



## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-241-2583 Monday through Friday from 8 a.m. to 9 p.m. Eastern time, with weekend hours October 1 through March 31. TTY users should call 711.

If you are not a member of this plan, you can call 1-833-844-3871 Monday through Friday from 8 a.m. to 9 p.m. Eastern time, with weekend hours October 1 through March 31. TTY users should call 711.

### Understanding the Benefits

- ☐ The Evidence of Coverage provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **[bcbsm.com/medicare](https://bcbsm.com/medicare)** or call 1-877-241-2583 (TTY users call 711) to view a copy of the EOC.
- ☐ Review the provider/pharmacy directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the provider/pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

 **Effect on current coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.



**Blue Cross  
Blue Shield  
Blue Care Network**  
of Michigan

Nonprofit corporations and independent licensees  
of the Blue Cross and Blue Shield Association

# Medicare Plus Blue<sup>SM</sup> PPO Essential and +Meijer

## 2026 Individual Enrollment Form

Medicare PLUS Blue<sup>SM</sup> PPO



**Blue Cross  
Blue Shield**  
of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

### Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

### When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare or three months prior
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

### What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

### Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

### What happens next?

Send your completed and signed form to:

Medicare Plus Blue PPO  
P.O. Box 44256  
Detroit, MI 48244-0256

Once they process your request to join, they'll contact you.

### How do I get help with this form?

Call Medicare Plus Blue PPO at **1-833-844-3871**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a Medicare Plus Blue PPO al **1-833-844-3871 / 711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

### Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

#### IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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OMB No. 0938-1378

Expires: 12/31/2026

## Section 1 – All fields in this section are required (unless marked optional)

Select the Medicare Plus Blue plan you want to join.

☐ **Essential – \$25 per month**

Check here to enroll in Essential, serving Allegan, Barry, Berrien, Branch, Cass, Calhoun, Genesee, Gratiot, Hillsdale, Ionia, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Montcalm, Muskegon, Oakland, Ottawa, St. Clair, St. Joseph, Van Buren, Washtenaw, and Wayne counties.

☐ **+Meijer – \$35 per month**

Check here to enroll in +Meijer, serving Allegan, Alpena, Bay, Berrien, Branch, Calhoun, Chippewa, Clinton, Delta, Eaton, Emmet, Genesee, Grand Traverse, Gratiot, Hillsdale, Ingham, Ionia, Isabella, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Manistee, Marquette, Mason, Mecosta, Midland, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Ogemaw, Otsego, Ottawa, Saginaw, Shiawassee, St. Clair, St. Joseph, Van Buren, Washtenaw, Wayne and Wexford counties.

To add the PPO Optional Supplemental Dental and Vision plan, check box:

☐ Available for an **additional \$30.50 per month.**

|            |           |                           |
|------------|-----------|---------------------------|
| First name | Last name | (Optional) Middle initial |
|------------|-----------|---------------------------|

|                         |                                                              |              |
|-------------------------|--------------------------------------------------------------|--------------|
| Birth date (mm/dd/yyyy) | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Phone number |
|-------------------------|--------------------------------------------------------------|--------------|

Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

|      |                   |       |          |
|------|-------------------|-------|----------|
| City | (Optional) County | State | ZIP code |
|------|-------------------|-------|----------|

Mailing address, if different from your permanent address (PO Box allowed)

|                |      |       |          |
|----------------|------|-------|----------|
| Street address | City | State | ZIP code |
|----------------|------|-------|----------|

Email address (optional)

### Your Medicare information

Medicare number: \_\_\_\_\_

### Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Medicare Plus Blue?

☐ Yes ☐ No

Name of other coverage: \_\_\_\_\_ Member number for this coverage: \_\_\_\_\_ Group number for this coverage: \_\_\_\_\_

**Special enrollment periods: Please check the box that applies to you.**

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of the annual enrollment period. **Please read the following statements carefully and check the box if the statement applies to you.** By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (Date of Medicare Entitlement Letter) \_\_\_\_\_.
- ☐ I had Medicare prior to now, but I'm now turning 65.
- ☐ Between 1/1-3/31: I'm in a Medicare Advantage Plan and want to make a change.
- ☐ Between 4/1-12/31: I'm in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date). \_\_\_\_\_.
- ☐ I recently was released from incarceration. I was released on (insert date) \_\_\_\_\_.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) \_\_\_\_\_.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) \_\_\_\_\_.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) \_\_\_\_\_.
- ☐ I am moving into a long-term care facility, like a nursing home or rehabilitation hospital. I will move into the facility on (insert date) \_\_\_\_\_.
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital. I moved out of the facility on (insert date) \_\_\_\_\_.
- ☐ I recently left a PACE program on (insert date) \_\_\_\_\_.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_.
- ☐ I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- ☐ I belong to a pharmacy assistance program provided by my state.

