

# 2026

# Health care plan comparison guide



#### The Blue Cross difference

There should be more to your health care coverage than deductibles, copayments and other out-of-pocket costs. With Blue Cross, your health plan comes with so much more, like exclusive features and benefits that don't expire, but stay with you wherever and whenever you use your member ID card.

You also get access to a vast selection of doctors and specialists that provide the kind of quality care you deserve. Blue Cross Blue Shield of Michigan and our HMO partner, Blue Care Network, offer a variety of health plans to fit your needs at every stage of life. For more than 80 years, we've been a trusted source to individuals and families and built a reputation on providing health coverage when people need it most.

We're here, and we're ready to help.

#### The numbers add up:

- Blue Cross is Michigan's largest health care company, serving millions of people here. We have the largest network of doctors and hospitals in Michigan with 131 hospitals and more than 37,000 doctors.
- BCN is the largest HMO in Michigan with more than 832,000 members, and a provider network that includes more than 6,000 primary care providers, more than 29,000 specialists and most of the state's leading hospitals.
- Blue Dental<sup>SM</sup> members have access to **thousands of dentists** around the country, including 3,600 in Michigan.

# We're here to help

When you have questions about your plan, we want to answer them as quickly and simply as possible. We offer a variety of resources you can use to get answers, find information and talk to experts.

#### These resources include:

- Our comprehensive website, **bcbsm.com**
- Blue Cross experts who can help you narrow your plan choices and help determine if you're eligible for a subsidy on the Marketplace. We're here to help. Just call 1-877-4MY-BLUE (469-2583)
- More than 3,000 agents throughout Michigan who are trained and certified to help you choose and enroll in a health care plan
- Your Blue Cross or BCN member ID card, where you can find our toll-free Customer Service number on the back



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# Blue Cross Coordinated Care<sup>SM</sup> – care that's centered around you

#### Services and savings

- Postnatal visits are treated the same as preventative prenatal visits
- Mental health program
- Local HMO network in Southeast Michigan

- Maven maternity and menopause programs
- Behavioral health assistance from Quartet
- Cancer support program
- Virtual Primary Care benefit for all PPO plans

#### What is it?

This program identifies members with complex or chronic conditions that could benefit from care management support and connects them to care.

#### How does it work?

A registered nurse leads a Blue Cross care team that works with members to help them develop a plan to better manage their conditions.

Doctors, dietitians and social workers are among the specialists that make up the Blue Cross care team. Together, they help members:

- Identify health risks
  - Connect with support in local communities
- Better understand treatment options
- Find behavioral health services and other care

Members can conveniently stay connected to their care plans through the BCBSM Coordinated Care app, powered by Wellframe<sup>1</sup>.

#### Where do I start?

Members identified for the program will receive a call from a Blue Cross registered nurse to get started.

#### BCBSM mobile app

Your health information is secure when you use our mobile app. **Protecting your information is our top priority.** You can be sure that using the mobile app is a safe and secure way to access information about your health plan.

We protect all information through secured connections, and regularly update our information systems to stay current and ensure the security of your data.

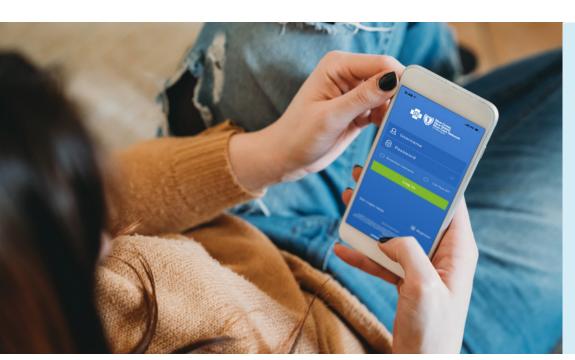
#### What you can do with the app:

- View deductible and other plan balances.
- Check claims and explanation of benefits statements.
- See medical, dental and vision coverage.
- Research drug prices.
- Access HealthEquity® spending account balances.
- View your member ID card.
- Find doctors and hospitals and compare costs for services.
- Access to Blue365® member discounts.

#### As part of your plan, you can:

- Call our 24-Hour Nurse Line and speak to a registered nurse.
- View our weekly Blue Cross Virtual Well-Being<sup>SM</sup> webinars. Topics include mindfulness, finance and emotional health.
- Use our online well-being tools and resources through Blue Cross Well-Being<sup>SM</sup>.
- Take part in our Tobacco Coaching program.
- Sign up for paperless billing and explanation of benefits statements in your member account.

<sup>1</sup>Wellframe is an independent company supporting Blue Cross Blue Shield of Michigan by providing the BCBSM Coordinated Care mobile app.



Download the app now
Get our mobile app wherever
you normally download apps
for your device. For more
information, visit
bcbsm.com/app.



HealthEquity is an independent company that contracts with Blue Cross Blue Shield of Michigan to provide spending account services.

Personify Health is an independent company that provides health and well-being services on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

# Additional health benefits and support programs available at no cost to you

#### Family building and women's health programs

Working together with **Maven**, members now have access to free virtual support for pregnancy, postpartum and menopause. Programs include:

A care advocate	Personalized, trustworthy resources	Unlimited video appointments and messaging*
You'll be matched with a dedicated care advocate who will:  Help you find the right provider or coach for your unique needs.  Provide support throughout your journey.	Access a library of content personalized to your specific journey, such as:  • Expert-approved articles and provider-led classes like Infant CPR, Breastfeeding 101 and Menopause 101.  • Access to the Maven community to connect with others going through similar experiences or journeys.	Schedule video and messaging appointments with top-rated virtual coaches:  • Speak with doctors, specialists and coaches from more than 35 specialties.  • Coaches are available to speak with in more than 35 languages.

<sup>\*</sup>Maven virtual coaches don't replace in-person care or relationships with your established care teams and providers. They're additional resources for you to schedule appointments when your providers aren't available.

The maternity program provides support for prenatal and postpartum time periods, a high-risk pregnancy, returning to work and more. Visit bcbsm.com/mavenfamily.

The menopause program provides support for early identification of menopausal symptoms and treatment guidance. Visit bcbsm.com/mavenmenopause to learn more.

#### To register for these programs, scan the QR code.



Maven is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing family building and women's health support services.

#### **Teladoc Health Condition Management**

This program combines advanced technology, coaching and support for mental health and chronic medical conditions to help people live happier, healthier lives.

#### Available personalized plans:

- Diabetes
- Hypertension
- Diabetes prevention

#### By participating, you and covered family members get access to:

- Connected devices: Depending on your health goals, you could receive a free blood glucose meter, blood pressure monitor and smart scale; each sends readings to your private account on an easy-to-use app.
- Coaching anytime and anywhere: Ask expert coaches your questions on nutrition, medications or anything else related to your health. Together, you'll create a custom plan to meet your needs and focus on health areas that are important to you.
- Digital behavioral health support: Get 24/7 access to practical tips and techniques that help you better manage stress, sleep, anxiety, depression, weight and more.

Learn more and join today at teladochealth.com/BCBSMI.

#### **Cancer Support Program**

Iris by OncoHealth provides members personalized support that's available to you at no cost through your health plan.

- 24 x 7 access to a team of oncology nurses.
- A peer mentor community to connect with others who have been in similar situations with cancer.
- Access to registered dietitians who focus on nutrition tailored to cancer care.
- Access to more than 300 articles and videos covering cancer, treatment, side effects and procedures.

To get started with Iris, visit bcbsm.com/cancersupport, scan this QR code or call Iris at 1-844-912-4747.





# We have provider networks to fit your needs

#### **Network types**

#### PPO

A PPO, or preferred provider organization, has a broad network of doctors and hospitals. You can choose any doctor you want, both in and out of network, and don't need referrals from a primary care provider to see a specialist.

With a PPO, you'll pay less out of pocket when you use an in-network provider.

Below you will find your choice of network options. Within the chart, look at how each of the plans might fit into your health care journey.

Network name	Blue Cross® Premier PPO	Blue Cross® Preferred HMO
Network description	You'll have a broad choice of doctors and hospitals within Blue Cross' statewide PPO network, including nationwide coverage for medical emergency, accidental injury or urgent care. You may receive services from hospitals or doctors outside the network within Michigan, but you'll pay less if you use providers within the network.	This plan offers a broad choice of doctors and hospitals from BCN's entire network, the largest HMO network in Michigan. Your primary care provider will coordinate care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network isn't covered.
Plan offered by	Blue Cross Blue Shield of Michigan	Blue Care Network
Out-of-network coverage Care you receive from an out-of-network hospital or doctor while traveling within Michigan	Yes	Emergencies and accidental injuries only
Coverage outside of Michigan Includes traveling abroad	Emergencies and accidental injuries have in-network cost sharing. Scheduled services from a participating provider will apply out-of-network cost sharing (2x in-network cost sharing).	Emergencies and accidental injuries only
Participating primary care providers  Numbers are estimates and subject to change	11,550 (Nurse Practitioners, Physician Assistants and PCPs)	6,716
Participating hospitals and systems Numbers are subject to change	131 Michigan hospitals	131 participating hospitals

#### HMO

With an HMO, or health maintenance organization, you choose a primary care provider who coordinates your care and provides referrals to specialists. You'll need to pick a BCN primary care provider in the HMO network and only use hospitals that participate in your plan's network. Other than emergency services and accidental injuries, health care services provided outside the network aren't covered.

