Blue Cross® Premier PPO Bronze Native American Zero

Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-288-2738 or go online to www.bcbsm.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov</u>/sbc-glossary or call 1-888-288-2738 to request a copy.

| Important Questions | Answers | Why This Matters: |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible? | In- <u>network providers</u> , \$0 individual /\$0 family <u>Out-of-network provider</u> s, \$0 individual /\$0 family | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. All covered health services are covered without a <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> ? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket Limit</u> on your expenses. |
| What is not included in the out-of-pocket limit? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See https://www.bcbsm.com/marketplace/ppo/ or call 1-888-288-2738 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> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</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 May | What You Will Pay | | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Event | Need Need | 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 | No charge | No charge | 24/7 medical virtual visits when performed through the | |
| If you visit a health care provider's office | Specialist visit | No charge | No charge | BCBSM selected vendor app. | |
| or clinic | Preventive care/screening/immunization | No charge | No charge | None | |
| | Diagnostic test (x-ray, blood work) | No charge | No charge | None | |
| If you have a test | Imaging (CT/PET scans, MRIs) | No charge | No charge | Prior authorization required. The penalty for not having prior authorization is denial of payment. | |
| | Generic drugs | No charge | Not covered | | |
| If you need drugs to treat your illness or condition More information | Preferred brand drugs | No charge | Not covered | Opioid-containing medications are limited to no more tha 30-day supply per fill and first fills of select opioid contain medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply select drugs. The penalty for not having prior authorization. | |
| about prescription drug coverage is available at https:// www.bcbsm.com/20 25-select-ppo- druglist | Non-preferred brand drugs | No charge | Not covered | 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. For out-of-network providers, member must pay the full cost of the drug and submit to BCBSM for reimbursement. | |

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

| Common Medical | on Medical Services You May What You Will Pay | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Event | Need | Network Provider | Out-of-Network Provider | Limitations, Exceptions, & Other Important Information |
| 16 | | (You will pay the least) | (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsm.com/2025-select-ppodruglist | Specialty drugs | No charge | Not covered | Specialty drugs are limited to a 30-day supply per fill, however some may be limited to a 15-day supply fill, depending on the medication. BCBSM has contracted with an exclusive pharmacy network for specialty drugs. Call the customer service phone number on the back of your ID card for the pharmacy's phone number or location nearest to you. 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 | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | Excludes cosmetic surgery, corrective eye surgery, investigational and experimental procedures. These services may require prior authorization. The penalty for not having |
| outpatient surgery | Physician/surgeon fees | No charge | No charge | prior authorization is denial of payment. Weight reduction procedures limited to one per lifetime. |
| lf | Emergency room care | No charge | No charge | None |
| If you need immediate medical attention | Emergency medical transportation | No charge | No charge | Includes air and ground transportation. Excludes transportation for convenience. |
| | <u>Urgent care</u> | No charge | No charge | None |
| If you have a | Facility fee (e.g., hospital room) | No charge | No charge | BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior |
| hospital stay | Physician/surgeon fees | No charge | No charge | authorization is denial of payment. Weight reduction procedures limited to one per lifetime. |
| If you need mental health, | Outpatient services | No charge | No charge | Includes virtual visit with participating BCBSM <u>provider</u> and Blue Cross virtual care visit from BCBSM selected vendor app only. BCBSM approved facilities only. |
| behavioral health, or substance abuse services | Inpatient services | No charge | No charge | BCBSM approved facilities only. These services require prior authorization. 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 Medical | Services You May Need | What You Will Pay | | | |
|---------------------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Event | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | Office visits | No charge | No charge | | |
| If you are pregnant | Childbirth/delivery professional services | No charge | No charge | None | |
| program | Childbirth/delivery facility services | No charge | No charge | BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment. | |
| | Home health care | No charge | No charge | BCBSM participating agencies only. Excludes housekeeping and custodial services. | |
| Rehabilitation services | | | | Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year. | |
| | | No charge | No charge | Speech therapy limited to a maximum of 30 visits per member per calendar year. | |
| | | | | Cardiac/pulmonary visits limited to a maximum of 30 visits per member per calendar year. | |
| If you need help recovering or have other special | <u>Habilitation</u> | No charge | No charge | Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year. | |
| health needs | <u>services</u> | | | Speech therapy limited to a maximum of 30 visits per member per calendar year. | |
| | Skilled nursing care | No charge | No charge | Limited to a maximum of 45 days per member per calendar year. BCBSM participating facilities only. Excludes custodial care. These services require prior authorization. The penalty for not having prior authorization is denial of payment. | |
| | Durable medical equipment | No charge | No charge | Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required. Rental and purchase limited to basic equipment. | |
| | Hospice services | No charge | No charge | Coverage includes inpatient and outpatient hospice care. BCBSM approved hospice programs only. Excludes housekeeping services. | |

^{*} 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 Medical Services You May | | What You Will Pay | | | |
|----------------------------------------------|----------------------------|----------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Event | Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | Children's eye exam | No charge | No charge | Limited to once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> . | |
| If your child needs dental or eye care | Children's glasses | No charge | No charge | 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 allowed amount. | |
| | 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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

^{*} 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 | \$0 |
|-----------------------------------|-----|
| ■ Specialist copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

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

Managing Joe's Type 2 Diabetes

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

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

This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

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

Mia's Simple Fracture

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

| ■ The plan's overall deductible | \$0 |
|-----------------------------------|-----|
| ■ Specialist copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

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

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

SBC Form # 2025SBC33

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 متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 2583-469-877 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。

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận 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 tuaj 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 বিনামূল্যে 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 বলন। 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 ТТҮ: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

Discrimination is against the law

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 (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- 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/policies-practices/nondiscrimination-notice/

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