Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Blue Cross® Premier PPO Silver

Coverage Period: 01/01/2019-12/31/2019
Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-227-2345 or go online to www.bcbsm.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-888-288-2738 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>in-network providers</u> , \$2,000 individual / \$4,000 family For <u>out-of-network providers</u> , \$4,000 individual / \$8,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive services</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>in-network providers</u> , \$7,900 individual / \$15,800 family For <u>out-of-network providers</u> , \$15,800 individual / \$31,600 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.bcbsm.com/index/com/mon/marketplace/ppo.html or call 1-888-288-2738 for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common	Services You	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you visit a health	Primary care visit/ Retail health clinic/ online visit to treat an injury or illness	\$30 <u>copayment</u> /visit \$10 <u>copayment</u> /online visit. <u>Deductible</u> does not apply to online visits.	40% <u>coinsurance</u>	Diagnostic and laboratory services are not included in the office visit <u>copayment</u> . These services are subject to the <u>plan's deductible</u> and <u>coinsurance</u> .	
care <u>provider's</u> office	Specialist visit	\$50 <u>copayment</u> /visit	40% <u>coinsurance</u>		
or clinic	Preventive care/screening/ immunization	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization required. The penalty for not having prior authorization is denial of payment.	
If you need drugs to treat your illness or condition More information about	prescription: less the <u>copayment</u> and the \$15 for 1-30 day supply difference between the out- sample of the street of the stree	Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment.			
prescription druq coverage is available at http://www.bcbsm.com/ 2019selectdruglist	Preferred brand drugs	Retail <u>coinsurance</u> per prescription: 25% for 1-30 day supply 25% for 84-90 day supply Mail order <u>coinsurance</u> per prescription: 25% for 1-30 day supply 25% for 31-60 day supply 25% for 61-90 day supply	approved amount for the drug. For out-of-network providers, member must pay the full cost of the drug and submit to BCBSM for reimbursement.	Minimum and maximum dollar amounts per prescription will apply, see policy document at: www.bcbsm.com/index/plans/michigan-health-insurance/2019.html . Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment.	

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2019.html

Common	Services You	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you need drugs to treat your illness or condition	Non-preferred brand drugs	Retail <u>coinsurance</u> per prescription: 50% for 1-30 day supply 50% for 84-90 day supply Mail order <u>coinsurance</u> per prescription: 50% for 1-30 day supply 50% for 31-60 day supply 50% for 61-90 day supply	BCBSM will reimburse 80% of the BCBSM-approved amount for covered drugs, less the copayment and the difference between the out-of-network pharmacy's	Minimum and maximum dollar amounts per prescription will apply, see policy document at: www.bcbsm.com/index/plans/michigan-health-insurance/2019.html . Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment.	
More information about prescription drug coverage is available at http://www.bcbsm.com/2019selectdruglist	Specialty drugs	Retail and mail order coinsurance per prescription: 40% for 1-30 day supply for Preferred Specialty 45% for 1-30 day supply for Non-Preferred Specialty	charge and the BCBSM-approved amount for the drug. For <u>out-of-network providers</u> , member must pay the full cost of the drug and submit to BCBSM for reimbursement.	The first specialty drug fill will be limited to a 15 day supply. Subsequent fills limited to a 15 or 30 day supply per fill, depending on the medication. BCBSM has contracted with an exclusive pharmacy network for specialty drugs. Call the customer service phone number on the back of your ID card for the pharmacy's phone number or location nearest to you. If you obtain your specialty drugs from any other pharmacy, you are responsible for the total cost. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Excludes cosmetic surgery, corrective eye surgery, investigational and experimental procedures. These services may require prior authorization. The penalty for not having prior authorization is denial of payment.	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	

 $^{^* \} For \ more \ information \ about \ limitations \ and \ exceptions, \ see \ the \ plan \ or \ policy \ document \ at \ \underline{www.bcbsm.com/index/plans/michigan-health-insurance/2019.html}$

Common	Services You	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Emergency room care	\$250 <u>copayment</u> / visit then 20% <u>coinsurance</u>	\$250 <u>copayment</u> / visit then 20% <u>coinsurance</u>	Copayment waived if admitted.	
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes air and ground transportation. Excludes transportation for convenience.	
	<u>Urgent care</u>	\$75 <u>copayment</u> / visit then 20% <u>coinsurance</u>	\$75 <u>copayment</u> / visit then 40% <u>coinsurance</u>	When the <u>urgent care</u> visit is for an emergency or accidental injury, <u>in-network</u> <u>cost sharing</u> applies.	
If you have a hospital	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.	
stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you need mental	Outpatient services	\$30 <u>copayment</u> / visit	40% <u>coinsurance</u>	<u>Copayment</u> applies to <u>provider's</u> office and online visit only. Additional services are subject to the <u>plan's deductible</u> and <u>coinsurance</u> . BCBSM approved facilities only.	
health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> for substance abuse 40% <u>coinsurance</u> for other inpatient services	BCBSM approved facilities only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.	
	Office visits	Prenatal visits: No charge. <u>Deductible</u> does not apply. Postnatal visits: \$30 <u>copayment</u> / visit	Prenatal and postnatal visits: 40% coinsurance	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.	

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Common Medical Event	Services You May Need	What You Network Provider (You will pay the least)	Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	BCBSM participating agencies only. Excludes housekeeping and custodial services.
If you need help	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year. Cardiac/pulmonary visits limited to a maximum of 30 visits per member per calendar year.
recovering or have other special health needs	<u>Habilitation</u> <u>services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year.
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to a maximum of 45 days per member per calendar year. BCBSM participating facilities only. Excludes custodial care. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
	Durable medical equipment	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required.
	Hospice services	No charge	No charge	BCBSM approved hospice programs only. Excludes housekeeping services.
	Children's eye exam	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Limited to once in a calendar year. A child is defined as a member up to the age of 19. Out-of-network is paid up to the <u>allowed amount</u> .
If your child needs dental or eye care	Children's glasses	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Frames (chosen from a select collection) and lenses are covered once in a calendar year. A child is defined as a member up to the age of 19. Out-of-network is paid up to the <u>allowed amount</u> .
	Children's dental check-up	Not covered	Not covered	Stand-alone dental <u>plans</u> available.

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in the case of when the life of the mother is endangered). See section 5 in the plan's certificate.
- Acupuncture
- Cosmetic surgery

- Dental care (Adult)
- Hearing aids
- Long-term care
 - Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care

Infertility treatment

Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Michigan Department of Insurance and Financial Services at michigan.gov/difs at 1-877-999-6442. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Michigan Department of Insurance and Financial Services at <u>michigan.gov/difs</u> at 1-877-999-6442.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? N/A

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 888-288-2738.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-288-2738.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-288-2738.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-288-2738.]

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.------

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2019.html

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
Total Example Cost	\$12,700
	•

In this example, Peg would pay:

Cost Sharing		
Deductibles	\$2,000	
Copayments	\$100	
Coinsurance	\$2,500	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,660	

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)
<u>Diagnostic tests</u> (*blood work*)

Drocerintian druge

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$800
Coinsurance	\$1,300
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,160

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900

In this example, Mia would pay:

Cost Sharing	
\$1,400	
\$200	
\$300	
What isn't covered	
\$0	
\$1,900	

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم -469-877 2513 TTY:711

如果您,或是您正在協助的對象,需要協助,您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員,請撥在您的卡背面的客戶服務電話;如果您還不是會員,請撥電話 877-469-2583. TTY: 711。

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা ৪77-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & 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, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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