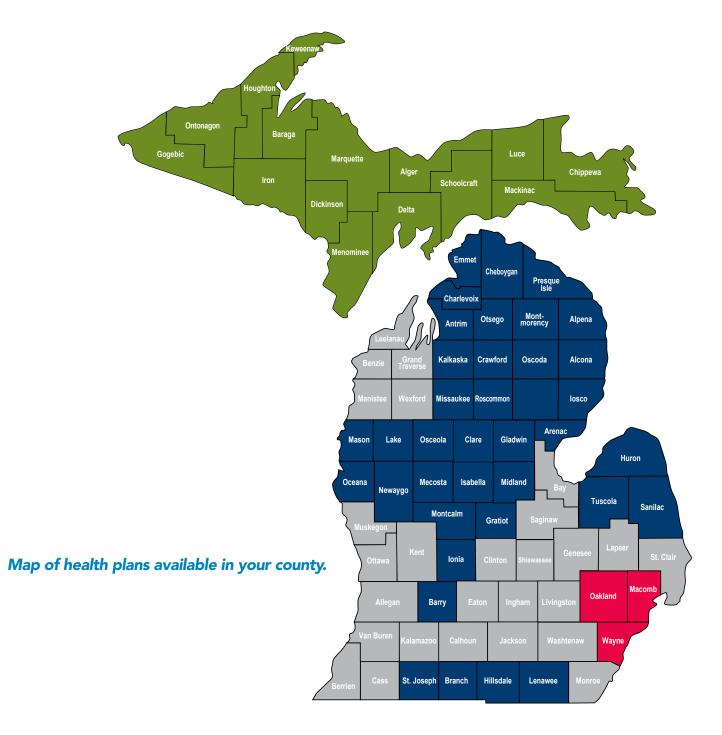
Blue Cross® Select HMO	Blue Cross <sup>®</sup> Local HMO
You may choose from a select network of quality, primary care providers and have complete access to specialists and hospitals within BCN's network, the largest HMO network in Michigan. Your primary care provider will coordinate care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network isn't covered.	This plan offers care within a network of quality doctors and hospitals in Wayne, Oakland and Macomb counties. A primary care provider will coordinate your care. Care with BCN's entire HMO network, but outside the Local HMO network, will require primary care provider and plan authorization. Other than emergency services and accidental injuries, care outside the network isn't covered.
Blue Care Network	Blue Care Network
Emergencies and accidental injuries only	Emergencies and accidental injuries only
Emergencies and accidental injuries only	Emergencies and accidental injuries only
4,704	1,019
131 participating hospitals	15 participating hospitals with Ascension and Trinity Health systems

<sup>-</sup> Location was limited to MI and each NPI number was counted only once

In 2026, Blue Cross offers plan choices that meet Affordable Care Act standards in all 83 Michigan counties. Use this map to see which plans are available in your area.

PPO options	PPO options	PPO options	PPO options
Blue Cross® Premier	Blue Cross® Premier	Blue Cross® Premier	Blue Cross® Premier
Gold	Gold	Gold	Gold
Gold Extra	Gold Extra	Gold Extra	Gold Extra
Silver Saver HSA/Silver Extra/ Silver Secure/ Silver Plus/ Silver HSA	Silver/Silver Extra/Silver Saver HSA/Silver Secure/ Silver Plus/ Silver HSA	Silver/Silver Extra/Silver Saver HSA/Silver Secure/ Silver Plus/ Silver HSA	Silver/Silver Extra/Silver Saver HSA/Silver Secure/ Silver Plus/ Silver HSA
Bronze Saver HSA/Bronze Extra/ Bronze Secure/ Bronze Plus/ Bronze HSA	Bronze Saver HSA/Bronze Extra/ Bronze Secure/ Bronze Plus/ Bronze HSA	Bronze Saver HSA/Bronze Extra/ Bronze Secure/Bronze Plus/ Bronze HSA	Bronze Saver HSA/Bronze Extra/ Bronze Secure/ Bronze Plus/ Bronze HSA
Value	Value	Value	Value

HMO options	HMO options	HMO options	HMO options
Blue Cross® Preferred Gold	Blue Cross® Preferred Gold	Blue Cross® Preferred Gold	Blue Cross® Preferred Gold
Gold Extra	Gold Extra	Gold Extra	Gold Extra
Silver Saver/Silver Extra/ Silver Secure/ Silver Plus/	Silver/Silver Extra/Silver Saver/ Silver Secure/Silver Plus/	Silver/Silver Extra/Silver Saver/ Silver Secure/ Silver Plus/	Silver Extra/Silver/Silver Secure/ Silver Plus/Silver HSA
Bronze Saver HSA/ Bronze Extra/Bronze Secure/ Bronze Plus/Bronze HSA	Silver HSA  Bronze Saver HSA/Bronze Extra/ Bronze Secure/ Bronze Plus/ Bronze HSA	Silver HSA  Bronze Saver HSA/Bronze Extra/ Bronze Secure/ Bronze Plus/ Bronze HSA	Bronze Extra/Bronze Saver HSA/ Bronze Plus/Bronze HSA Blue Cross® Select
Value	Value	Blue Cross® Select Silver/Silver Extra/Silver Saver/	Silver/Silver Extra/Silver Saver/ Silver Secure/ Silver Plus/ Silver HSA
		Silver Secure/ Silver Plus/ Silver HSA	Bronze Extra/Bronze Saver HSA/ Bronze Secure/ Bronze Plus/
		Bronze Saver HSA/Bronze Extra/ Bronze Secure/ Bronze Plus/	Bronze HSA
		Bronze HSA	Value
		Value	Blue Cross® Local HMO Silver Extra/Silver Saver/Silver Secure/ Silver Plus/Silver HSA
			Bronze Secure/Bronze Extra/ Bronze Saver HSA/Bronze Plus/ Bronze HSA



# Gold health plan comparison

#### PPO

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	Blue Cross® Premier PPO Gold	Blue Cross® Premier PPO Gold Extra
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$1,450 per individual plan \$2,900 per family plan	\$2,000 per individual plan \$4,000 per family plan
Coinsurance	20% after deductible for most services	25% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$9,000 per individual plan \$18,000 per family plan	\$8,200 per individual plan \$16,400 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
	\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit after deductible;	\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit with no deductible
Physician office visits	\$50 copay per specialist visit after deductible	\$60 copay per specialist office visit with no deductible.
	Diagnostic and laboratory services subject to deductible and coinsurance	Diagnostic and laboratory services subject to deductible and coinsurance
Retail health clinic visit and a medical	\$30 copay after deductible	\$30 copay with no deductible
evaluation at an affiliated immunization pharmacy	Diagnostic and laboratory services subject to deductible and coinsurance	Diagnostic and laboratory services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$30 copay after deductible for behavioral health online visits	\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 80% after deductible	Covered 75% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 80% after deductible	Covered 75% after deductible
Inpatient hospital care – semi-private room	Covered 80% after deductible	Covered 75% after deductible
Surgical care	Covered 80% after deductible	Covered 75% after deductible
Emergency room	\$250 copay after deductible, then covered 80% Copay waived if admitted	Covered 75% after deductible
Transportation by ambulance	Covered 80% after deductible	Covered 75% after deductible
Urgent care visits at urgent care centers	\$75 copay with no deductible	\$45 copay with no deductible
or outpatient locations	Diagnostic and laboratory services subject to deductible and coinsurance	Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 80% after deductible	Covered 75% after deductible
Outpatient Behavioral Health	\$30 copay per visit after deductible	\$30 copay per visit with no deductible
Prescription drugs 1 to 30 days	Generic: \$15 copay after integrated deductible	
Includes retail network pharmacies and mailorder providers.	Preferred brand: \$100 copay after integrated deductible	Generic: \$15 copay with no deductible Preferred brand: \$30 copay with no deductible
Any coupon, rebate or other credits received	Nonpreferred brand: \$150 copay after integrated deductible	Nonpreferred brand: \$60 copay with no deductible
directly or indirectly from an assistance program or the drug manufacturer may not be applied to deductibles, cost-sharing or	Preferred specialty: 40% coinsurance after integrated deductible  Nonpreferred specialty: 45% coinsurance	Specialty: \$250 copay with no deductible
out-of-pocket maximums.	after integrated deductible	

