Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Blue Cross® Premier PPO Bronze Extra Native American Limited

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 1-888-288-2738 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 <u>underlined</u> 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 <u>deductible</u> ?	\$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at a non-IHCP or In- <u>network providers</u> , \$7,500 individual /\$15,000 family <u>Out-of-network provider</u> s, \$15,000 individual /\$30,000 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</u> <u>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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.
Are there other <u>deductibles</u> 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> ?	In- <u>network providers</u> , \$9,400 individual /\$18,800 family <u>Out-of-network provider</u> s, \$18,800 individual /\$37,600 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</u> charges, 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 https://www.bcbsm.com/marketpl ace/ppo/ or call 1-888-288-2738 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>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</u> 's 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 to</u> see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies. Native American limited <u>plans</u> have zero <u>cost sharing</u> when you see an IHCP <u>provider</u> or with IHCP <u>referral</u> to a non-IHCP <u>provider</u> .					
Common Medical	Services You	What You Will Pay			
Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
lf you visit a health care	Primary care/ Office & Virtual Retail health clinic/ 24/7 medical virtual visit to treat an injury or illness	 \$50 <u>copayment</u> /primary care office and virtual visits, and retail health clinic visit. No charge 24/7 medical virtual visit. <u>Deductible</u> does not apply. 	70% <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> . No charge for 24/7 medical virtual visits when performed	
provider's office or clinic	<u>Specialist</u> visit	\$100 <u>copayment</u> /visit <u>Deductible</u> does not apply.	70% <u>coinsurance</u>	through the BCBSM selected vendor app.	
	Preventive care/ screening/ immunization	No charge <u>Deductible</u> does not apply.	70% coinsurance	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	
	Diagnostic test (x-ray, blood work)	50% <u>coinsurance</u>	70% coinsurance	None	
lf you have a test	Imaging		70% coinsurance	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 <u>prescription</u> <u>drug coverage</u> is available at <u>https://</u> <u>www.bcbsm.com/2</u> 024-select-ppo- druglist	Generic drugs	Retail <u>copayment</u> per prescription: \$25 for 1-30 day supply \$75 for 84-90 day supply Mail order <u>copayment</u> per prescription: \$25 for 1-30 day supply \$50 for 31-60 day supply \$75 for 61-90 day supply <u>Deductible</u> does not apply.	Not covered	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. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's <u>deductible, cost-sharing or out of pocket maximum</u> . For <u>out-of-network provider</u> s, member must pay the full cost of the drug and submit to BCBSM for reimbursement.	

Common Medical Services You What You Will Pay		Limitationa Exacutiona 8 Other Important			
Event	May Need	Network Provider Out-of-Network Provider		Limitations, Exceptions, & Other Important Information	
		(You will pay the least)	(You will pay the most)		
	Preferred brand drugs	Retail <u>copayment</u> per prescription: \$50 for 1-30 day supply \$150 for 84-90 day supply Mail order <u>copayment</u> per prescription: \$50 for 1-30 day supply \$100 for 31-60 day supply \$150 for 61-90 day supply	Not covered	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	
If you need drugs to treat your illness or condition More information	Non-preferred brand drugs	Retail <u>copayment</u> per prescription: \$100 for 1-30 day supply \$300 for 84-90 day supply Mail order <u>copayment</u> per prescription: \$100 for 1-30 day supply \$200 for 31-60 day supply \$300 for 61-90 day supply	Not covered	apply to select drugs. The penalty for not having prior authorization is denial of payment. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> . For <u>out-of-network provider</u> s, member must pay the full cost of the drug and submit to BCBSM for reimbursement.	
about prescription drug <u>coverage</u> is available at <u>https://</u> <u>www.bcbsm.com/</u> <u>2024-select-ppo-</u> <u>druglist</u>	Specialty drugs	Retail and mail order copay per prescription: \$500 for 1-30 day supply.	Not covered	<u>Specialty drug</u> s are limited to a 30-day supply per fill, however some may be limited to a 15-day supply fill, depending on the medication. BCBSM has contracted with an exclusive pharmacy <u>network</u> for <u>specialty drug</u> s. 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 <u>specialty drug</u> s 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. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket</u> <u>maximum</u> .	

