As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Ans	wers	Why this Matters:
	In-Network	Out-of-Network	Willy this Matters.
What is the overall <u>deductible</u> ?	\$500 Individual/ \$1,000 Family	\$500 Individual/ \$1,000 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 care</u> before you meet you	services are covered deductible.	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 limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)		\$2,000 Individual/ \$4,000 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-</u> pocket limit?	Premiums, <u>balance-b</u> pharmacy penalty an <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.bcbsn</u> number on the back of card for a list of <u>netw</u>	of your BCBSM ID	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</u> <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'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 <u>specialist</u> you choose without a <u>referral</u> .

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, visit <u>www.bcbsm.com</u> or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined

DELTA COLLEGE

Community Blue<sup>SM</sup> PPO ASC

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

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page. Coverage for: Individual/Family | Plan Type: PPO

Coverage Period: Beginning on or after 01/01/2025



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.

		What Ye	ou Will Pay	Limitations Exacutions 2 Other Important
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit	20% coinsurance	None
lf you visit a health care	<u>Specialist</u> visit	\$25 <u>copay</u> /office visit	20% <u>coinsurance</u>	None
provider's office or clinic	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge; <u>deductible</u> does not apply	Not covered	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.
Kuran hava a taat	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% <u>coinsurance</u>	None
lf you have a test	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	May require prior authorization
If you need drugs to treat your illness or condition More information about	Generic or select prescribed over-the- counter drugs	\$15 <u>copay</u> /prescription for retail 30-day supply; \$30 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Prior authorization, step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs
prescription drug coverage is available at www.bcbsm.com/druglists	Preferred brand-name drugs	\$50 <u>copay</u> /prescription for retail 30-day supply; \$100 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.

		What Yo	ou Will Pay	Limitations, Exceptions, & Other Important
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Nonpreferred brand-name drugs	\$70 <u>copay</u> /prescription or 50% <u>coinsurance</u> of the approved amount (whichever is greater), but no more than \$100 <u>copay</u> /prescription for retail 30-	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not	
	Generic and preferred brand-name <u>specialty</u> <u>drugs</u>	20% <u>coinsurance</u> of the approved amount, but no more than \$200 <u>copay</u> /prescription for retail or mail order 30-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Prior authorization is required. Specialty drugs
	Nonpreferred brand-name <u>specialty drugs</u>	25% <u>coinsurance</u> of the approved amount, but no more than \$300 <u>copay</u> /prescription for retail or mail order 30-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	limited to a 15 or 30-day supply.
lf you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% coinsurance	None
	Emergency room care	\$250 <u>copay</u> /visit	\$250 <u>copay</u> /visit	<u>Copay</u> and <u>deductible</u> waived if admitted or for an accidental injury
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	<u>Urgent care</u>	\$40 <u>copay</u> /office visit	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>coinsurance</u>	Prior authorization is required

		What Yo	ou Will Pay	Limitations, Exceptions, & Other Important
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Physician/surgeon fee	No Charge	20% <u>coinsurance</u>	None
lf you need behavioral health services (mental health and substance use	Outpatient services	No Charge	No Charge for mental health; 20% <u>coinsurance</u> for substance use disorder	Your cost share may be different for services performed in an office setting
disorder)	Inpatient services	No Charge	20% <u>coinsurance</u>	Prior authorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Prenatal: 20% <u>coinsurance</u> Postnatal: 20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	None
	<u>Home health care</u>	No Charge	No Charge	Physician certification required.
	Rehabilitation services	No Charge	20% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
If you need help recovering or have other special health	Habilitation services	\$25 <u>copay</u> /office visit; <u>deductible</u> does not apply for Applied Behavior Analysis; No Charge for Physical, Speech and Occupational Therapy	20% <u>coinsurance</u> for Applied Behavior Analysis; 20% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In- network cost-sharing.
needs	Skilled nursing care	No Charge	No Charge	Prior authorization is required. Limited to 120 days per member per calendar year
	<u>Durable medical</u> equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Physician certification required. Visit limits apply.
If your child needs dental or	Children's eye exam	Not covered	Not covered	None
eye care	Children's glasses	Not covered	Not covered	None

			ou Will Pay	Limitations, Exceptions, & Other Important
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
For more information on pediatric vision or dental, contact your plan administrator	Children's dental check- up	Not covered	Not covered	None