#### HMO

Blue Cross® Preferred HMO Gold	Blue Cross® Preferred HMO Gold Extra
\$2,050 per individual plan \$4,100 per family plan	\$2,000 per individual plan \$4,000 per family plan
20% after deductible for most services	25% after deductible for most services
\$8,800 per individual plan \$17,600 per family plan	\$8,200 per individual plan \$16,400 per family plan
No	No
Covered 100% with no deductible	Covered 100% with no deductible
\$30 copay per primary care office visit with no deductible \$50 copay per specialist office visit after deductible Diagnostic services subject to deductible and coinsurance	\$30 copay per primary care office visit with no deductible \$60 copay per specialist office visit with no deductible. Diagnostic and laboratory services subject to deductible and coinsurance
\$30 copay with no deductible Diagnostic services subject to deductible and coinsurance	\$30 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits	\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits
Covered 100% with no deductible	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
\$250 copay after deductible, then covered 80% Copay waived if admitted	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
\$40 copay with no deductible Diagnostic services subject to deductible and coinsurance	\$45 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Covered 80% after deductible	Covered 75% after deductible
\$30 copay per visit with no deductible	\$30 copay per visit with no deductible
Preferred generic: \$4 copay after integrated deductible Generic: \$20 copay after integrated deductible Preferred brand: \$100 copay after integrated deductible Nonpreferred brand: \$150 copay after integrated deductible Preferred specialty: 40% coinsurance after integrated deductible Nonpreferred specialty: 45% coinsurance after integrated deductible	Generic: \$15 copay with no deductible Preferred brand: \$30 copay with no deductible Nonpreferred brand: \$60 copay with no deductible Specialty: \$250 copay with no deductible

# Silver health plan comparison

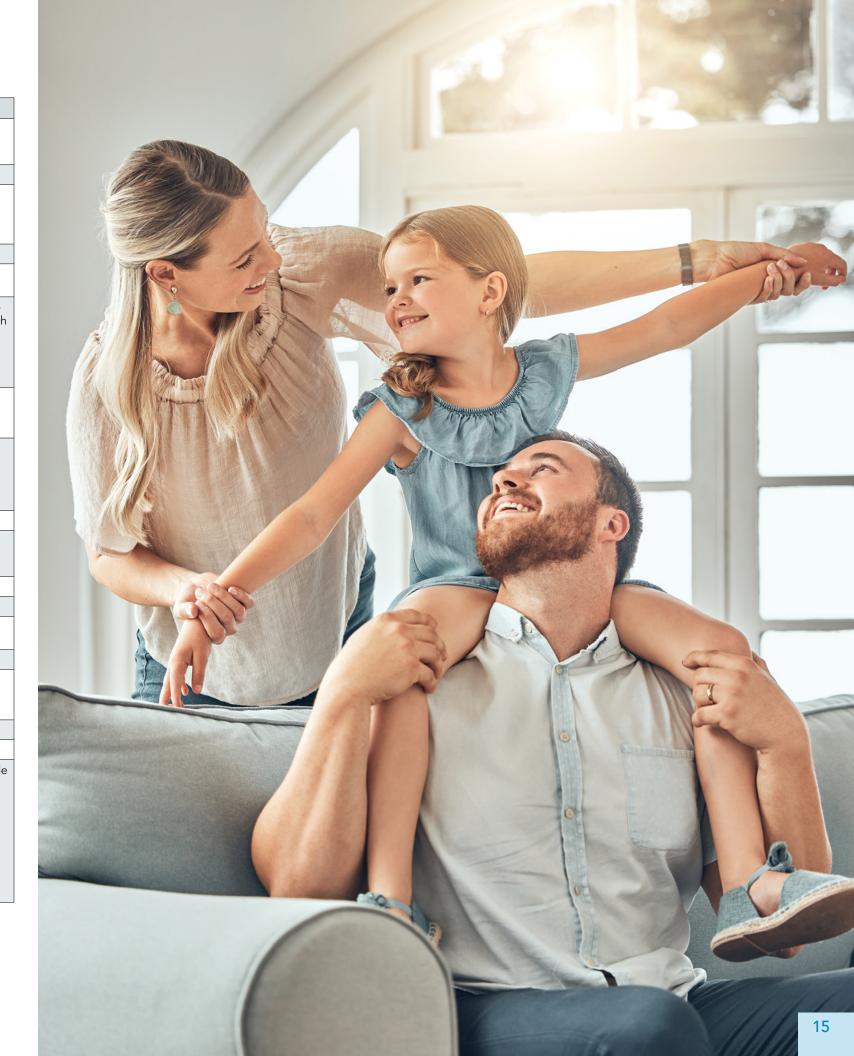
PPO

PPO	Blue Cross® Premier PPO Silver Extra	Blue Cross® Premier PPO Silver
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$6,000 per individual plan \$12,000 per family plan	\$3,200 per individual plan \$6,400 per family plan
Coinsurance	40% after deductible for most services	20% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$8,900 per individual plan \$17,800 per family plan	\$10,100 per individual plan \$20,200 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Dhysician office visits	\$40 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit with no deductible	\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit after deductible
Physician office visits	\$80 copay per specialist office visit with no deductible	\$50 copay per specialist office visit after deductible
	Diagnostic and laboratory services subject to deductible and coinsurance	Diagnostic and laboratory services subject to deductible and coinsurance
Retail health clinic visit and a medical evaluation at an affiliated immunization pharmacy	\$40 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$30 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$40 copay with no deductible for behavioral health online visits	\$0 copay with no deductible for medical online visits, \$30 copay after deductible for behavioral health online visits
Laboratory tests and pathology	Covered 60% after deductible	Covered 80% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 60% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 60% after deductible	Covered 80% after deductible
Surgical care	Covered 60% after deductible	Covered 80% after deductible
Emergency room	Covered 60% after deductible	\$250 copay after deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Covered 60% after deductible	Covered 80% after deductible
Urgent care visits at urgent care centers or outpatient locations	\$60 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 60% after deductible	Covered 80% after deductible
Outpatient Behavioral Health	\$40 copay per visit with no deductible	\$30 copay per visit after deductible
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers.  Any coupon, rebate or other credits	Generic: \$20 copay with no deductible Preferred brand: \$40 copay with no deductible Nonpreferred brand: \$80 copay	Generic: \$15 copay after deductible Preferred brand: \$100 copay after deductible Nonpreferred brand: \$150 copay after deductible
received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	after integrated deductible  Specialty: \$350 copay  after integrated deductible	Preferred specialty: 40% coinsurance after integrated deductible Nonpreferred specialty: 45% coinsurance after integrated deductible

Blue Cross® Premier PPO Silver Secure	Blue Cross® Premier PPO Silver Saver HSA
\$4,100 per individual plan \$8,200 per family plan	\$3,900 per individual plan \$7,800 per family plan
20% after deductible for most services	20% after deductible for most services
\$9,900 per individual plan \$19,800 per family plan	\$7,700 per individual plan \$15,400 per family plan
No	Yes
Covered 100% with no deductible	Covered 100% with no deductible
\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit after deductible \$50 copay per specialist office visit after deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit after deductible \$50 copay per specialist office visit after deductible Diagnostic and laboratory services subject to deductible and coinsurance
\$30 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$30 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance
\$0 copay with no deductible for medical online visits, \$30 copay after deductible for behavioral health online visits	\$0 copay after deductible for medical online visits, \$30 copay after deductible for behavioral health online visits
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
\$250 copay after deductible, then covered 80% Copay waived if admitted	\$250 copay after deductible, then covered 80% Copay waived if admitted
Covered 80% after deductible	Covered 80% after deductible
\$75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$75 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Covered 80% after deductible	Covered 80% after deductible
\$30 copay per visit after deductible	\$30 copay per visit after deductible
Generic: \$15 copay after integrated deductible Preferred brand: \$100 copay after integrated deductible Nonpreferred brand: \$150 copay after integrated deductible Preferred specialty: 40% coinsurance after integrated deductible Nonpreferred specialty: 45% coinsurance after integrated deductible	Generic: \$15 copay after integrated deductible Preferred brand: \$100 copay after integrated deductible Nonpreferred brand: \$150 copay after integrated deductible Preferred specialty: 40% coinsurance after integrated deductible Nonpreferred specialty: 45% coinsurance after integrated deductible

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PPO	Blue Cross® Premier PPO Silver Plus	Blue Cross® Premier PPO Silver HSA
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$5,500 per individual plan \$11,000 per family plan	\$3,500 per individual plan \$7,000 per family plan
Coinsurance	20% after deductible for most services	20% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$10,600 per individual plan \$21,200 per family plan	\$8,500 per individual plan \$17,000 per family plan
HSA qualified	No	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	\$30 copay per in-person primary care office visit or Virtual Primary care by Teladoc Health visit with no deductible and a \$75 copay per specialist office visit with no deductible	\$25 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit after deductible and a \$60 copay per specialist office visit after deductible
	Diagnostic services subject to deductible and coinsurance.	Diagnostic and laboratory services subject to deductible and coinsurance
Retail health clinic visit and a medical	\$30 copay with no deductible	\$25 copay after deductible
evaluation at an affiliated immunization pharmacy	Diagnostic services subject to deductible and coinsurance.	Diagnostic and laboratory services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits	\$0 copay with no deductible for medical online visits,	\$0 copay after deductible for medical online visits,
24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$30 copay with no deductible for behavioral health online visits	\$25 copay after deductible for behavioral health online visits
Laboratory tests and pathology	\$20 copay with no deductible	Covered 80% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 80% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 80% after deductible	Covered 80% after deductible
Surgical care	Covered 80% after deductible	Covered 80% after deductible
Emergency room	\$250 copay after deductible, then covered 80% copay waived if admitted	\$250 copay after deductible, then covered 80% copay waived if admitted
Transportation by ambulance	Covered 80% after deductible	Covered 80% after deductible
Urgent care visits at urgent care centers or outpatient locations	\$40 copay with no deductible Diagnostic services subject to deductible and coinsurance.	\$40 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 80% after deductible	Covered 80% after deductible
Outpatient Behavioral Health	\$30 copay per visit with no deductible	\$25 copay per visit after deductible
Procesintian drugs 1 20 days	Generic: \$20 copay with no deductible	Generic: \$15 copay after integrated deductible
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers.	Preferred brand: \$100 copay after integrated deductible	Preferred brand: \$100 copay after integrated deductible
Any coupon, rebate or other credits	Nonpreferred brand: \$150 copay after integrated deductible	Nonpreferred brand: \$150 copay after integrated deductible
received directly or indirectly from the drug manufacturer may not be applied to	Preferred specialty: 40% coinsurance after integrated deducible	Preferred specialty: 40% coinsurance after integrated deductible
deductibles, cost-sharing or out-of-pocket maximums.	Nonpreferred specialty: 45% coinsurance after integrated deductible	Nonpreferred specialty: 45% coinsurance after integrated deductible