### Special enrollment periods *(continued)*

- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) \_\_\_\_\_.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) \_\_\_\_\_.
- ☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan. My plan went into receivership on (insert date) \_\_\_\_\_.
- ☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- ☐ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare Drug Plan (Part D) or Medicare Advantage Plan with drug coverage.
- ☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ Other

If none of these statements applies to you or you're not sure, please contact Medicare Plus Blue PPO at **1-833-844-3871** (TTY users call **711**) to see if you are eligible to enroll. We are open from 8 a.m. to 9 p.m. Eastern time Monday through Friday, with weekend hours Oct. 1 through March 31.

**IMPORTANT: Read and sign below**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Medicare Plus Blue PPO.
- By joining this Medicare Advantage Plan, I acknowledge that Medicare Plus Blue PPO will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Medicare Plus Blue PPO coverage begins, I must get all my medical and prescription drug benefits from Medicare Plus Blue. Benefits and services provided by Medicare Plus Blue PPO and contained in my Medicare Plus Blue PPO *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Medicare Plus Blue PPO will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under state law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

**Signature****Today's date****If you're the authorized representative, sign above and fill out these fields:**

Name

Address

Phone number

Relationship to enrollee

## Section 2 – All fields in this section are optional

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Select one if you want us to send you information in a language other than English.

☐ English (default)      ☐ Spanish      ☐ Other (language other than English)

Select one if you want us to send you information in an accessible format.

☐ Large print      ☐ Audio CD      ☐ Data CD

Please contact Medicare Plus Blue PPO at **1-877-241-2583** (TTY users call **711**) if you need information in an accessible format or language other than what's listed above. Our office hours are from 8 a.m. to 9 p.m. Monday through Friday, with weekend hours from October 1 through March 31.

Do you work?      ☐ Yes    ☐ No

Does your spouse work?      ☐ Yes    ☐ No

Please list your primary care physician (PCP), clinic or health center:

## Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently owe) by mail, phone, online or automatic withdrawal from your bank account each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare or the RRB. **DON'T** pay Medicare Plus Blue PPO the Part D-IRMAA.

### Please select a premium payment option:

☐ Get a bill each month.

You may choose from the following payment methods:

- **Pay online:** To learn how to pay your premium online, go to **bcbsm.com/paymedicare**. Members can make one-time payments or set up automatic withdrawals from a bank account or credit/debit card.
- **Pay by phone:** To make a one-time payment or set up an automatic withdrawal from a bank account or credit/debit card, call Customer Service at **1-877-241-2583**, 8 a.m. to 9 p.m. Eastern time Monday through Friday, with weekend hours from October 1 through March 31. TTY users call **711**.
- **Pay by mail:** Mail your check, cashier's check or money order made payable to:  
Blue Cross Blue Shield of Michigan  
P.O. Box 553912  
Detroit, Michigan 48255-3912

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or the RRB approves the deduction. Please pay any premium bills prior to your Social Security/Railroad Retirement Board deduction effective date. If Social Security/the RRB doesn't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums.)

## For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agent, broker, SHIP counselor, family member, or other third party) helping an enrollee fill out this form.

|           |                                                |
|-----------|------------------------------------------------|
| Name      | Relationship to enrollee                       |
| Signature | National Producer Number (Agents/Brokers only) |

**AGENT/OFFICE USE ONLY (Applicants do not complete this section)**

**Note to producing agents:** Paper enrollment forms must be keyed in by logging into the BCBSM Agent Portal at **bcbsm.com/agents/** or submitted to the general agent within 24 hours of accepting the paper enrollment form.

Date producing agent accepted paper enrollment from Medicare eligible: \_\_\_\_\_

Date managing or general agent or association received  
paper enrollment form from producing agent: \_\_\_\_\_

Name of managing/general agent or association: \_\_\_\_\_

Name of producing agent (print first/last names): \_\_\_\_\_  
*First name* *Last name*

Signature of producing agent: \_\_\_\_\_

Email of producing agent: \_\_\_\_\_

2-digit managing or general agent or association code: \_\_\_\_/\_\_\_\_/

5-digit producing agent code: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of person entering enrollment information online (print first/last names):

\_\_\_\_\_  
*First name*

\_\_\_\_\_  
*Last name*

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

2026

READY  
TO HELP



## Medicare Plus Blue<sup>SM</sup> PPO Essential, +Meijer

### Summary of Benefits

To get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back cover of this booklet).

To join Medicare Plus Blue PPO Essential or +Meijer, you must have both Medicare Part A and Medicare Part B, be a United States citizen or lawfully present in the United States and live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. Our service area includes the state of Michigan.

[www.bcbsm.com/medicare](http://www.bcbsm.com/medicare)

Blue Cross Blue Shield of Michigan is a PPO plan with a Medicare contract.  
Enrollment in Blue Cross Blue Shield of Michigan depends on contract renewal.

