Blue Cross® Premier PPO Silver Saver Native American Limited **Coverage for: Individual/Family | Plan Type: PPO**

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 1-888-288-2738 or go online to 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 www.healthcare.gov/sbc-glossary or call 1-888-288-2738 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at a non-IHCP or In-network providers, $3,650 individual /$7,300 family Out-of-network providers, $7,300 individual /$14,600 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network providers, $7,500 individual /$15,000 family Out-of-network providers, $15,000 individual /$30,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan 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 network provider?	Yes. See https://www.bcbsm.com/marketplace/ppo/ or call 1-888-288-2738 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
Native American limited plans have zero cost sharing when you see an IHCP provider or with IHCP referral to a non-IHCP provider.

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)	
If you visit a health care provider's office or clinic	Primary care/ Office & Virtual Retail health clinic/ 24/7 medical virtual visit to treat an injury or illness	$30 copayment /primary care office and virtual visits, and retail health clinic visit. No charge 24/7 medical virtual visit.	40% coinsurance	Diagnostic and laboratory services are not included in the office visit copayment. These services are subject to the plan's deductible and coinsurance. 24/7 medical virtual visits when performed through the BCBSM selected vendor app.
	Specialist visit	$50 copayment /visit	40% coinsurance	
	Preventive care/screening/ immunization	No charge Deductible does not apply.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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 **prescription drug coverage** is available at https://www.bcbsm.com/2024-select-ppo-druglist	Generic drugs	Retail copayment per prescription: $15 for 1-30 day supply $45 for 84-90 day supply Mail order copayment per prescription: $15 for 1-30 day supply $30 for 31-60 day supply $45 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 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 deductible, cost-sharing or out of pocket maximum. For out-of-network providers, member must pay the full cost of the drug and submit to BCBSM for reimbursement.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsm.com/2024-select-ppo-druglist	Preferred brand drugs	Retail copayment per prescription: $100 for 1-30 day supply $300 for 84-90 day supply Mail order copayment per prescription: $100 for 1-30 day supply $200 for 31-60 day supply $300 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 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 deductible, cost-sharing or out of pocket maximum. For out-of-network providers, member must pay the full cost of the drug and submit to BCBSM for reimbursement.
	Non-preferred brand drugs	Retail copayment per prescription: $150 for 1-30 day supply $450 for 84-90 day supply Mail order copayment per prescription: $150 for 1-30 day supply $300 for 31-60 day supply $450 for 61-90 day supply	Not covered	
	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.	Not covered	Specialty drugs 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 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. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's deductible, cost sharing or out of pocket maximum.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	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. 50% coinsurance for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.
	Physician/ surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copayment /visit then 20% coinsurance	$250 copayment /visit then 20% coinsurance	Copayment waived if admitted inpatient into the hospital. Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Includes air and ground transportation. Excludes transportation for convenience.
	Urgent care	$75 copayment /visit	40% coinsurance	When the urgent care visit is for an emergency or accidental injury, in-network cost sharing applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment. 50% coinsurance for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.
	Physician/ surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment /visit 20% coinsurance for other outpatient services.	40% coinsurance	Copayment applies to provider's office, virtual visit by participating BCBSM provider and Blue Cross virtual care visit from BCBSM selected vendor app only. Additional services are subject to the plan's deductible and coinsurance. BCBSM approved facilities only.
	Inpatient services	20% coinsurance	20% coinsurance for substance abuse 40% coinsurance for other inpatient services	BCBSM approved facilities 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 Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge Deductible does not apply.	40% coinsurance	Cost sharing does not apply for preventive services with a network provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/ delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/ delivery facility services	20% coinsurance	40% coinsurance	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	BCBSM participating agencies only. Excludes housekeeping and custodial services.
	Rehabilitation services	20% coinsurance	40% coinsurance	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	20% coinsurance	40% 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.
	Skilled nursing care	20% coinsurance	40% 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.

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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)	
If you need help recovering or have other special health needs	Durable medical 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.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply.	No charge Deductible 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 allowed amount.
	Children's glasses	No charge Deductible does not apply.	No charge Deductible 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 allowed amount.
	Children's dental check-up	Not covered	Not covered	Stand-alone dental plans available.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

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
- 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 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 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 on how 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: 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, 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/2024.html

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 plan's overall deductible	**$3,650**
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$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 well-controlled condition)

The plan's overall deductible	**$3,650**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

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	**$3,650**
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*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
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 877-469-2583 TTY:711، 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。

ܐܢ ܐܢܬܘܢ، ܐܘ ܚܕ ܦܪܨܘܦܐ ܕܥܕܪܝܬܘܢ، ܣܢܝܩ ܠܗܘܢ ܥܘܕܪܢܐ، ܐܝܬܠܘܢ ܙܕܩܐ ܕܡܫܟܚܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܡܦܩܬܐ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܐܝܬܗ ܥܠ ܚܨܐ ܕܟܪܛܝܣܘܟܘܢ ܐܘ 877-469-2583 TTY:711 ܐܢ ܗܫܐ ܠܝܬܘܢ ܗܕܡܐ.

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, 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*