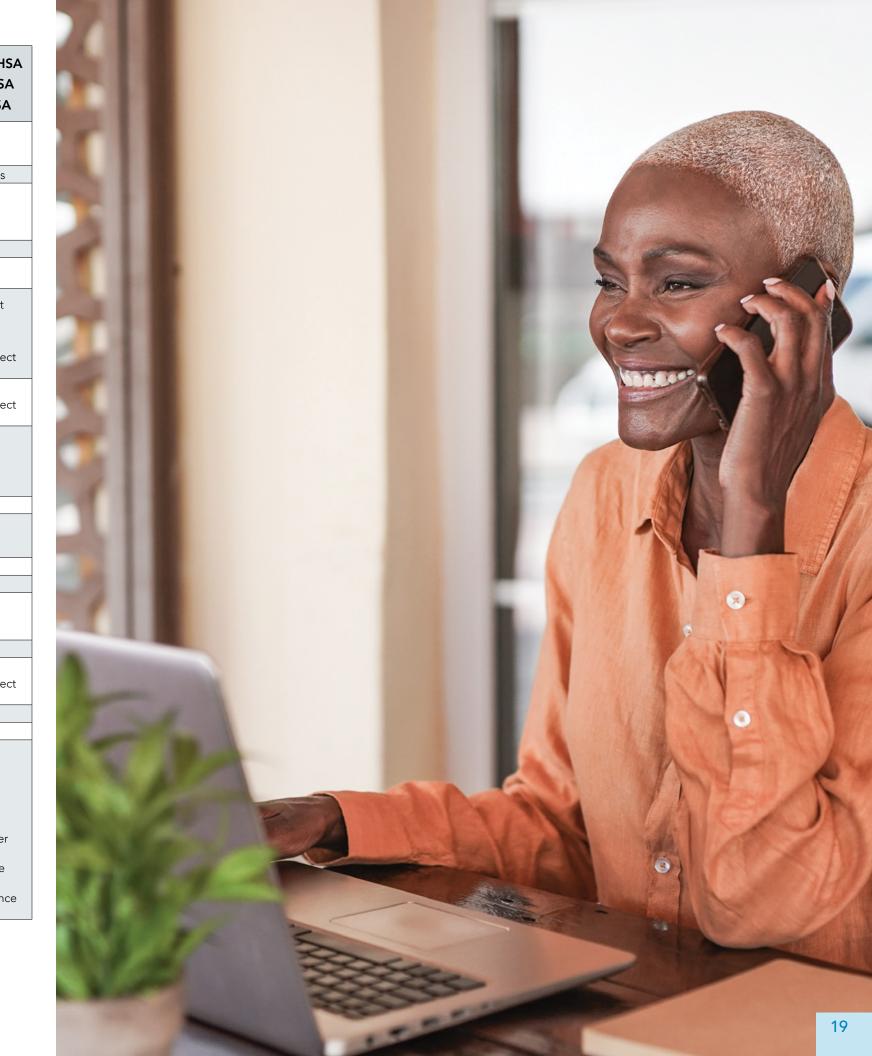
#### **HMO**

HIVIO		
	Blue Cross® Preferred HMO Silver Extra Blue Cross® Select HMO Silver Extra Blue Cross® Local HMO Silver Extra	Blue Cross® Preferred HMO Silver Blue Cross® Select HMO Silver
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$6,000 per individual plan \$12,000 per family plan	\$4,500 per individual plan \$9,000 per family plan
Coinsurance	40% after deductible for most services	20% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$8,900 per individual plan \$17,800 per family plan	\$10,600 per individual plan \$21,200 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	\$40 copay per primary care office visit with no deductible \$80 copay per specialist office visit with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$30 copay per primary care office visit with no deductible \$50 copay per specialist office visit after deductible Diagnostic services subject to deductible and coinsurance
Retail health clinic visit and a medical evaluation at an affiliated immunization pharmacy	\$40 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$30 copay with no deductible Diagnostic services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$40 copay with no deductible for behavioral health online visits	\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 60% after deductible	Covered 100% with no deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 60% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 60% after deductible	Covered 80% after deductible
Surgical care	Covered 60% after deductible	Covered 80% after deductible
Emergency room	Covered 60% after deductible	\$250 copay after deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Covered 60% after deductible	Covered 80% after deductible
Urgent care visits at urgent care centers or outpatient locations	\$60 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	\$40 copay with no deductible Diagnostic services subject to deductible and coinsurance
Maternity benefit	Covered 60% after deductible	Covered 80% after deductible
Outpatient Behavioral Health	\$40 copay per visit with no deductible	\$30 copay per visit with no deductible
Prescription drugs 1 to 30 days Includes retail network pharmacies and mailorder providers.  Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	Generic \$20 copay with no deductible Preferred brand: \$40 copay with no deductible Nonpreferred brand: \$80 after integrated deductible Specialty: \$350 copay after integrated deductible	Preferred generic: \$4 copay after integrated deductible  Generic: \$20 copay after integrated deductible  Preferred brand: \$100 copay after integrated deductible  Nonpreferred brand: \$150 copay after integrated deductible  Preferred specialty: 40% coinsurance after integrated deductible  Nonpreferred specialty: 45% coinsurance after integrated deductible

Blue Cross® Preferred HMO Silver Secure Blue Cross® Select HMO Silver Secure Blue Cross® Local HMO Silver Secure	Blue Cross® Preferred HMO Silver Saver Blue Cross® Select HMO Silver Saver Blue Cross® Local HMO Silver Saver
\$6,300 per individual plan \$12,600 per family plan	\$5,800 per individual plan \$11,600 per family plan
20% after deductible for most services	35% after deductible for most services
\$9,800 per individual plan \$19,600 per family plan	\$7,650 per individual plan \$15,300 per family plan
No	No
Covered 100% with no deductible	Covered 100% with no deductible
\$30 copay per primary care office visit with no deductible \$50 copay per specialist office visit after deductible Diagnostic services subject to deductible and coinsurance	\$60 copay per primary care office visit with no deductible \$110 copay per specialist office visit with no deductible Diagnostic services subject to deductible and coinsurance
\$30 copay with no deductible Diagnostic services subject to deductible and coinsurance	\$60 copay with no deductible Diagnostic services subject to deductible and coinsurance
\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits	\$0 copay with no deductible for medical online visits, \$60 copay with no deductible for behavioral health online visits
Covered 100% with no deductible	Covered 100% with no deductible
Covered 80% after deductible	Covered 65% after deductible
Covered 80% after deductible	Covered 65% after deductible
Covered 80% after deductible	Covered 65% after deductible
\$250 copay after deductible, then covered 80%	\$250 copay after deductible, then covered 65%
Copay waived if admitted	Copay waived if admitted
Covered 80% after deductible	Covered 65% after deductible
\$40 copay with no deductible Diagnostic services subject to deductible and coinsurance	\$45 copay with no deductible Diagnostic services subject to deductible and coinsurance
Covered 80% after deductible	Covered 65% after deductible
\$30 copay per visit with no deductible	\$60 copay per visit with no deductible
Preferred generic: \$4 copay after integrated deductible Generic: \$20 copay after integrated deductible Preferred brand: \$100 copay after integrated deductible Nonpreferred brand: \$150 copay after integrated deductible Preferred specialty: 40% coinsurance after integrated deductible Nonpreferred specialty: 45% coinsurance after integrated deductible	Preferred generic: \$4 copay after integrated deductible Generic: \$20 copay after integrated deductible Preferred brand: \$100 copay after integrated deductible Nonpreferred brand: \$150 copay after integrated deductible Preferred specialty: 40% coinsurance after integrated deductible Nonpreferred specialty: 45% coinsurance after integrated deductible

