



MARSH AND MCLENNAN AGENCY LLC COMPANY

Classic

Coverage for: All Plan Types | Plan Type: HMO



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 [www.bcbsm.com](http://www.bcbsm.com) or call (800)-662-6667 . 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 (<https://www.healthcare.gov/sbc-glossary>) or call (800)-662-6667 to request a copy.

| Important Questions                                         | Answers: Member / Family                                                                                                                                                                                    | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible?                             | \$1,000/\$2,000                                                                                                                                                                                             | 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 Lab, preventive care, DME/P&O, diabetic supplies, PCP office visits, specialist office visits, urgent care, allergy injections, prescription drugs, outpatient mental health and substance use services | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                     |
| 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?              | \$8,150/\$16,300<br>Coinsurance Maximum - \$2,500/\$5,000                                                                                                                                                   | 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 billed charges and health care this plan does not 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 ( <a href="http://www.BCBSM.com">www.BCBSM.com</a> ) or call customer service for a list of network providers and out-of-state coverage. (800)-662-6667                                            | 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?                 | Yes.                                                                                                                                                                                                        | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.                                                                                                                                                                                                                                                                                                                  |



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<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                 |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply | Not covered                                        | Only the <u>PCP</u> office visit is exempt from the <u>deductible</u> . Other services received in the office, <u>deductible</u> applies. \$20 <u>copay</u> for medical online visits.                                                                                          |
|                                                        | <u>Specialist visit</u>                          | \$30 <u>copay</u> /visit. <u>Deductible</u> does not apply | Not covered                                        | Requires <u>referral</u> . \$5 <u>copay</u> for allergy injections/50% <u>coinsurance</u> for allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician. <u>Deductible</u> applies for allergy testing |
|                                                        | <u>Preventive care/screening/immunization</u>    | 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.                                                                                         |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u> .                                   | Not covered                                        | May require <u>preauthorization</u> . No charge for lab services. <u>Deductible</u> does not apply to lab services.                                                                                                                                                             |
|                                                        | Imaging (CT/PET scans, MRIs)                     | \$150 <u>copay</u>                                         | Not covered                                        | Requires <u>preauthorization</u>                                                                                                                                                                                                                                                |

| Common Medical Event                                                                                                                                                                                      | Services You May Need                          | What You Will Pay                                               |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                           |                                                | Network Provider<br>(You will pay the least)                    | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.bcbsm.com/hcdl">www.bcbsm.com/hcdl</a> | Preferred Generic Tier                         | \$10 <u>copay</u> /30 days.<br><u>Deductible</u> does not apply | Not covered                                                | Prior-auth & step therapy apply to select drugs. No charge for Preferred Generic contraceptives and <u>preventive</u> drugs. Your <u>plan</u> includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. 50% <u>coinsurance</u> for sexual dysfunction drugs. No charge for Preferred Generic contraceptives. 84-90 day retail & 31-90 day mail order <u>copays</u> are 3x the 30-day <u>copay</u> minus \$10. |
|                                                                                                                                                                                                           | Non-Preferred Generic Tier                     | \$30 <u>copay</u> /30 days.<br><u>Deductible</u> does not apply | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                           | Preferred Brand Tier                           | \$60 <u>copay</u> /30 days.<br><u>Deductible</u> does not apply | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                           | Non-Preferred Brand Tier                       | \$80 <u>copay</u> /30 days.<br><u>Deductible</u> does not apply | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                           | Preferred <u>Specialty</u> Tier                | 20% <u>coinsurance</u> .<br><u>Deductible</u> does not apply    | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                           | Non-Preferred <u>Specialty</u> Tier            | 20% <u>coinsurance</u> .<br><u>Deductible</u> does not apply    | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                          | Not covered                                                | May require <u>preauthorization</u> /50% <u>coinsurance</u> for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy, elective abortion                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                          | Not covered                                                | See "Outpatient surgery facility fee"                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you need immediate medical attention</b>                                                                                                                                                            | <u>Emergency room care</u>                     | \$250 <u>copay</u> /visit.                                      | \$250 <u>copay</u> /visit.                                 | <u>Copay</u> waived if admitted as inpatient.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                           | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                          | 20% <u>coinsurance</u>                                     | Non-emergent transport is covered when preauthorized                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                           | <u>Urgent care</u>                             | \$35 <u>copay</u> /visit. <u>Deductible</u> does not apply      | \$35 <u>copay</u> /visit. <u>Deductible</u> does not apply | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                              | Services You May Need                     | What You Will Pay                                          |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                   |                                           | Network Provider<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                                       | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                                     | Not covered                                        | <u>Preauthorization</u> is required. 50% <u>coinsurance</u> for weight reduction procedures. 50% <u>coinsurance</u> for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy, elective abortion                                                                                                                                                                              |
|                                                                                   | Physician/surgeon fee                     | No charge                                                  | Not covered                                        | See "Hospital stay facility fee"                                                                                                                                                                                                                                                                                                                                                          |
| If you need behavioral health services (mental health and substance use disorder) | Outpatient services                       | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply | Not covered                                        | <u>Preauthorization</u> may be required.                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                   | Inpatient services                        | 20% <u>coinsurance</u>                                     | Not covered                                        | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                                                      |
| If you are pregnant                                                               | Office visits                             | No charge. <u>Deductible</u> does not apply                | Not covered                                        | 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. Office visit <u>copay</u> applies to non-routine prenatal and postnatal office visits.. Only the routine prenatal and postnatal visit is exempt from the <u>deductible</u> . Other services, <u>deductible</u> applies |
|                                                                                   | Childbirth/delivery professional services | No charge                                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                   | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                     | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                                                             |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | Network Provider<br>(You will pay the least)                                                                                  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | \$30 <u>copay</u> /visit                                                                                                      | Not covered                                        | Requires <u>preauthorization</u> . Custodial care not covered.                                                                                                                                                                                                                                                                                                                         |
|                                                                | <u>Rehabilitation services</u>   | \$30 <u>copay</u> /visit                                                                                                      | Not covered                                        | Requires <u>preauthorization</u> / Limited to 60 visits per calendar year for any combination of outpatient <u>rehabilitation</u> therapies. Subject to meaningful improvement within 60 days.                                                                                                                                                                                         |
|                                                                | <u>Habilitation services</u>     | ABA - \$20 <u>copay</u> per visit. \$30 <u>copay</u> per visit for PT/OT/ST. <u>Deductible</u> does not apply to ABA services | Not covered                                        | <u>Habilitation services</u> are limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders. PT/OT/ST for autism spectrum disorder has unlimited visits. See <u>Rehabilitation services</u> for PT/OT/ST <u>cost share</u> . Requires <u>preauthorization</u> .                     |
|                                                                | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                                                                                                        | Not covered                                        | Requires <u>preauthorization</u> /Limited to 45 days per calendar year. Custodial care not covered.                                                                                                                                                                                                                                                                                    |
|                                                                | <u>Durable medical equipment</u> | 50% <u>coinsurance</u> . <u>Deductible</u> does not apply                                                                     | Not covered                                        | Requires <u>preauthorization</u> and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered with 20% <u>coinsurance</u> . Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply. <u>Deductible</u> does not apply to diabetic supplies |
|                                                                | <u>Hospice services</u>          | No charge                                                                                                                     | Not covered                                        | Inpatient care requires <u>preauthorization</u> . Housekeeping and custodial care not covered.                                                                                                                                                                                                                                                                                         |
| If your child needs dental or eye care                         | Children's eye exam              | Not covered                                                                                                                   | Not covered                                        | Contact benefit administrator for coverage.                                                                                                                                                                                                                                                                                                                                            |
|                                                                | Children's glasses               | Not covered                                                                                                                   | Not covered                                        | Contact benefit administrator for coverage.                                                                                                                                                                                                                                                                                                                                            |
|                                                                | Children's dental check-up       | Not covered                                                                                                                   | Not covered                                        | Contact benefit administrator for coverage.                                                                                                                                                                                                                                                                                                                                            |

