Coverage for: Individual/Family | Plan Type: HMO

Blue Cross® Preferred HMO Silver 87

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 1-888-227-2345 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 <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-888-227-2345 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,050 Individual/\$2,100 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 deductible?	Yes. <u>Preventive care</u> services, primary care visits, lab, and <u>urgent care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$2,300 Individual/\$4,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billing charges, and health care this plan 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 https://www.bcbsm.com/marketplace/preferred-hmo/ or call 1-888-227-2345 for a list of network providers.	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</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Services You What You Will Pay				
Event	May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	(You will pay the least) \$30 copayment /primary care office and virtual visits, retail health clinic visit, and medical evaluation at an affiliated immunization pharmacy. No charge 24/7 medical virtual visit.	(You will pay the most) Not covered	Diagnostic services are not included in the office visit copayment. These services are subject to the plan's deductible and coinsurance. No charge for 24/7 medical virtual visits when performed through the BCN selected vendor app.
If you visit a health care <u>provider's</u> office or clinic	Specialist visit	Deductible does not apply. \$50 copayment /visit	Not covered	Referral required. The penalty for not having a referral is denial of payment. Diagnostic services are not included in the office visit copayment. These services are subject to the plan's deductible and coinsurance.
	Preventive care/screening/ immunization	No charge <u>Deductible</u> does not apply.	Not covered	May require prior authorization. The penalty for not having prior authorization is denial of payment. 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)	10% coinsurance No charge for lab services. Deductible does not apply for lab services.	Not covered	May require prior authorization. The penalty for not having prior authorization is denial of payment.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment.

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.html

Common Madical	Services You	What You Will Pay		
Common Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preferred generic drugs	\$4 <u>copayment</u> /prescription- Retail & mail order 30-day supply. \$12 <u>copayment</u> /prescription- Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for preferred generic contraceptives. Opioid containing medications are limited to no more than a 30-day supply per fill. First fills of select opioid containing medications will be limited to a 5-day supply. Any coupon, rebate, or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to a consumer's deductible, cost-sharing or out of pocket maximum.
If you need drugs to treat your illness or condition More information about	Non-preferred generic drugs	\$20 <u>copayment</u> /prescription-Retail & mail order 30-day supply. \$60 <u>copayment</u> /prescription-Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	
coverage is available at https://www.bcbsm.com/2025-select-hmo-druglist	Preferred brand drugs	\$100 copayment /prescription-Retail & mail order 30-day supply. \$300 copayment /prescription - Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for preferred generic contraceptives. Opioid containing medications are limited to no more than a 30-day supply per fill. First fills of select opioid containing medications will be limited to a 5-day supply. Any coupon, rebate, or other credits received directly or indirectly from an assistance program or the drug
	Non-preferred brand drugs	\$150 copayment /prescription-Retail & mail order 30-day supply. \$450 copayment /prescription - Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> .

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Common Medical Services You What You Will Pay				
Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preferred specialty drugs	40% coinsurance	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
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsm.com/2025-select-hmodruglist	Non-preferred specialty drugs	45% coinsurance	Not covered	medication. BCN 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 an assistance program or the drug manufacturer may not be applied to a consumer's deductible,
				cost-sharing or out of pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	These services may require prior authorization. The penalty for not having prior authorization is denial of payment. Excludes cosmetic surgery, corrective eye surgery,
	Physician/ surgeon fees	10% coinsurance	Not covered	investigational and experimental procedures. 50% coinsurance for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.
	Emergency room care	\$250 copayment / visit then 10% coinsurance	\$250 <u>copayment</u> / visit then 10% <u>coinsurance</u>	Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only. <u>Copayment</u> waived if admitted inpatient into the hospital.
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Includes air and ground transportation. Excludes transportation for convenience.
	<u>Urgent care</u>	\$40 <u>copayment</u> <u>Deductible</u> does not apply.	\$40 <u>copayment</u> <u>Deductible</u> does not apply.	Urgent care visits will be covered at non-participating providers for medical emergencies and accidental injuries only.