НМО

НМО		
	Blue Cross® Preferred HMO Silver Plus Blue Cross® Select HMO Silver Plus Blue Cross® Local HMO Silver Plus	Blue Cross® Preferred HMO Silver HSA Blue Cross® Select HMO Silver HSA Blue Cross® Local HMO Silver HSA
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$5,500 per individual plan \$11,000 per family plan	\$3,500 per individual plan \$7,000 per family plan
Coinsurance	20% after deductible for most services	20% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$10,600 per individual plan \$21,200 per family plan	\$8,500 per individual plan \$17,000 per family plan
HSA qualified	No	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	\$30 copay per primary care office visit with no deductible \$75 copay per specialist office visit with no deductible Diagnostic services subject to deductible and coinsurance	\$25 copay per primary care office visit after deductible \$60 copay per specialist office visit after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Retail health clinic visit and a medical evaluation at an affiliated immunization pharmacy	\$30 copay with no deductible Diagnostic services subject to deductible and coinsurance	\$25 copay after deductible Diagnostic and laboratory services subjec to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$30 copy with no deductible for behavioral health online visits	\$0 copay after deductible for medical online visits, \$25 copay after deductible for behavioral health online visits
Laboratory tests and pathology	\$20 copay with no deductible	Covered 80% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 80% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 80% after deductible	Covered 80% after deductible
Surgical care	Covered 80% after deductible	Covered 80% after deductible
Emergency room	\$250 copay after deductible, then covered 80% Copay waived if admitted	\$250 copay after deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Copay waived if admitted  Covered 80% after deductible	Copay waived if admitted  Covered 80% after deductible
Transportation by ambulance	\$40 copay with no deductible	\$40 copay after deductible
Urgent care visits at urgent care centers or outpatient locations	Diagnostic services subject to deductible and coinsurance	Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 80% after deductible	Covered 80% after deductible
Outpatient Behavioral Health	\$30 copay per visit with no deductible	\$25 copay per visit after deductible
Prescription drugs 1 to 30 days	Preferred generic: \$20 copay with no deductible	Preferred generic: \$4 copay after integrated deductible
Includes retail network pharmacies and mail- order providers.	Generic: \$20 copay with no deductible Preferred brand: \$100 copay after integrated deductible	Generic: \$20 copay after integrated deductible Preferred brand: \$100 copay after
Any coupon, rebate or other credits received directly or indirectly from the	Nonpreferred brand: \$150 copay after integrated deductible	integrated deductible  Nonpreferred brand: \$150 copay after integrated deductible
drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	Preferred specialty: 40% coinsurance after integrated deductible  Nonpreferred specialty: 45% coinsurance	Preferred specialty: 40% coinsurance after integrated deductible
	after integrated deductible	Nonpreferred specialty: 45% coinsuranc after integrated deductible



# Bronze health plan comparison

### PPO

	Blue Cross® Premier PPO Bronze Extra
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$7,500 per individual plan \$15,000 per family plan
Coinsurance	50% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$10,000 per individual plan \$20,000 per family plan
HSA qualified	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	\$50 copay per in-person primary care office visit or Virtual Primary Care through Teladoc Health visit with no deductible \$100 copay per specialty visit with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Retail health clinic visit and a medical evaluation at an affiliated	\$50 copay with no deductible
immunization pharmacy	Diagnostic and laboratory services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$50 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 50% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 50% after deductible
Inpatient hospital care – semi-private room	Covered 50% after deductible
Surgical care	Covered 50% after deductible
Emergency room	Covered 50% after deductible
Transportation by ambulance	Covered 50% after deductible
Urgent care visits at urgent care centers or outpatient locations	Covered \$75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 50% after deductible
Outpatient Behavioral Health	\$50 copay per visit with no deductible
Prescription drugs 1 to 30 days Includes retail network pharmacies and mail-order providers.  Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	Generic: \$25 copay with no deductible Preferred brand: \$50 copay after integrated deductible Nonpreferred brand: \$100 copay after integrated deductible Specialty: \$500 copay after integrated deductible

Blue Cross® Premier PPO Bronze Saver HSA	Blue Cross® Premier PPO Bronze Secure
\$8,500 per individual plan \$17,000 per family plan	\$10,600 per individual plan \$21,200 per family plan
None	None
\$8,500 per individual plan \$17,000 per family plan	\$10,600 per individual plan \$21,200 per family plan
Yes	Yes
Covered 100% with no deductible	Covered 100% with no deductible
Primary care and specialist office visits are covered 100% after deductible, including visits through Virtual Primary Care by Teladoc Health  Diagnostic and laboratory services subject to deductible	Primary care and specialist office visits are covered 100% after deductible, including Virtual Primary Care by Teladoc Health Diagnostic and laboratory services subject to deductible
Covered 100% after deductible	Covered 100% after deductible
Diagnostic and laboratory services subject to deductible	Diagnostic and laboratory services subject to deductible
Covered 100% after deductible	\$0 copay with no deductible for medical online visits, \$0 copay after deductible for behavioral health online visits
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible Diagnostic and laboratory services subject to deductible	Covered 100% after deductible Diagnostic and laboratory services subject to deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Generic: Covered 100% after integrated deductible Preferred brand: Covered 100% after integrated deductible Nonpreferred brand: Covered 100% after integrated deductible Preferred specialty: Covered 100% after integrated deductible Nonpreferred specialty: Covered 100% after integrated deductible	Generic: Covered 100% after integrated deductible Preferred brand: Covered 100% after integrated deductible Nonpreferred brand: Covered 100% after integrated deductible Preferred specialty: Covered 100% after integrated deductible Nonpreferred specialty: Covered 100% after integrated deductible

Pediatric vision covered 100%: One vision exam per pediatric member per year. Covered 100%: Standard lenses and frames or contact lenses. Frequency limits apply.

The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

## PPO

	Blue Cross® Premier PPO Bronze Plus
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$8,500 per individual plan \$17,000 per family plan
Coinsurance	50% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$10,600 per individual plan \$21,200 per family plan
HSA qualified	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit with no deductible and a \$50 copay per specialist office visit after deductible  Diagnostic services subject to deductible and coinsurance
Retail health clinic visit and a medical evaluation at an affiliated immunization pharmacy	\$30 copay with no deductible Diagnostic services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	\$15 copay with no deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 50% after deductible
Inpatient hospital care – semi-private room	Covered 50% after deductible
Surgical care	Covered 50% after deductible
Emergency room	Covered 50% after deductible
Transportation by ambulance	Covered 50% after deductible
Urgent care visits at urgent care centers or outpatient locations	\$40 copay with no deductible Diagnostic services subject to deductible and coinsurance
Maternity benefit	Covered 50% after deductible
Outpatient Behavioral Health	\$30 copay per visit with no deductible
Prescription drugs 1 to 30 days Includes retail network pharmacies and mail-order providers.  Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	Generic: \$20 copay with no deductible Preferred brand: 50% coinsurance after integrated deductible Nonpreferred brand: 50% coinsurance after integrated deductible Preferred Specialty: 50% coinsurance after integrated deductible Nonpreferred specialty: 50% coinsurance after integrated deductible

Blu	e Cross® Premier PPO Bronze HSA
	\$5,500 per individual plan \$11,000 per family plan
3	0% after deductible for most services
	\$8,500 per individual plan \$17,000 per family plan
	Yes
	Covered 100% with no deductible
by Telado	person primary care office visit or Virtual Primary Ca c Health visit after deductible and a \$60 copay er specialist office visit after deductible
Diag	nostic and laboratory services subject to deductible and coinsurance
	\$25 copay after deductible
Diag	nostic and laboratory services subject to deductible and coinsurance
· ·	ay after deductible for medical online visits, fter deductible for behavioral health online visits
	Covered 70% after deductible
	\$40 copay after deductible
Diagnostic and lal	boratory services subject to deductible and coinsuran
	Covered 70% after deductible
	\$25 copay per visit after deductible
Preferred Nonpreferre	eric: \$15 copay after integrated deductible brand: \$100 copay after integrated deductible ed brand: \$150 copay after integrated deductible cialty: 40% coinsurance after integrated deductible

HIVIO	
	Blue Cross® Preferred HMO Bronze Saver HSA
	Blue Cross® Local HMO Bronze Saver HSA
	Blue Cross® Select HMO Bronze Saver HSA
Annual deductible	
Medical and drug expenses are	\$8,500 per individual plan
combined to meet the integrated deductible.	\$17,000 per family plan
Coinsurance	0%
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$8,500 per individual plan \$17,000 per family plan
HSA qualified	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
	Primary care and specialist office visits covered 100% after deductible
Physician office visits	Diagnostic and laboratory services subject to deductible
Retail health clinic visit and a	Covered 100% after deductible
medical evaluation at an affiliated	Diagnostic and laboratory services subject to deductible
immunization pharmacy	Diagnostic and laboratory services subject to deductible
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	Covered 100% after deductible
Laboratory tests and pathology	Covered 100% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 100% after deductible
Inpatient hospital care – semi-private room	Covered 100% after deductible
Surgical care	Covered 100% after deductible
Emergency room	Covered 100% after deductible
Transportation by ambulance	Covered 100% after deductible
Urgent care visits at urgent care	Covered 100% after deductible
centers or outpatient locations	Diagnostic and laboratory services subject to deductible
Maternity benefit	Covered 100% after deductible
Outpatient Behavioral Health	Covered 100% after deductible
Prescription drugs 1 to 30 days	Preferred generic: Covered 100% after integrated deductible
Includes retail network pharmacies and	Generic: Covered 100% after integrated deductible
mail-order providers.	Preferred brand: Covered 100% after integrated deductible
Any coupon, rebate or other credits	Nonpreferred brand: Covered 100%
received directly or indirectly from the drug manufacturer may not be applied	after integrated deductible
to deductibles, cost-sharing or out-of-	Preferred specialty: Covered 100% after integrated deductible
pocket maximums.	Nonpreferred specialty: Covered 100% after integrated deductible

