
 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) 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 (800) 662-6667 or visit [www.bcbsm.com](http://www.bcbsm.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call (800) 662-6667 to request a copy.

Important Questions	Answers: individual/family	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1000/\$2000	Generally, you must pay all of the costs from <a href="#">provider</a> s up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. lab, <a href="#">preventive</a> care, DME/P&O, office visits, urgent care, allergy injections, prescription drugs	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Out-of-Pocket Maximum</a> : \$6600/\$13200 <a href="#">Coinsurance</a> Maximum: \$2500/\$5000	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , balanced billed charges and health care this <a href="#">plan</a> does not cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call (800) 662-6667 for a list of <a href="#">network providers</a>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply.	Not covered	Only the PCP office visit is exempt from the <a href="#">deductible</a> . Other services received in the office, <a href="#">deductible</a> applies
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply.	Not covered	Requires <a href="#">referral</a> . \$5 <a href="#">copay</a> for allergy injections/50% <a href="#">coinsurance</a> for allergy office visit and testing/30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply.	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply to lab services	Not covered	May require <a href="#">Preauthorization</a> /No charge for lab services
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copay</a>	Not covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsm.com/2018selectdruglist">www.bcbsm.com/2018selectdruglist</a>	Tier 1A - Value Generics	\$10 <a href="#">copay</a> /30 days; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> & step-therapy apply to select drugs. Drugs for sexual dysfunction, weight loss, cough & cold and compounds are excluded. No charge for Tier 1A contraceptives. 84-90 day retail & 31-90 day mail order <a href="#">copays</a> are 3x the 30-day <a href="#">copay</a> minus \$10. Preventive Drugs covered in full.
	Tier 1B – Generics	\$30 <a href="#">copay</a> /30 days; <a href="#">deductible</a> does not apply	Not covered	
	Tier 2 - Preferred Brand	\$60 <a href="#">copay</a> /30 days; <a href="#">deductible</a> does not apply	Not covered	
	Tier 3 - Non-Preferred Brand	\$80 <a href="#">copay</a> /30 days; <a href="#">deductible</a> does not apply	Not covered	
	Tier 4 - Preferred Specialty	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	
	Tier 5 - Non-Preferred Specialty	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not	Not covered	\$300 <a href="#">copay</a> max. Limited to a 30 day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	Requires <a href="#">preauthorization</a> /50% <a href="#">coinsurance</a> for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	\$150 <a href="#">copay</a> /visit	Copay waived if admitted
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Non-emergent transport is covered when <a href="#">preauthorized</a>
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	\$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	Requires <a href="#">preauthorization</a> /50% <a href="#">coinsurance</a> for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy.
	Physician/surgeon fees	No charge	Not covered	See "Hospital stay facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	\$20 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	Requires <a href="#">preauthorization</a>
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	No charge; <a href="#">deductible</a> does not apply	Not covered	Postnatal and non-routine prenatal office visits - \$20 <a href="#">copay</a>
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$40 <a href="#">copay</a> /visit	Not covered	Requires <a href="#">preauthorization</a> . Custodial care not covered.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit	Not covered	Requires <a href="#">preauthorization</a> . Limited to 60 visits per calendar year for any combination of therapies. Subject to meaningful improvement within 60 days.
	<a href="#">Habilitation services</a>	ABA only - \$20 <a href="#">copay</a>	Not covered	Requires <a href="#">preauthorization</a> . PT/OT/ST for

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		per visit; <a href="#">deductible</a> does not apply/\$40 <a href="#">copay</a> per visit for PT/OT/ST		autism spectrum disorder has unlimited visits.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Requires <a href="#">preauthorization</a> . Limited to 45 days per calendar year. Custodial care not covered.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	Requires <a href="#">preauthorization</a> and must be obtained from a BCN supplier. Convenience and comfort items not covered. Home use only. Diabetic supplies covered 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.
	<a href="#">Hospice services</a>	No charge	Not covered	Inpatient care requires <a href="#">preauthorization</a> . Housekeeping and custodial care not covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage information.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage information.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage information.

**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](#).)**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>● Acupuncture</li> <li>● Cosmetic surgery</li> <li>● Dental Care (Adult)</li> <li>● Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>● Long term care</li> <li>● Non emergency care outside of the U.S.</li> <li>● Private-duty nursing</li> <li>● Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>● Routine foot care</li> <li>● Weight loss programs</li> <li>● Elective Abortion</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>● Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>● Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>● Infertility treatment</li> </ul> |
|---|---|---|

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax . 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7<sup>th</sup> Floor, P. O. Box 30220, Lansing, MI 48909-7720, [michigan.gov/difs](http://michigan.gov/difs); call 1-877-999-6442 or fax: 517-284-8838

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, [michigan.gov/difs](http://michigan.gov/difs); [Ofir-hicap@michigan.gov](mailto:Ofir-hicap@michigan.gov).

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) 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 Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#). (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

**Language Access Services:**

To get help reading in your language call the customer service number on the back of your ID card.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20 %
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,790</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20 %
■ Other <a href="#">coinsurance</a>	20 %

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$1,200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,560</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20 %
■ Other <a href="#">coinsurance</a>	20 %

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1,000
Copayments	\$400
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

If you are also covered by an account-type [plan](#) such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain [out-of-pocket expenses](#)-like [deductible](#), [copayments](#), or [coinsurance](#) or benefits not otherwise covered. \*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

# ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

## 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 تساعد 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 877-469-2583 TTY:711، إذا لم تكن مشتركاً بالفعل.

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。

میں نے یہ سہولتیں، آپ کو ہمدردی اور مدد کے ساتھ فراہم کرنے کے لیے تیار ہیں، تاکہ آپ اپنی زبان میں سہولتیں حاصل کر سکیں۔ اگر آپ ابھی تک راجسٹر نہیں ہوئے ہیں، تو براہ کرم اپنے کارڈ کی پیٹھ پر موجود میمبر سروس نمبر 877-469-2583 TTY:711 پر بلا ٹیپ کریں۔

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 비용 부담 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 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujesz 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](mailto: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](mailto:OCRComplaint@hhs.gov). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.