Medicare Plus Blue PPO Essential and +Meijer have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at [www.bcbsm.com/medicare](http://www.bcbsm.com/medicare).

Out-of-network/non-contracted providers are under no obligation to treat Medicare Plus Blue PPO Essential or +Meijer members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

## Premium/Cost-sharing Table for Medicare Plus Blue Essential and +Meijer PPO

Premiums per plan and by region in which you permanently reside are listed in the chart below. You must continue to pay your Medicare Part B premium. **For Essential, a Medicare Part B premium reduction is provided (Region 1 = \$9.20, Region 2 = \$20.10, Region 4 = \$15.10, Region 6 = \$10.90). For +Meijer, a Medicare Part B premium reduction is provided (Region 1 = \$11.90, Region 2 = \$22.70, Region 3 = \$16.70, Region 4 = \$17.70, Region 6 = \$15.90).**

- 1) Find the county and region that you live in.
- 2) Look across the plan option columns to find your monthly premium rate.

| Regions with counties                                                                                                                                                                                                                                                                                          | Medicare Plus Blue Essential premium rates per month | Medicare Plus Blue + Meijer premium rates per month |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|
| <b>Region 1</b><br><u><b>Essential</b></u><br>Allegan, Barry, Ionia, Kalamazoo, Muskegon and Ottawa counties<br><u><b>+Meijer</b></u><br>Allegan, Ionia, Kalamazoo, Mason, Muskegon, Newaygo and Ottawa counties                                                                                               | \$25                                                 | \$35                                                |
| <b>Region 2</b><br><u><b>Essential</b></u><br>Berrien, Branch, Calhoun, Gratiot, Hillsdale, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties<br><u><b>+Meijer</b></u><br>Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties | \$25                                                 | \$35                                                |
| <b>Region 3</b><br><u><b>Essential</b></u><br>Not offered<br><u><b>+Meijer</b></u><br>Alpena, Bay, Chippewa, Ogemaw, Saginaw and Shiawassee counties                                                                                                                                                           | Not offered                                          | \$35                                                |
| <b>Region 4</b><br><u><b>Essential</b></u><br>Cass, Genesee, Kent, Lenawee, Livingston and St. Clair counties<br><u><b>+Meijer</b></u><br>Clinton, Delta, Emmet, Genesee, Grand Traverse, Isabella, Kent, Lenawee, Livingston, Manistee, Marquette, Mecosta, Midland, Otsego, St. Clair and Wexford counties   | \$25                                                 | \$35                                                |

| Regions with counties                                                                                   | Medicare Plus Blue Essential premium rates per month | Medicare Plus Blue + Meijer premium rates per month |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|
| <b>Region 6</b><br><u><b>Essential and +Meijer</b></u><br>Macomb, Oakland, Washtenaw and Wayne counties | \$25                                                 | \$35                                                |
| <b>Optional Supplemental Dental and Vision</b>                                                          | \$30.50 (additional monthly premium)                 |                                                     |

Region 5 is not being used at this time.

|                                                                                             | Medicare Plus Blue Essential                                                                                                                         | Medicare Plus Blue + Meijer                                                                                                                          |
|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b>                                                                           | This plan does not have a deductible for hospital and medical services.<br><br>\$150 deductible for Tiers 3, 4, and 5 for Part D prescription drugs. | This plan does not have a deductible for hospital and medical services.<br><br>\$150 deductible for Tiers 3, 4, and 5 for Part D prescription drugs. |
| <b>Maximum Out-of-Pocket Responsibility</b><br><i>(does not include prescription drugs)</i> | \$6,250 for services from in-network providers<br>\$6,250 for services from any provider                                                             | \$6,750 for services from in-network providers<br>\$6,750 for services from any provider                                                             |

| Benefits                                                                                                             | Medicare Plus Blue Essential                                                                                                                          | Medicare Plus Blue + Meijer                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Note:</b> Services with a <sup>1</sup> may require prior authorization                                            |                                                                                                                                                       |                                                                                                                                                       |
| <b>Inpatient Hospital Coverage<sup>1</sup></b><br>Our plan covers an unlimited number of days for an inpatient stay. | <b>In-network:</b><br>\$350 copay per day for days 1-7, per admission<br>\$0 copay for days 8-90<br><b>Out-of-network:</b><br>50% of approved amount  | <b>In-network:</b><br>\$325 copay per day for days 1-7, per admission<br>\$0 copay for days 8-90<br><b>Out-of-network:</b><br>50% of approved amount  |
| <b>Outpatient Hospital Coverage<sup>1</sup></b>                                                                      | <b>In-network:</b><br>\$125 copay for non-surgical services.<br>\$350 copay for surgical services<br><b>Out-of-network:</b><br>50% of approved amount | <b>In-network:</b><br>\$150 copay for non-surgical services.<br>\$375 copay for surgical services<br><b>Out-of-network:</b><br>50% of approved amount |
| <b>Ambulatory Surgical Center (ASC) Services<sup>1</sup></b>                                                         | <b>In-network</b><br>\$0 copay for Medicare-covered arthroplasty knee and hip services in an ASC                                                      |                                                                                                                                                       |
|                                                                                                                      | \$100 for non-surgical services<br>\$250 for surgical services<br><b>Out-of-network:</b><br>50% of the approved amount                                | \$125 for non-surgical services<br>\$325 for surgical services<br><b>Out-of-network</b><br>50% of the approved amount                                 |