Blue Cross® Preferred HMO Bronze Secure	Blue Cross® Preferred HMO Bronze Extra	
Blue Cross® Select HMO Bronze Secure	Blue Cross® Select HMO Bronze Extra	
Blue Cross® Local HMO Bronze Secure	Blue Cross® Local HMO Bronze Extra	
\$10,600 per individual plan \$21,200 per family plan	\$7,500 per individual plan \$15,000 per family plan	
0%	50%	
\$10,600 per individual plan \$21,200 per family plan	\$10,000 per individual plan \$20,000 per family plan	
Yes	Yes	
Covered 100% with no deductible	Covered 100% with no deductible	
Primary care and specialist office visits covered 100% after deductible Diagnostic and laboratory services subject to deductible	\$50 copay per primary care office visit with no deductible \$100 copay per specialist office visit with no deductible. Diagnostic and laboratory services subject to deductible and coinsural	
Covered 100% after deductible	\$50 copay with no deductible	
Diagnostic and laboratory services subject to deductible	Diagnostic and laboratory services subject to deductible and coinsural	
\$0 copay with no deductible for medical online visits, \$0 copay after deductible for behavioral health online visits	\$0 copay with no deductible for medical online visits, \$50 copay with no deductible for behavioral health online visits	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	\$75 copay with no deductible	
Diagnostic and laboratory services subject to deductible	Diagnostic and laboratory services subject to deductible and coinsural	
Covered 100% after deductible	Covered 50% after deductible	
Covered 100% after deductible	\$50 copay per visit with no deductible	
Preferred generic: Covered 100% after integrated deductible Generic: Covered 100% after integrated deductible Preferred brand: Covered 100% after integrated deductible Nonpreferred brand: Covered 100% after integrated deductible Preferred specialty: Covered 100% after integrated deductible Nonpreferred specialty: Covered 100% after integrated deductible	Generic: \$25 copay with no deductible Preferred brand: \$50 after integrated deductible Nonpreferred brand: \$100 after integrated deductible Specialty: \$500 after integrated deductible	

Pediatric vision covered 100%: One vision exam per pediatric member per year. Covered 100%: Standard lenses and frames or contact lenses. Frequency limits apply.

The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

pocket maximums.

ПИО	
	Blue Cross® Preferred HMO Bronze Plus
	Blue Cross® Select HMO Bronze Plus
	Blue Cross® Local HMO Bronze Plus
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	\$8,500 per individual plan \$17,000 per family plan
Coinsurance	50% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of- pocket maximum.	\$10,600 per individual plan \$21,200 per family plan
HSA qualified	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	\$30 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit with no deductible and a \$50 copay per specialist office visit after deductible  Diagnostic services subject to deductible and coinsurance
Retail health clinic visit and a medical evaluation at an affiliated immunization pharmacy	\$30 copay with no deductible Diagnostic services subject to deductible and coinsurance
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for medical online visits, \$30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	\$15 copay with no deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 50% after deductible
Inpatient hospital care – semi-private room	Covered 50% after deductible
Surgical care	Covered 50% after deductible
Emergency room	Covered 50% after deductible
Transportation by ambulance	Covered 50% after deductible
Urgent care visits at urgent care centers or outpatient locations	\$40 copay with no deductible Diagnostic services subject to deductible and coinsurance
Maternity benefit	Covered 50% after deductible
Outpatient Behavioral Health	\$30 copay per visit with no deductible
Prescription drugs 1 to 30 days Includes retail network pharmacies and mail-order providers.	Preferred generic: \$20 copay with no deductible  Generic: \$20 copay with no deductible  Preferred brand: 50% coinsurance after integrated deductible
Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	Nonpreferred brand: 50% coinsurance after integrated deductible Preferred specialty: 50% coinsurance after integrated deductible Nonpreferred specialty: 50% coinsurance after integrated deductible

# Blue Cross® Preferred HMO Bronze HSA Blue Cross® Select HMO Bronze HSA Blue Cross® Local HMO Bronze HSA

\$5,500 per individual plan \$11,000 per family plan

30% after deductible for most services

\$8,500 per individual plan \$17,000 per family plan

Yes

Covered 100% with no deductible

\$25 copay per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit after deductible and a \$60 copay per specialist office visit after deductible

Diagnostic and laboratory services subject to deductible and coinsurance

\$25 copay after deductible

Diagnostic and laboratory services subject to deductible and coinsurance

\$0 copay after deductible for medical online visits, \$25 copay after deductible for behavioral health online visits

Covered 70% after deductible

Covered 70% after deductible

Covered 70% after deductible

Covered 70% after deductible Covered 70% after deductible Covered 70% after deductible

\$40 copay after deductible

Diagnostic and laboratory services subject to deductible and coinsurance

Covered 70% after deductible

\$25 copay per visit after deductible

Preferred generic: \$4 copay after integrated deductible
Generic: \$20 copay after integrated deductible
Preferred brand: \$100 copay after integrated deductible
Nonpreferred brand: \$150 copay after integrated deductible
Preferred specialty: 40% coinsurance after integrated deductible
Nonpreferred specialty: 45% coinsurance after integrated deductible

	PPO
	Blue Cross® Premier PPO Value
Annual deductible  Medical and drug expenses are combined to meet the integrated deductible.	\$10,600 per individual plan \$21,200 per family plan
Coinsurance	None
Out-of-pocket maximum  The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	\$10,600 per individual plan \$21,200 per family plan
HSA qualified	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	\$30 copay with no deductible per in-person primary care office visit or Virtual Primary Care by Teladoc Health visit (applies to the first three primary care visits per member per calendar year)  Additional primary care visits subject to the deductible  Specialist office visits subject to the deductible  Diagnostic and laboratory services subject to deductible  After deductible is met, office visits covered at 100%
Retail health clinic visit and a medical evaluation at an affiliated immunization pharmacy	\$30 copay with no deductible for the first three visits, including primary care and retail health clinic visits, per member per calendar year  Additional visits and diagnostic and laboratory services subject to deductible
Virtual Care by Teladoc Health You have access to virtual urgent care visits 24/7 and virtual mental health care visits by appointment that include evening and weekend availability.	\$0 copay with no deductible for online medical visits.  \$30 copay for behavioral health online visits with no deductible for the first three visits, including primary care and retail health clinic visits, per member per calendar year  Additional visits and diagnostic and laboratory services subject to deductible
Laboratory tests and pathology	Covered 100% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 100% after deductible
Urgent care visits at urgent care centers or outpatient locations	Covered 100% after deductible Diagnostic and laboratory services subject to deductible
Inpatient and surgical care	Covered 100% after deductible
Transportation by ambulance and emergency room visit	Covered 100% after deductible
Maternity benefit	Covered 100% after deductible
Outpatient Behavioral Health	\$30 copay per visit (applies to the first three visits combined with primary care visits per member per calendar year)  Additional visits subject to the deductible
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers.  Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out-of-pocket maximums.	Generic: Covered 100% after integrated deductible Preferred brand: Covered 100% after integrated deductible Nonpreferred brand: Covered 100% after integrated deductible Preferred specialty: Covered 100% after integrated deductible Nonpreferred specialty: Covered 100% after integrated deductible

# **HMO** Blue Cross® Select HMO Value Blue Cross® Preferred HMO Value \$10,600 per individual plan \$21,200 per family plan None \$10,600 per individual plan \$21,200 per family plan Yes Covered 100% with no deductible \$30 copay per primary care visit with no deductible Specialist office visits covered 100% after deductible Diagnostic services subject to deductible \$30 copay with no deductible Diagnostic services subject to deductible \$0 copay with no deductible for online medical visits, \$30 copay with no deductible for behavioral health online visits Covered 100% with no deductible Covered 100% after deductible \$40 copay with no deductible Diagnostic services subject to deductible Covered 100% after deductible Covered 100% after deductible Covered 100% after deductible \$30 copay per visit with no deductible Preferred generic: Covered 100% after integrated deductible Generic: Covered 100% after integrated deductible Preferred brand: Covered 100% after integrated deductible Nonpreferred brand: Covered 100% after integrated deductible Preferred specialty: Covered 100% after integrated deductible Nonpreferred specialty: Covered 100% after integrated deductible

Pediatric vision covered 100%: One vision exam per pediatric member per year. Covered 100%: Standard lenses and frames or contact lenses. Frequency limits apply.