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.)

- |                       |                                                      |                        |
|-----------------------|------------------------------------------------------|------------------------|
| • Acupuncture         | • Long-term care                                     | • Routine foot care    |
| • Cosmetic surgery    | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental Care (Adult) | • Private-duty nursing                               |                        |
| • Hearing aids        | • Routine eye care (Adult)                           |                        |

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

- |                                                                              |                     |                                                                                                                                                                                         |
|------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Bariatric surgery (Limited to one per lifetime. Requires preauthorization) | • Chiropractic care | • Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions) |
|------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### 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/healthreform](http://www.dol.gov/ebsa/healthreform), 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, <http://www.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, <http://www.michigan.gov/difs> or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov)

### 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 Standard? 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.)

### Translation available

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

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



## 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   | \$1000 |
| ■ Specialist copayment            | \$30   |
| ■ 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$1,400        |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,470</b> |

### Managing Joe's Type 2 Diabetes

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

|                                   |        |
|-----------------------------------|--------|
| ■ The plan's overall deductible   | \$1000 |
| ■ Specialist copayment            | \$30   |
| ■ 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,100        |
| <u>Coinsurance</u>                | \$200          |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,320</b> |

### Mia's Simple Fracture

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

|                                   |        |
|-----------------------------------|--------|
| ■ The plan's overall deductible   | \$1000 |
| ■ Specialist copayment            | \$30   |
| ■ Hospital (facility) coinsurance | 20%    |
| ■ Other coinsurance               | 20%    |

#### This EXAMPLE event includes services like:

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

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

#### In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$400          |
| <u>Coinsurance</u>                | \$200          |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,600</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.

The plan would be responsible for the other costs of these EXAMPLE covered services.



## 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، ف لديك 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。

සි ඔබ හෝ ඔබට ආධාර කිරීමට අවශ්‍ය වන්නේ නම්, ඔබට ඔබගේ මවුබසින් ආධාර සහ තොරතුරු ලබා ගැනීමට අයදා ගැනීමට අයිතිකමක් ඇත. ඔබගේ ආධාර ලබා ගැනීමට අවශ්‍ය වන්නේ නම්, ඔබගේ කාඩ්පතේ පිටුපස ඇති පාරිභෝගික සේවා අංකයට, හෝ 877-469-2583 TTY: 711 දුරකථන කථන කරන්න.

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>.