| Benefits                                                                                                                      | Medicare Plus Blue<br>Essential                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Medicare Plus Blue +<br>Meijer                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Doctor Visits</b> <ul style="list-style-type: none"> <li>Primary</li> <li>Specialists</li> <li>Telehealth</li> </ul>       | <b>In-network:</b><br>\$0<br><br><b>Out-of-network:</b><br>\$25 copay<br><br><b>In-network:</b><br>\$45 copay<br><br><b>Out-of-network:</b><br>\$50 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>In-network:</b><br>\$0 copay<br><br><b>Out-of-network:</b><br>\$0 copay<br><br><b>In-network:</b><br>\$50 copay<br><br><b>Out-of-network:</b><br>\$55 copay |
| <b>Preventive Care</b><br>(Any additional preventive services approved by Medicare during the contract year will be covered.) | <b>In- and Out-of-network: \$0</b><br><br>Our plan covers many preventive services, including: <ul style="list-style-type: none"> <li>Abdominal aortic aneurysm screening</li> <li>Alcohol misuse counseling</li> <li>Annual physical exam</li> <li>Annual wellness visit</li> <li>Bone mass measurement</li> <li>Breast cancer screening (mammogram)</li> <li>Cardiovascular disease risk reduction visit</li> <li>Cardiovascular disease testing</li> <li>Cervical and vaginal cancer screening</li> <li>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>Depression screening</li> <li>Diabetes screenings</li> <li>Diabetes self-management training</li> <li>Glaucoma screening</li> <li>HIV screening</li> <li>Immunizations, including COVID-19, flu, hepatitis B, and pneumococcal vaccines</li> <li>Medical nutrition therapy services</li> <li>Medicare Diabetes Prevention Program (MDPP)</li> <li>Obesity screening and counseling</li> <li>Pre-exposure prophylaxis (PrEP) for HIV prevention</li> <li>Prostate cancer screenings (PSA)</li> </ul> |                                                                                                                                                                |

| Benefits                                                                                                                                                                                                                                                                                                         | Medicare Plus Blue<br>Essential                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Medicare Plus Blue +<br>Meijer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Preventive Care<br/>(Continued)</b>                                                                                                                                                                                                                                                                           | <ul style="list-style-type: none"> <li>• Screening for lung cancer with low-dose computed tomography (LDCT)</li> <li>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</li> <li>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</li> <li>• “Welcome to Medicare” preventive visit (one-time)</li> </ul>                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Emergency Care</b><br>You are covered for emergency medical care worldwide.                                                                                                                                                                                                                                   | <p style="text-align: center;">\$130 copay</p> <p><b>Note:</b> The copay is waived if you are admitted to the hospital within three days for the same condition.</p>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Urgently Needed Services</b><br>You are covered for urgently needed services worldwide                                                                                                                                                                                                                        | <p style="text-align: center;">\$50 copay at urgent care center<br/>\$0 copay at primary care physician’s office</p>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Diagnostic Services/Labs/<br/>Imaging<sup>1</sup></b> <ul style="list-style-type: none"> <li>○ Diagnostic radiology services</li> <li>○ Lab services</li> <li>○ Diagnostic tests and procedures including COVID -19 testing</li> <li>○ Outpatient X-rays</li> <li>○ Therapeutic radiology services</li> </ul> | <p><b>In-network:</b><br/>\$100-\$150 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> <p><b>In-network:</b><br/>\$0-\$40 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> <p><b>In-network:</b><br/>\$0-\$150 copay</p> <p><b>Out-of-network:</b><br/>\$0-\$50/50% of approved amount</p> <p><b>In-network:</b><br/>\$35-\$150 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> <p><b>In-network:</b><br/>\$35 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> | <p><b>In-network:</b><br/>\$150-\$250 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> <p><b>In-network:</b><br/>\$0-\$40 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> <p><b>In-network:</b><br/>\$0-\$150 copay</p> <p><b>Out-of-network:</b><br/>\$55 copay</p> <p><b>In-network:</b><br/>\$35-\$150 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> <p><b>In-network:</b><br/>\$35 copay</p> <p><b>Out-of-network:</b><br/>50% of the approved amount</p> |