The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

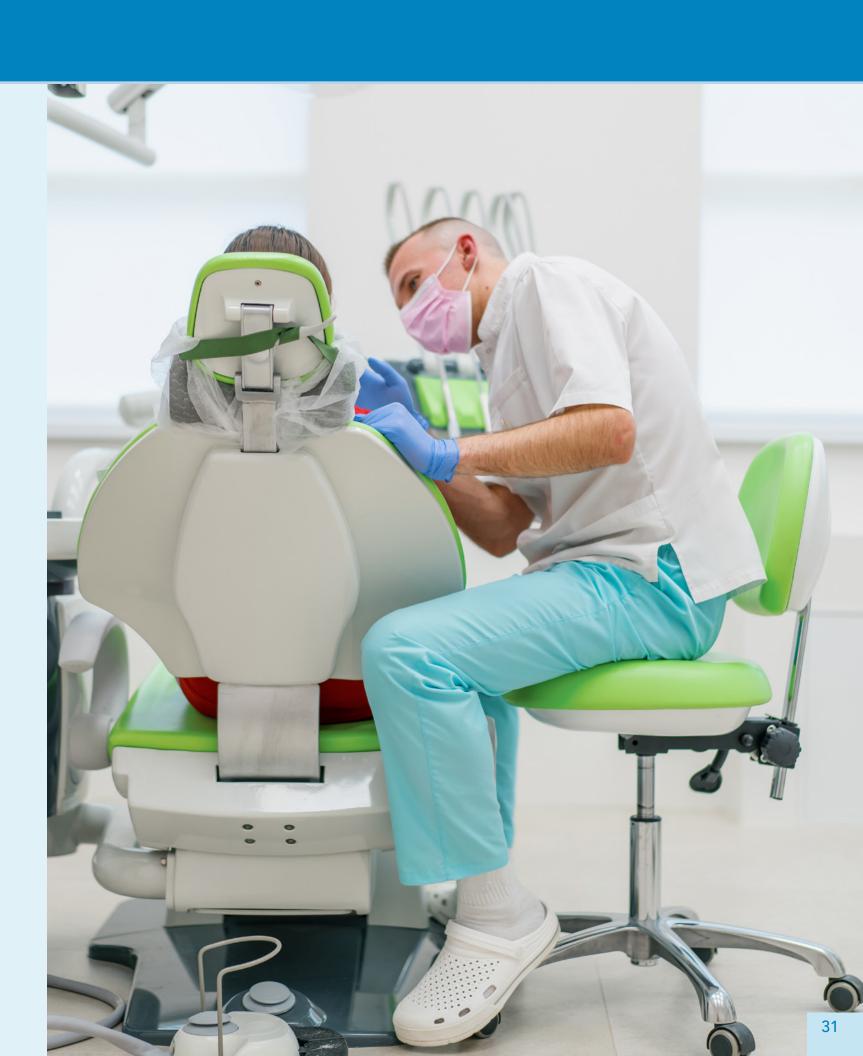
# **Choosing your dentist**

Blue Dental<sup>SM</sup> offers the broadest access to participating dentists for savings and choice with our two-tiered approach. Tier 1, our contracted Blue Dental PPO network, includes thousands of dentists nationwide and 3,600 in Michigan. You get great care and cost savings, with discounts of up to 40% on covered services when you see Tier 1 PPO dentists. (Members in our EPO plans must choose PPO dentists.)

Non-PPO dentists can participate through our Tier 2 per-claim participation arrangement, with discounts on services ranging 15 to 18%. Dentists who participate in Tier 2 offer an easy experience for you and don't bill for any difference between our approved amounts and their normal charges for covered services.

This two-tiered access allows you to choose the dental care that's right for you and still save money.

Looking for a dentist in your area? Log into your member account at **bcbsm.com**. Once logged in, click *My Coverage* and then *Dental*. Or call **1-888-826-8152**.



# Individual dental plan options

All of our Blue Dental plans offer the same quality benefits, but with different premiums and cost-sharing amounts, allowing you to choose the plan that best fits your needs and budget.

Plan name	Blue Dental <sup>sM</sup> EPO 80/50/50 (0/0/0)		Blue Dental <sup>™</sup> PPO 80/50/50 (50/50/50)		Blue Dental <sup>sм</sup> PPO 100/50/50 (50/50/50)	
	In network	Out of network	In network	Out of network	In network	Out of network
Deductible (1 person/ 2 person/3 person) Applies to Class II & Class III services only	\$25/\$50/\$75	Not covered	\$25/\$50/\$75	\$50/\$100/\$150	\$25/\$50/\$75	\$50/\$100/\$150
Class I diagnostic and pr	reventive service	es				
Coinsurance	20%	Not covered	20%	50%	0%	50%
Dental checkup – Child	Cleaning – 3x per calendar year; Exams – 2x per calendar year  heckup – Child  Bitewing X-rays – one set (up to four) per calendar year; Fluoride – 2x per calendar year  Pediatric members 18 or younger when coverage begins					
Routine dental – Adult	В	itewing X-rays - or	2x per calendar year ne set (up to four) p der when coverage	er calendar year; <b>Fl</b>	<b>uoride –</b> not covere	ed
Class II basic services*						
Coinsurance	50%	Not covered	50%	50%	50%	50%
Basic dental care – Child	Sealants – 1x per permanent molars, every three years Fillings – 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Periodontal maintenance – 3x per calendar year in combination with routine cleaning Simple extractions – 1x per lifetime per tooth; Root canals – 1x per lifetime per tooth Pediatric members 18 or younger when coverage begins.					
Basic dental care – Adult	Periodontal maintenance – 2x per calendar year in combination with routine cleaning;  Sealants – not covered; Fillings – 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth  Simple extractions – 1x per lifetime per tooth; Root canals – 1x per lifetime per tooth  Members 19 or older when coverage begins are considered nonpediatric. Six-month waiting period on  Class II services for nonpediatric members except for emergency palliative treatments.					
						ing period on
Class III major services*						ing period on
Class III major services* Coinsurance						ing period on
•	Clas	Not covered  Planing – 1x per Bridges and de	pediatric members of the second secon	50% Onths; <b>Onlays, crov</b> 34 months; <b>Implant</b>	50%  vns, veneers – 1x 6 s – not covered	ing period on ients.
Coinsurance	50% Scaling and roo	Not covered  to planing – 1x per Bridges and de Pediatric  to planing – 1x per planing – 1x	50%  quadrant, per 24 mentures – 1x every 8 members 18 or you quadrant, per 36 mentures – 1x every 8	50%  onths; Onlays, crov 34 months; Implant unger when coverage onths; Onlays, crov 34 months; Implant ared nonpediatric. T	50%  vns, veneers – 1x et s – not covered ge begins  vns, veneers – 1x et s – not covered	50% every 60 months;
Coinsurance  Major dental care – Child	50% Scaling and roo	Not covered  ot planing – 1x per Bridges and de Pediatric  ot planing – 1x per Bridges and de	50%  quadrant, per 24 mentures – 1x every 8 members 18 or you  quadrant, per 36 mentures – 1x every 8 begins are consider	50%  onths; Onlays, crov 34 months; Implant unger when coverage onths; Onlays, crov 34 months; Implant ared nonpediatric. T	50%  vns, veneers – 1x et s – not covered ge begins  vns, veneers – 1x et s – not covered	50% every 60 months;
Coinsurance  Major dental care – Child  Major dental care – Adult	50%  Scaling and roo  Scaling and roo  Members 19 or of	Not covered  ot planing – 1x per Bridges and de Pediatric  ot planing – 1x per Bridges and de Bridges and de Bridges and de Bridges and de Ider when coverage	50%  quadrant, per 24 mentures – 1x every 8 members 18 or you  quadrant, per 36 mentures – 1x every 8 begins are consider III services for none	50% onths; Onlays, crov 34 months; Implant unger when coverace onths; Onlays, crov 34 months; Implant ared nonpediatric. Toediatric members	50%  vns, veneers – 1x es s – not covered ge begins  vns, veneers – 1x es s – not covered ge begins	50% every 60 months; every 60 months;

**Note:** Pediatric out-of-pocket maximum for all dental plans is \$450 for one pediatric member and \$900 for two or more pediatric members.

