询您的服务提供商。

ध्यान आपो: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 800-332-5762 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 800-332-5762 (TTY : 711) ou parlez à votre fournisseur.

ማሳሰቢያ:- አማርኛ የሚናገሩ ስዊድን የቋንቋ አገልግሎት በነፃ ይቀርባል፡፡ ማረጋገጫ በተደራሽ ቅርጽ ለማቅረብ ተገቢ የሆኑ ተጨማሪ አገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ፡፡ በስልክ ቁጥር 800-332-5762 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ፡፡

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 800-332-5762 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-332-5762 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فيستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-332-5762 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

توجه: اگر [وارد کردن زبان] صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 800-332-5762 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-332-5762 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-332-5762 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ, ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-332-5762 (TTY: 711) ຫຼື ລົມ ກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-332-5762 (TTY: 711) o makipag-usap sa iyang provider.

Here when you need us.



bluecareplus.bcbst.com



Questions? Please call us.

800-332-5762, TTY 711

Oct. 1 to March 31, 8 a.m. to 9 p.m. ET, seven days a week

April 1 to Sept. 30, 8 a.m. to 9 p.m. ET, Monday through Friday



1 Cameron Hill Circle | Chattanooga, TN 37402 | bluecareplus.bcbst.com

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

H3259_27WKRB_C (08/26)