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Medicare Plus Blue<br>Essential                                                                                                                                                                                                          | Medicare Plus Blue +<br>Meijer                                                                                                                                                                                                                                                                                                                                                                              |
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| <p><b>Hearing Services</b></p> <p><b>Medicare-covered hearing services</b></p> <ul style="list-style-type: none"> <li>Hearing exam to diagnose and treat hearing and balance issues</li> </ul> <p><b>Non-Medicare-covered hearing services</b></p> <p><b>Must be received from a TruHearing® provider.</b></p> <ul style="list-style-type: none"> <li>Routine hearing exam (1 every year)</li> <li>Hearing aid fitting/evaluation (1 every year)</li> <li>Hearing aids (1 per ear, per year) from applicable TruHearing catalog</li> </ul> <p>All content © 2026 TruHearing, Inc. All Rights Reserved. TruHearing® is a registered trademark of TruHearing, Inc.</p> | <p><b>In-network:</b><br/>\$0-\$45 copay</p> <p><b>Out-of-network:</b><br/>\$50 copay</p> <p>Not offered</p>                                                                                                                             | <p><b>In-network:</b><br/>\$0-\$50 copay</p> <p><b>Out-of-network:</b><br/>\$55 copay</p> <p><b>In-network:</b><br/>\$0 copay</p> <p><b>In-network:</b><br/>\$0 copay</p> <p>\$495 copay per aid for Basic Aids</p> <p>\$895 copay per aid for Standard Aids</p> <p>\$1,295 copay per aid for Advanced Aids</p> <p>\$1,695 copay per aid for Premium Aids</p> <p><b>Out-of-network:</b><br/>Not offered</p> |
| <p><b>Dental Services (Medicare-covered)</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p><b>In-network:</b><br/>\$0-\$45 copay</p> <p><b>Out-of-network:</b><br/>\$50 copay</p>                                                                                                                                                | <p><b>In-network:</b><br/>\$0-\$50 copay</p> <p><b>Out-of-network:</b><br/>\$55 copay</p>                                                                                                                                                                                                                                                                                                                   |
| <p><b>Enhanced dental services (Preventive and Comprehensive)</b></p> <ul style="list-style-type: none"> <li>Preventive Services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment</li> <li>Comprehensive Services include brush biopsies, resin and amalgam fillings, crowns for permanent teeth only, crown repairs, root canals, deep cleaning, extractions and oral surgery</li> </ul>                                                                                                                                                                                                                                         | <p>This benefit provides a \$950 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.</p> <p><b>In-network:</b><br/>\$0 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p> | <p>This benefit provides a \$1,000 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.</p> <p><b>In-network:</b><br/>\$0 copay</p> <p><b>Out-of-network:</b><br/>50% of approved amount</p>                                                                                                                                                                  |

| Benefits                                                                                                                                                                                                                                                                                                                                              | Medicare Plus Blue<br>Essential                                                                                                                                                                                                                                                                 | Medicare Plus Blue +<br>Meijer                                                        |
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| <b>Optional Supplemental Dental (available for additional monthly premium)</b><br>Includes, but not limited to, dentures, bridges, onlays and implants                                                                                                                                                                                                | The benefit provides a \$1,500 combined in- and out-of-network annual maximum (in addition to the enhanced dental annual maximum) for comprehensive dental services.<br>No deductible.<br><br><b>In-network:</b><br>25% coinsurance<br><br><b>Out-of-network:</b><br>50% of the approved amount |                                                                                       |
| <b>Vision Services (Medicare-covered)</b> <ul style="list-style-type: none"> <li>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).</li> <li>Screening for diabetic retinopathy is covered once per year for those at risk.</li> <li>Eyeglasses or contact lenses after cataract surgery</li> </ul> | <b>In-network:</b><br>\$0-\$45 copay<br><br><b>Out-of-network:</b><br>\$50 copay                                                                                                                                                                                                                | <b>In-network:</b><br>\$0-\$50 copay<br><br><b>Out-of-network:</b><br>\$55 copay      |
|                                                                                                                                                                                                                                                                                                                                                       | <b>In-network:</b><br>\$0<br><br><b>Out-of-network:</b><br>50% of the approved amount                                                                                                                                                                                                           | <b>In-network:</b><br>\$0<br><br><b>Out-of-network:</b><br>50% of the approved amount |