Blue Dental <sup>™</sup> PPO 100/70/50 (80/60/50)		Blue Dental <sup>sM</sup> PPO Plus 80/60/50		Blue Dental <sup>™</sup> PPO Pediatric 80/50/50 (50/50/50)	
In network	Out of network	In network	Out of network	In network	Out of network
\$0/\$0/\$0	\$50/\$100/\$150	\$75/\$150/\$225	\$75/\$150/\$225	\$25/\$50/\$75	\$50/\$100/\$150
0%	20%	20%	20%	20%	50%
	Bitewing X-rays – c	one set (up to four) per ca	r; <b>Exams –</b> 2x per calend alendar year; <b>Fluoride</b> – 2 ınger when coverage be	2x per calendar year	
Bitewing X-ra	<b>ys –</b> one set (up to four) p	r; <b>Exams</b> – 2x per calendar year; ver calendar year; <b>Fluoride</b> – not covered be begins are considered nonpediatric.  Not covered		overed	
2004	100/	400/	400/	F00/	F00/
30%	Fillings – 1x per 2 Periodontal maint Simple extraction	24 months for primary tea t <b>enance –</b> 3x per calenda <b>s –</b> 1x per lifetime per to	nt molars, every three yeeth, 1x per 48 months for ar year in combination when coverage because here.	permanent teeth th routine cleaning r lifetime per tooth	50%
Periodontal ma Fillings – 1x per Simple extract Members 1	Fillings – 1x per 2 Periodontal maint Simple extraction Ped  intenance – 2x per calend Sealants – 124 months for primary tee ions – 1x per lifetime per to 9 or older when coverage waiting period on Class I	alants – 1x per permane 24 months for primary testenance – 3x per calenda s – 1x per lifetime per to iatric members 18 or you ar year in combination without covered; eth, 1x per 48 months for both; Root canals – 1x per to begins are considered all services for nonpediatr	nt molars, every three yeeth, 1x per 48 months for ar year in combination with the following the fol	ars permanent teeth th routine cleaning r lifetime per tooth gins.	overed
Periodontal ma Fillings – 1x per Simple extract Members 1	Fillings – 1x per 2 Periodontal maint Simple extraction Ped  intenance – 2x per calend Sealants – 124 months for primary tee ions – 1x per lifetime per to 9 or older when coverage waiting period on Class I	alants – 1x per permane 24 months for primary testenance – 3x per calenda s – 1x per lifetime per to iatric members 18 or you ar year in combination without covered; eth, 1x per 48 months for both; Root canals – 1x per te begins are considered in the considered in	nt molars, every three yeeth, 1x per 48 months for ar year in combination with the following the fol	ars permanent teeth th routine cleaning r lifetime per tooth gins.	
Periodontal ma Fillings – 1x per Simple extract Members 1	Fillings – 1x per 2 Periodontal maint Simple extraction Ped  intenance – 2x per calend Sealants – 124 months for primary tee ions – 1x per lifetime per to 9 or older when coverage waiting period on Class I	alants – 1x per permane 24 months for primary testenance – 3x per calenda s – 1x per lifetime per to iatric members 18 or you ar year in combination without covered; eth, 1x per 48 months for both; Root canals – 1x per to begins are considered all services for nonpediatr	nt molars, every three yeeth, 1x per 48 months for ar year in combination with the following the fol	ars permanent teeth th routine cleaning r lifetime per tooth gins.	
Periodontal ma Fillings – 1x per Simple extract Members 1 Six-month	Fillings – 1x per 2 Periodontal maint Simple extraction Ped  Intenance – 2x per calend Sealants – 1 24 months for primary tec ions – 1x per lifetime per to 9 or older when coverage waiting period on Class I except for emergence  50%  Ing and root planing – 1x Bridges a	alants – 1x per permane 24 months for primary teatenance – 3x per calendars – 1x per lifetime per to iatric members 18 or you ar year in combination without covered; eth, 1x per 48 months for both; Root canals – 1x per expenses begins are considered all services for nonpediatry palliative treatments	nt molars, every three yeeth, 1x per 48 months for ar year in combination wie oth; <b>Root canals</b> – 1x penger when coverage begath routine cleaning;  permanent teeth; lifetime per tooth monpediatric. ic members	ars permanent teeth th routine cleaning r lifetime per tooth gins.  Not co	overed 50%
Periodontal ma Fillings – 1x per Simple extract Members 1 Six-month  50%  Scal caling and root pl Bridges Members 19 or old	Fillings – 1x per 2 Periodontal maint Simple extraction Ped  intenance – 2x per calend Sealants – 1 24 months for primary tee ions – 1x per lifetime per to 9 or older when coverage waiting period on Class I except for emergence  50%  Ing and root planing – 1x Bridges a Ped  aning – 1x per quadrant,	alants – 1x per permane 24 months for primary teatenance – 3x per calendars – 1x per lifetime per to iatric members 18 or you ar year in combination without covered; eth, 1x per 48 months for both; Root canals – 1x per to begins are considered all services for nonpediatry palliative treatments  50%  x per quadrant, per 24 m and dentures – 1x every 8 iatric members 18 or you per 36 months; Onlays, 1 months; 84 months; Implants – not are considered nonpediated are considered nonpediated.	nt molars, every three yeeth, 1x per 48 months for ar year in combination with the following of the routine cleaning;  permanent teeth; lifetime per tooth monpediatric. ic members  50%  onths; Onlays, crowns, value months; Implants – not anger when coverage becomes, veneers – 1x ont covered iatric. Twelve-month	ars permanent teeth th routine cleaning r lifetime per tooth gins.  Not co	overed 50%

# Blue Dental members can choose from 3,600 dentists throughout Michigan.

Not covered

Out-of-pocket maximum applies only to essential health benefits provided by PPO (in-network) dentists for pediatric members. \*Services are subject to waiting periods as follows; Class II services = six-month waiting period for nonpediatric members.

<sup>\*</sup>Services are subject to waiting periods as follows; Class II services = six-month waiting period for nonpediatric members Class III services = Twelve-month waiting period for nonpediatric members.

<sup>\*\*</sup>The amount listed under "In network" is the total annual maximum available to members. The amount listed under "Out of network" is the portion of the total that can be used for services provided by non-PPO (out-of-network) dentists.

# Individual vision plan options

#### **Choosing your eye doctor**

Blue Cross members can purchase a packaged dental with adult vision plan, or a stand-alone adult vision plan by itself. (Kids 18 and younger get pediatric vision coverage with their Blue medical coverage.)

And, if you see a VSP Choice in-network eye doctor, you can save big on vision care. If you choose a provider who doesn't participate with VSP, you're responsible for additional charges. This may include the difference between our approved amount and the doctor's charge and copayments required by your plan.

Choosing a doctor who participates in the VSP Choice network is easy. Visit bcbsm.com, then click Find a Doctor. You can also call VSP member services at 1-800-877-7195. For Blue Cross® Vision Glasses and Contacts for Adults in the Heritage network, visit heritagevisionplans.com to find a provider.

#### Packaged individual dental and vision plans

	Packaged adult vision benefits  Benefits you receive if you purchase the following plans:  Blue Dental <sup>SM</sup> PPO 80/50/50 (50/50/50) with Vision Blue Dental <sup>SM</sup> PPO Plus 80/60/50 with Vision Blue Dental <sup>SM</sup> PPO 100/50/50 (50/50/50) with Vision Blue Dental <sup>SM</sup> PPO 100/70/50 (80/60/50) with Vision Blue Dental <sup>SM</sup> PPO 80/50/50 (0/0/0) with Vision	<b>Stand-alone adult vision benefits</b> Benefits you receive if you purchase the following plan: Blue Vision for Adults				
Network	VSP Choice	VSP Choice	Heritage Vision Plans			
Eligibility	Nonpediatric members 19 or older have coverage on the start date of the plan					
Benefits	Exams every 12 months					
	Lenses every 12 months					
	Frames every 24 months	Frames every 12 months				
Allowance	\$130 allowance for frames or elective contact lenses	\$150 allowance for frames or elective contact lenses	\$150 allowance for frames and \$150 allowance for elective contact lenses			
Copayments	\$10 exam, \$25 materials	\$15 exam, \$25 materials	\$5 exam, \$10 materials			
Notes	When purchasing a package, canceling dental will also cancel adult vision overage and vice versa	Two premium payment options - monthly & annually.				

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You can score big savings on a variety of health products and services with our member discount program, Blue365®. Get exclusive discounts on items, such as:

- Fitness and wellness: Health magazines, fitness gear and gym memberships
- Healthy eating: Meal delivery kits and weight-loss programs
- **Lifestyle:** Travel and recreation
- Personal care: LASIK and eye care services, dental care and hearing aids

Log in to your member account or visit **bcbsm.com/discounts** to learn more.

Blue365® is brought to you by the Blue Cross and Blue Shield Association, an association of independent, locally operated Blue Cross and Blue Shield plans. Value-added items and services are not a part of your insurance benefits and are not covered under contracts with Medicare or any other applicable federal health care program.

For complete terms and conditions see blue365deals.com/terms-use.



# Helpful links

Enroll in a Blue Cross or BCN plan

bcbsm.com/myblue • 1-877-4MY-BLUE (469-2583)

Eligible for savings?

bcbsm.com/subsidy

Find a doctor or hospital:

bcbsm.com/findcare

Find a dentist:

mibluedentist.com

Summary of benefits and coverage:

bcbsm.com/sbc

Billing, claims and benefits:

Look for the Customer Service number on the back of your member ID card

Pay my bill:

bcbsm.com/paybill bcbsm.com/payments

Search or select a primary care provider:

bcbsm.com/find-a-doctor

Virtual Care by Teladoc Health®:

http://www.teladochealth.com/BCBSMI

Download our Blue Cross mobile app at **bcbsm.com/app**. Use it to select your primary care provider and many more useful features.



To enroll in a plan, scan this code or go to bcbsm.com/myblue



#### 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 TTY:711 872-469-877، إذا لم تكن مشتر كا 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。

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 লা 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, ТТҮ: 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. Lafavette 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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: <a href="mailto:ocroomplaint@hhs.gov">ocroomplaint@hhs.gov</a>. Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.

#### YOU MADE THE RIGHT CHOICE





For cost information and to purchase your plans for 2026, scan the code or go to bcbsm.com/myblue.



Call us at 1-877-4MY-BLUE (469-2583), or contact your Blue Cross or BCN agent.



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