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Common Medical Services You What You Will Pay				
Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment.
If you have a hospital stay	Physician/ surgeon fees	10% coinsurance	Not covered	50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copayment</u> /office visit and applied behavior analysis (ABA) treatment. <u>Deductible</u> does not apply. 10% <u>coinsurance</u> for other outpatient services.	Not covered	Copayment applies to provider's office, virtual visit by participating BCN provider and Blue Cross virtual care visit from BCN selected vendor app only. Additional services are subject to the plan's deductible and coinsurance. Prior authorization is not required for outpatient, office, virtual and online visits. Prior authorization is required for other outpatient services. The penalty for not having prior authorization is denial of payment.
	Inpatient services	10% coinsurance	Not covered	Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment.
	Office visits	No charge <u>Deductible</u> does not apply.	Not covered	Cost sharing does not apply for preventive services. 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).
If you are pregnant	Childbirth/ delivery professional services	10% coinsurance	Not covered	None
	Childbirth/ delivery facility services	10% coinsurance	Not covered	Prior authorization is required for inpatient services. 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	10% coinsurance	Not covered	Excludes housekeeping and custodial services.

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Common Medical	Services You	What You Will Pay			
Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Rehabilitation services	10% coinsurance / visit	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment.	
	Habilitation services	10% coinsurance / visit	Not covered	Physical and occupational therapy are limited to a combined 30 visits per member per calendar year.	
				Speech therapy is limited to 30 visits per member per calendar year.	
If you need help recovering or have	Skilled nursing care	10% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Limited to 45 days per calendar year. Custodial care is excluded.	
other special health needs		50% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Breast pumps are covered in full when preauthorized.	
		10% <u>coinsurance</u> for diabetic testing supplies.		Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required. Rental and purchase limited to basic equipment.	
		No charge	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Coverage includes inpatient and outpatient hospice care. BCN participating hospice programs only. Excludes housekeeping services.	
	Children's eye exam	No charge <u>Deductible</u> does not apply.	Not covered	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.	
If your child needs dental or eye care	Children's glasses	No charge <u>Deductible</u> does not apply.	Not covered	Frames (chosen from a select collection) and lenses are covered once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> .	
	Children's dental check-up	Not covered	Not covered	Stand-alone dental <u>plans</u> available.	

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.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 cases of rape, incest, or when the life of the mother is endangered)
- 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Michigan Department of Insurance and Financial Services at michigan.gov/difs at 1-877-999-6442.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Not Applicable

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-288-2738.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-288-2738.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码888-288-2738.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-288-2738.

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

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^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.html

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	\$1,050
Specialist copayment	\$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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		
<u>Deductibles</u>	\$1,050	
<u>Copayments</u>	\$10	
Coinsurance	\$1,000	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$2,120	

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,050
Specialist copayment	\$50
Hospital (facility) coinsurance	10%
Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

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Durable medical equipment (glucose meter)

Total Example Cost	\$5,600			
In this example, Joe would pay:				
Cost Sharing				
<u>Deductibles</u>	\$1,050			
Copayments	\$600			
Coinsurance	\$60			
What isn't covered				
Limits or exclusions	\$20			
The total Joe would pay is	\$1,730			

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,050
Specialist copayment	\$50
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$1,050
Copayments	\$400
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,650

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge.

Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متو فرة لك. تتو فر أبضًا المساعدات والخدمات المساعدة المناسبة لتو فبر المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم -469-877 2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意: 如果您说[中文], 我们将免费为您提供语言协助服 务。我们还免费提供适当的辅助工具和服务,以无障碍格式 提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提 供商。

المعجعة حماتتهم المحمل المحمد المحمدة المعتقدة مَجْ حِمْجَتَهُ ہِمْ جَمِر جُمِهُ 2583 TTY: 711 مشمریحہ کے جم مشمریحہ کے ا

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vu hỗ trơ ngôn ngữ. Các hỗ trơ và dịch vu phù hợp để cung cấp thông tin bằng các định dang dễ tiếp cân cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuai të shërbimit. 알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다.

877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। ৪77-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung, Rufen Sie

877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider. ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注:日本語を話される場合、無料の言語支援サービスをご利用 いただけます。情報をアクセスしやすい形式で提供するための 適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご 相談ください。

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

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- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these 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 website

https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services

200 Independence Ave, SW Room 509, HHH Building Washington, D.C. 20201

Phone: 800-368-1019, TTD: 800-537-7697

Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health

& Human Services Office for Civil Rights website https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website:

https://www.bcbsm.com/important-information/policiespractices/nondiscrimination-notice/