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Medicare Plus Blue<br>Essential                                                         | Medicare Plus Blue +<br>Meijer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <b>Enhanced Vision Services</b> <ul style="list-style-type: none"> <li>○ Routine eye exam through VSP Choice Network, one per calendar year</li> <li>○ Eyewear - Eligible for one each calendar year: <ul style="list-style-type: none"> <li>○ Elective contacts, OR</li> <li>○ One pair standard lenses, OR</li> <li>○ One frame OR</li> <li>○ One complete pair of eyeglasses (excludes Essential)</li> </ul> </li> </ul> <p>For a complete pair of eyeglasses, the maximum allowance is used toward the frame only.</p> | <b>In-network:</b><br>\$0 copay<br><br><b>Out-of-network:</b><br>50% of approved amount |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Not offered                                                                             | <b>In-network:</b><br>\$0 copay for standard eyeglass lenses<br><br><b>Out-of-network:</b><br>50% of the approved amount for standard eyeglass lenses<br><br><b>In-network:</b><br>Eyewear benefit provides a combined in- and out-of-network maximum up to \$100 every calendar year and may be used for either (a) elective contact lenses or (b) one frame.<br><br>One pair of standard eyeglass lenses is covered in full every calendar year.<br><br><b>Out-of-network:</b><br>Eyewear benefit provides a combined in- and out-of-network maximum with 50% of allowed amounts up to \$100 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame.<br><br>Standard eyeglass lenses are reimbursed up to 50% of the allowed amount |

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Medicare Plus Blue<br>Essential                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Medicare Plus Blue +<br>Meijer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| <p><b>Optional Supplemental Vision (available for additional monthly premium)</b></p> <p>You are eligible for ONE of the following, every calendar year:</p> <ul style="list-style-type: none"> <li>○ Elective contact lenses OR</li> <li>○ One pair of standard eyeglass lenses OR</li> <li>○ One frame OR</li> <li>○ One complete pair of eyeglasses</li> </ul> <p>For a complete pair of eyeglasses, the allowance can be used for the frame only.</p> <p>Routine vision care must be from a participating VSP Choice Network provider. To locate a VSP Choice Network provider, call 1-800-877-7195 from 8 a.m. to 11 p.m. Eastern time, Monday through Saturday, hearing impaired users call 711, or visit <a href="http://www.vsp.com">www.vsp.com</a>.</p> | <p><b>In-network:</b></p> <p>The optional eyewear benefit provides a \$250 combined in- and out-of-network maximum once every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame.</p> <p>Includes lens options: polycarbonate lenses and anti reflective coating.</p> <p><b>Out-of-network:</b></p> <p>The benefit provides a combined in- and out-of-network benefit maximum with 50% coinsurance up to \$250 every calendar year and may be used for either (a) elective contact lenses or (b) frames.</p> <p>For out-of-network services, you may be required to pay the cost up front and submit for reimbursement. Other limitations apply.</p> | <p><b>In-network:</b></p> <p>The optional eyewear benefit provides a \$250 combined in and out-of-network maximum (in addition to the enhanced vision benefit) once every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame.</p> <p>Includes lens options: polycarbonate lenses and anti reflective coating.</p> <p>Standard eyeglass lenses are covered in full every calendar year as part of the Enhanced Vision benefit.</p> <p><b>Out-of-network:</b></p> <p>The benefit provides (in addition to the Enhanced vision benefit) a combined in- and out-of-network benefit maximum with 50% coinsurance up to \$250 every calendar year and may be used for either (a) elective contact lenses or (b) frames</p> <p>For out-of-network services, you may be required to pay the cost up front and submit for reimbursement. Other limitations apply.</p> |
| <p><b>Inpatient Mental Health Care<sup>1</sup></b></p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p><b>In-network:</b></p> <p>\$300 copay per day for days 1-7, per admission</p> <p>\$0 days 8-90</p> <p><b>Out-of-network:</b></p> <p>50% of approved amount</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p><b>In-network:</b></p> <p>\$325 copay per day for days 1-7, per admission</p> <p>\$0 per day for days 8-90</p> <p><b>Out-of-network:</b></p> <p>50% of approved amount</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p><b>Outpatient Mental Health Care</b></p> <p>Individual and group therapy</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p><b>In-network:</b></p> <p>\$20 copay</p> <p><b>Out-of-network:</b></p> <p>50% of approved amount</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p><b>In-network:</b></p> <p>\$20 copay</p> <p><b>Out-of-network:</b></p> <p>\$55 copay</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| Benefits                                                                                                                                                                                         | Medicare Plus Blue<br>Essential                                                                                                                                        | Medicare Plus Blue +<br>Meijer                                                                                                               |
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| <b>Skilled Nursing Facility (SNF)<sup>1</sup></b><br>Our plan covers up to 100 days in a SNF.<br><br>No prior hospital stay is required for a skilled nursing facility stay.                     | <b>In-network:</b><br>\$0 for days 1-20<br>\$218 for days 21-100<br><br><b>Out-of-network:</b><br>50% of approved amount                                               |                                                                                                                                              |
| <b>Outpatient Rehabilitation</b><br>Physical/Speech/<br>Occupational therapy                                                                                                                     | <b>In-network:</b><br>\$45 copay<br><br><b>Out-of-network:</b><br>50% of approved amount                                                                               | <b>In-network:</b><br>\$50 copay<br><br><b>Out-of-network:</b><br>50% of approved amount                                                     |
| <b>Ambulance Services</b> <ul style="list-style-type: none"> <li>Ground or air transportation</li> <li>Ambulance services without transportation</li> </ul>                                      | <b>In- and Out-of-Network</b><br>\$350 copay<br><br><b>In-network:</b><br>\$90 copay<br><br><b>Out-of-network:</b><br>50% of approved amount                           | <b>In- and Out-of-Network</b><br>\$350 copay<br><br><b>In-network:</b><br>\$90 copay<br><br><b>Out-of-network:</b><br>50% of approved amount |
| <b>Transportation</b>                                                                                                                                                                            | Not offered                                                                                                                                                            |                                                                                                                                              |
| <b>Medicare Part B Drugs<sup>1</sup></b> <ul style="list-style-type: none"> <li>Medicare Part B Insulin Drugs (one-month's supply)</li> <li>Chemotherapy drugs and other Part B drugs</li> </ul> | <b>In-network:</b><br>0% - 20% coinsurance<br><br><b>Out-of-network:</b><br>0% - 50% coinsurance<br><br><b>In- and Out-of-network:</b><br>Not more than \$35 per month |                                                                                                                                              |
|                                                                                                                                                                                                  | <b>In-network:</b><br>0% - 20% coinsurance<br><br><b>Out-of-network:</b><br>0% - 50% coinsurance                                                                       |                                                                                                                                              |