Common Medical	dical Services You		Limitations, Exceptions, & Other Important	
Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
lf you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	<u>coinsurance</u> 70% <u>coinsurance</u> 70% <u>coinsurance</u> 70% <u>coinsurance</u> 70% <u>coinsurance</u> 70% <u>coinsurance</u> 70% <u>coinsurance</u> 8 Excludes cosmetic surgery, corre investigational and experimental p services may require prior authorization is d	
surgery	Physician/ surgeon fees	50% <u>coinsurance</u>	70% <u>coinsurance</u>	50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.
	Emergency room care	50% coinsurance	50% coinsurance	Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	Includes air and ground transportation. Excludes transportation for convenience.
	Urgent care	\$75 <u>copayment</u> /visit <u>Deductible</u> does not apply.	70% coinsurance	When the <u>urgent care</u> visit is for an emergency or accidental injury, <u>in-network cost sharing</u> applies.
If you have a	Facility fee (e.g., hospital room)	50% coinsurance	70% coinsurance	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
hospital stay	Physician/ surgeon fees	50% <u>coinsurance</u>	70% <u>coinsurance</u>	50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.
lf you need mental health, behavioral	Outpatient services	\$50 <u>copayment</u> /visit <u>Deductible</u> does not apply 50% <u>coinsurance</u> for other outpatient services.	70% coinsurance	<u>Copayment</u> applies to <u>provider</u> 's office, virtual visit by participating BCBSM <u>provider</u> and Blue Cross virtual care visit from BCBSM selected vendor app only. Additional services are subject to the <u>plan</u> 's <u>deductible</u> and <u>coinsurance</u> . BCBSM approved facilities only.
health, or substance abuse services	Inpatient services	50% <u>coinsurance</u>	50% <u>coinsurance</u> for substance abuse 70% <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.

Common Modical	ical Services You		Limitations Exceptions & Other Important	
Common Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Office visits	No charge <u>Deductible</u> does not apply.	70% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> with a <u>network provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
lf you are pregnant	Childbirth/ delivery professional services	50% <u>coinsurance</u>	70% <u>coinsurance</u>	None
	Childbirth/ delivery facility services	50% <u>coinsurance</u>	70% coinsurance	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
	<u>Home health</u> care	50% coinsurance	50% coinsurance	BCBSM participating agencies only. Excludes housekeeping and custodial services.
If you need help recovering or have other special health needs	Rehabilitation services	\$50 <u>copayment</u> / physical, occupational & speech visits. <u>Deductible</u> does not apply to physical, occupational, & speech visits.	70% <u>coinsurance</u>	 <u>Plan</u>'s <u>coinsurance</u> and <u>deductible</u> will apply to chiropractic, osteopathic manipulative therapy and cardiac/pulmonary visits. 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.
	Habilitation services	\$50 <u>copayment</u> /visit <u>Deductible</u> does not apply.	70% coinsurance	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.

Common Medical	mon Medical Services You What You Will Pay		ill Pay	Limitations, Exceptions, & Other Important	
Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you need help recovering or	<u>Skilled</u> nursing care	50% <u>coinsurance</u>	70% coinsurance	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.	
have other special health needs	<u>Durable</u> <u>medical</u> equipment	50% coinsurance	70% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required. Rental and purchase limited to basic equipment.	
	Hospice services	No charge	No charge	Coverage includes inpatient and outpatient hospice care. 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. <u>Out-of-network</u> 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. <u>Out-of-network</u> 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.	

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 <u>plan</u>'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 <u>plan</u> document.)				
Bariatric surgery	Chiropractic	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 www.michigan.gov/difs at 1-877-999-6442. Other coverage options may be available to you, too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, 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 on how 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 michigan.gov/difs at 1-877-999-6442.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

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.

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, kwijijgo holne' 888-288-2738

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

PRA Disclosure Statement: 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 **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 <u>plans</u>. 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	á
hospital delivery)	

The <u>plan's</u> overall <u>deductible</u>	\$7,500
Specialist copayment	\$100
Hospital (facility) <u>coinsurance</u>	50%
Other <u>coinsurance</u>	50%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$0	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$60	

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

The <u>plan's</u> overall <u>deductible</u>	\$7,500
Specialist copayment	\$100
Hospital (facility) <u>coinsurance</u>	50%
Other <u>coinsurance</u>	50%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	\$7,500
Specialist copayment	\$100
Hospital (facility) <u>coinsurance</u>	50%
Other <u>coinsurance</u>	50%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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 TTY:711 (2583 إذا لم تكن مشتركا 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。

سی بنسلاف، نی بند فند وفقه دفیمیونوالف ، هیسور ملف فینتگ، بنسلاف سیلالمجف فوموتلام دفطیلاف فینتگام مجمدعیمتکام طیعتمجف دیکم دستکم خط بند حافذ کمتک، مذف خل الملیف چیتکم دستکم خط شدی می نی 2523-469-877 TTY:711 سی میکم لیولی فوتیجی.

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 সাহাম্য করছেন এমন কারো, সাহাম্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহাম্য 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.htm

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