Excluded Services & Other Covered Services:				
Services Your Plan Generally Does NOT Cover (C	check	your policy or <u>plan</u> document for more information	tion	and a list of any other <u>excluded services</u> .)
Acupuncture treatment	•	Long term care	•	Weight loss programs
Cosmetic surgery	•	Routine eye care (Adult)		
Dental care (Adult)	٠	Routine foot care		
<ul> <li>Other Covered Services (Limitations may apply to</li> <li>Bariatric surgery</li> </ul>	o the	se services. This isn't a complete list. Please see Hearing aids	e you	ur <u>plan</u> document.) Private-duty nursing
	•	5	•	Private-duty hursing
Chiropractic care	•	Infertility treatment		
Coverage provided outside the United States.     See http://provider.bcbs.com	•	Non-emergency care when traveling outside the U.S		

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa/healthreform</u>, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u> or by calling the number on the back of your BCBSM ID card. 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 <u>www.HealthCare.gov</u> 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 Blue Cross<sup>®</sup> and Blue Shield<sup>®</sup> of Michigan by calling the number on the back of your BCBSM ID card.

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 or <a href="http://www.michigan.gov/difs">http://www.michigan.gov/difs</a> or <a href="http://www.michigan.gov/difs">difs-HICAP@michigan.gov/difs</a> or <a href="http://www.michigan.gov/difs">difs-HICAP@michigan.gov/difs</a> or <a href="http://www.michigan.gov/difs">difs-HICAP@michigan.gov/difs</a>

# 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 Minimum Value Standards? Yes

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>. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your <u>plan</u> may be affected if your <u>plan</u> does not cover certain EHB categories, such as <u>prescription drugs</u>, or if your <u>plan</u> provides coverage of specific EHB categories, for example <u>prescription drugs</u>, through another carrier.)

# Language Access Services: See Addendum

-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 <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 a hospital delivery)

The plan's overall deductible	\$500
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	0%
Other coinsurance	0%

# 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	\$500
<u>Copayments</u>	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$570

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

The plan's overall <u>deductible</u>	\$500
Specialist copayment	\$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

### 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)

|--|

# In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

# Mia's Simple Fracture

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

The plan's overall deductible	\$500
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like: <u>Emergency room care</u> (including medical supplies) <u>Diagnostic tests</u> (x-ray) <u>Durable medical equipment</u> (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
--------------------	---------

### In this example, Mia would pay:

\$500
\$60
\$0
\$0
\$560

If you are also covered by an account-type <u>plan</u> such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain <u>out-of-pocket expenses</u> – like the <u>deductible</u>, <u>copayments</u>, or <u>coinsurance</u>, or benefits not otherwise covered.

### 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 تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضر ورية بلغتك دون أية تكلفة. التحدت إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم TTY:711 2589-469-2583 إذا لم تكن مستركا 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。

ى مىسلام، نې نېد فېرى قىگە دۇرىمۇملاق ، ھىلىمۇ بىلاق خۇنلالام، مىسلاق مىلالمدىق خەھمالام دۇھلىلاق خۇنلالام مەھەدىدىمالام دېلىقى دىلىم كېيىمى خلى تىتى مەدھەھمەمى نې بېلىقى جىنىكە دىمىكى خلى تىتى مەدھەھمەمى نې TTY:711 مىلام 269-278 مى خىلىدى خۇچى.

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 আগনার, বা আগনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আগনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আগনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আগনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আগনি 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.