Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Benefits-at-a-Glance
Classic
00159653 WAYNE COUNTY REGIONAL EDUCATION SERVICE AGENCY
0003/0003
Effective Date: 07/01/2025

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Preauthorization for Select Services - Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **https://bcbsm.com/priorauth**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	$1,000 per member/$2,000 per family per calendar year
Fixed Dollar Copays	$5 for allergy injections $30 for office visits $60 for urgent care visits $250 for emergency room visits $25 for ambulance $50 for referral physician visits $150 for high tech imaging
Coinsurance	50% for select services as noted below
Coinsurance Maximum	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,350 per member/$12,700 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%

Preventive services (continued)

Benefits	
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	$30 Copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **Note:** Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$30 Copay
Referral Physician Visits - when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	$50 Copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	$250 Copay after deductible
Urgent Care Center	$60 Copay
Retail Health Clinic	$60 Copay
Ambulance Services - medically necessary	$25 Copay for ground and air services after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 Copay after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care - professional services (see "Hospital Care" for facility charges)	100% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	100% after deductible Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$50 Copay after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	Not covered
Human Organ Transplants (subject to medical criteria)	100% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$30 Copay
Outpatient Substance Use Disorder	$30 Copay

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	$30 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$50 Copay after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	50% after deductible
Allergy Office Visits	50%
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$50 Copay Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - Subject to meaningful improvement within 60 days	$50 Copay after deductible 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment	50% (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	50%
Prosthetic and Orthotic Appliances	50%
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100%
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Preferred Generic Tier	$4 copay
Nonpreferred Generic Tier	$15 copay
Preferred Brand Tier	$40 copay
Nonpreferred Brand Tier	$80 copay
Preferred Specialty Tier	20% coinsurance (Max $200)
Nonpreferred Specialty Tier	20% coinsurance (Max $300)
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic - $15 copay, Preferred Brand - $40 copay, Non-Preferred Brand - $80 copay
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance

Prescription drugs (continued)

Benefits	
Mail Order Prescription Drugs	30-day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30-day copay/coinsurance minus $10. 90-day retail 84-90 day supply, 3X's the 30-day copay/coinsurance minus $10.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Variable Cost Share Coupon Program	Your plan 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.
Prescription Drug Deductible	None
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only
Benefits Selected - CLSSLG : 50RP,6350PM,90D3X,AMB25,CO30,D1000,DSRCW,ER250,IMG150,OMRR,P415CL,UR60,WDRPOV

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WAYNE COUNTY REGIONAL EDUCATION SERVICE AG

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 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$6,350/$12,700	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 (www.BCBSM.com) 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit. Deductible does not apply	Not covered	Only the PCP office visit is exempt from the deductible. Other services received in the office, deductible applies. $30 copay for medical online visits.
	Specialist visit	$50 copay/visit. Deductible does not apply	Not covered	Requires referral. $5 copay for allergy injections/50% coinsurance for allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician. Deductible applies for allergy testing
	Preventive care/screening/immunization	No charge. Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization. No charge for lab services. Deductible does not apply to lab services.
	Imaging (CT/PET scans, MRIs)	$150 copay	Not covered	Requires preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/hcdl	Preferred Generic Tier	$4 copay/30 days. Deductible does not apply	Not covered	Prior-auth & step therapy apply to select drugs. No charge for Preferred Generic contraceptives and preventive drugs. Your plan 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. Sexual Dysfunction Drugs 50% coinsurance. No charge for Preferred Generic contraceptives. Any out-of-pocket maxes apply. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10.
	Non-Preferred Generic Tier	$15 copay/30 days. Deductible does not apply	Not covered	
	Preferred Brand Tier	$40 copay/30 days. Deductible does not apply	Not covered	
	Non-Preferred Brand Tier	$80 copay/30 days. Deductible does not apply	Not covered	
	Preferred Specialty Tier	20% coinsurance. Deductible does not apply	Not covered	$200 copay max. Limited to a 30 day supply. Specialty Drugs are covered only within the Exclusive Specialty Pharmacy Network.
	Non-Preferred Specialty Tier	20% coinsurance. Deductible does not apply	Not covered	$300 copay max. Limited to a 30 day supply. Specialty Drugs are covered only within the Exclusive Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require preauthorization/50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	$250 copay/visit.	$250 copay/visit.	Copay waived if admitted as inpatient.
	Emergency medical transportation	$25 copay	$25 copay	Non-emergent transport is covered when preauthorized
	Urgent care	$60 copay/visit. Deductible does not apply	$60 copay/visit. Deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance for weight reduction procedures. 50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	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	$30 copay/visit. Deductible does not apply	Not covered	Preauthorization may be required.
	Inpatient services	No charge	Not covered	Preauthorization is required.
If you are pregnant	Office visits	No charge. Deductible 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, cost share may apply. Office visit copay applies to non-routine prenatal and postnatal office visits.. Only the routine prenatal and postnatal visit is exempt from the deductible. Other services, deductible applies
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$50 copay/visit	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	$50 copay/visit	Not covered	Requires preauthorization/ Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies. Subject to meaningful improvement within 60 days
	Habilitation services	ABA - $30 copay per visit. $50 copay per visit for PT/OT/ST. Deductible does not apply to ABA services	Not covered	Habilitation services 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 Rehabilitation services for PT/OT/ST cost share. Requires preauthorization.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance. Deductible does not apply	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full. Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply. Deductible does not apply to diabetic supplies
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. 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
- Cosmetic surgery
- Dental Care (Adult)
- Elective Abortion
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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, 7th 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

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

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.

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	$50
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	
Deductibles	$1,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,070**

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	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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 تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری پێویست بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری کڕیار لەسەر پشتەوەی کارتەکەت بکە، یان 877-469-2583 TTY:711 بکە ئەگەر هێشتا ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

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

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.