| Benefits                                                                                                                                                                                                                                                                             | Medicare Plus Blue<br>Essential                                                                                                                                                                                                                                                                                             | Medicare Plus Blue +<br>Meijer                                    |
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| <b>Medical Equipment/<br/>Supplies<sup>1</sup></b> <ul style="list-style-type: none"> <li>○ Durable Medical Equipment</li> <li>○ Prosthetics and Orthotics/<br/>Medical supplies</li> <li>○ Diabetes supplies</li> </ul>                                                             | <p><b>In-network:</b><br/>0%-20%</p> <p><b>Out-of-network:</b><br/>0%-50%</p> <p><b>In-network:</b><br/>20% of the approved amount</p> <p><b>Out-of-network:</b><br/>50% of the approved amount</p> <p><b>In-network:</b><br/>0% - 20% of approved amount</p> <p><b>Out-of-network:</b><br/>0% - 40% of approved amount</p> |                                                                   |
| <b>Health fitness program<br/>(SilverSneakers®)</b><br><br>SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.                                                                                                           | Not offered                                                                                                                                                                                                                                                                                                                 | <b>In-network:</b><br>You pay \$0 for the health fitness program. |
| <b>Over-the-Counter (OTC)<br/>Allowance: Advantage<br/>Dollars</b><br><br>Over-the-Counter (OTC) items are drugs and health-related products that do not need a prescription. This benefit covers certain approved non-prescription over-the-counter drugs and health-related items. | <b>Allowance Amount</b>                                                                                                                                                                                                                                                                                                     |                                                                   |
|                                                                                                                                                                                                                                                                                      | Not offered                                                                                                                                                                                                                                                                                                                 | You receive \$60 per quarter.                                     |
|                                                                                                                                                                                                                                                                                      | An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will <u>not</u> carry forward into the next quarter or the next calendar year.<br><br>Note: All purchases must be made through plan-approved retailers                                                                           |                                                                   |

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Medicare Plus Blue<br>Essential | Medicare Plus Blue +<br>Meijer                                                                                                                                                                                                             |
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| <p><b>Special supplemental benefits for the chronically ill</b></p> <p><b>Food and Produce Allowance</b></p> <p>This benefit will be available to plan-identified members with a history of one or more specified chronic conditions.</p> <ul style="list-style-type: none"> <li>• Autoimmune disorders including polyarteritis nodosa, polymyalgia rheumatica, polymyositis, dermatomyositis, rheumatoid arthritis, systemic lupus erythematosus, psoriatic arthritis and scleroderma</li> <li>• Cancer</li> <li>• Cardiovascular disorders including cardiac arrhythmias, coronary artery disease, peripheral vascular disease and valvular heart disease</li> <li>• Chronic alcohol use disorder and other substance use disorders (SUDs)</li> <li>• Chronic and disabling mental health conditions including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder (PTSD), eating disorders and anxiety disorders</li> </ul> | <p>Not offered</p>              | <p>You receive \$60 per quarter.</p> <p>Your OTC account will be loaded automatically with the above amount on January 1, April 1, July 1 and October 1. Unused amounts will <u>not</u> carry over quarter to quarter or year to year.</p> |

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Medicare Plus Blue<br>Essential | Medicare Plus Blue +<br>Meijer |
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| <p><b>Special supplemental benefits for the chronically ill (continued)</b></p> <ul style="list-style-type: none"> <li>• Chronic gastrointestinal disease including chronic liver disease, (non-alcoholic fatty liver disease (NAFLD), hepatitis B, hepatitis C, pancreatitis, irritable bowel syndrome, inflammatory bowel disease</li> <li>• Chronic heart failure</li> <li>• Chronic hypertension</li> <li>• Chronic kidney disease (CKD) including CKD requiring dialysis/End-stage renal disease (ESRD) and CKD not requiring dialysis</li> <li>• Chronic lung disorders including cystic fibrosis, emphysema, pulmonary fibrosis, pulmonary hypertension and chronic obstructive pulmonary disease (COPD)</li> <li>• Conditions with functional challenges including spinal cord injuries, paralysis, limb loss, stroke and arthritis</li> <li>• Dementia</li> <li>• Diabetes Mellitus</li> <li>• HIV/AIDS</li> </ul> |                                 |                                |

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Medicare Plus Blue<br>Essential | Medicare Plus Blue +<br>Meijer |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------|
| <p><b>Special supplemental benefits for the chronically ill</b> (continued)</p> <ul style="list-style-type: none"> <li>• Neurologic disorders including amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, multiple sclerosis, Parkinson's disease, polyneuropathy, fibromyalgia, chronic fatigue syndrome, spinal cord injuries, spinal stenosis and stroke-related neurologic deficit</li> <li>• Pre-diabetes</li> <li>• Severe hematologic disorders including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait) and chronic venous thromboembolic disorder.</li> </ul> <p><b>Note:</b> This benefit works with the over-the-counter (OTC) Advantage Dollars allowance and is limited to the maximum OTC allowance amount.</p> <p>See Chapter 4, Section 2.1 Over-the-Counter Allowance (OTC): Advantage Dollars for more information.</p> |                                 |                                |

## Essential

### Medicare Part D: Prescription Drugs

Costs may differ based on pharmacy type (standard, preferred or mail-order).  
Your provider may need to obtain prior authorization.

#### Stage 1: Annual Deductible

No deductible for Tiers 1 and 2. \$150 total deductible per year for Tiers 3, 4 and 5.  
Deductible does not apply to insulins.

#### Phase 2: The Initial Coverage Stage

You pay the amounts listed in the table below until your out-of-pocket costs reach \$2,100.

|                                      | Standard retail and standard mail-order cost sharing (in-network) 31-day supply                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply | Standard retail and standard mail-order cost sharing (in-network) 32- to 90-day supply | Preferred retail and mail-order cost sharing (in-network) 32- to 90-day supply |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Tier 1: Preferred Generic            | \$5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0                                                                               | \$15                                                                                   | \$0                                                                            |
| Tier 2: Generic                      | \$10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$5                                                                               | \$30                                                                                   | \$0                                                                            |
| Tier 3: Preferred Brand              | 20%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 20%                                                                               | 20%                                                                                    | 20%                                                                            |
| Tier 4: Non-Preferred Drugs          | 25%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 25%                                                                               | 25%                                                                                    | 25%                                                                            |
| Tier 5: Specialty                    | 31%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31%                                                                               | Not offered                                                                            | Not offered                                                                    |
| Phase 3: Catastrophic Coverage Stage | <p>You won't pay more than \$35 for a 31-day supply and no more than \$105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier. You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay \$0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your <i>Evidence of Coverage</i>. You can also see our plan's pharmacy directory at our website <a href="http://www.bcbsm.com/pharmaciesmedicare">www.bcbsm.com/pharmaciesmedicare</a>. For the most current information about covered drugs visit (<a href="http://www.bcbsm.com/formularymedicare">www.bcbsm.com/formularymedicare</a>).</p> |                                                                                   |                                                                                        |                                                                                |

### Medicare Part D: Prescription Drugs

Costs may differ based on pharmacy type (standard, preferred or mail-order).  
Your provider may need to obtain prior authorization.

#### Phase 1: The Deductible Stage

No deductible for Tiers 1 and 2. \$150 total deductible per year for Tiers 3, 4 and 5.  
Deductible does not apply to insulins.

#### Phase 2: The Initial Coverage Stage

You pay the amounts listed in the table below until your out-of-pocket costs reach \$2,100.

|                                      | Standard retail and standard mail-order cost sharing (in-network) 31-day supply                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply | Standard retail and standard mail-order cost sharing (in-network) 32- to 90-day supply | Preferred retail and mail-order cost sharing (in-network) 32- to 90-day supply |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Tier 1: Preferred Generic            | \$5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0                                                                               | \$15                                                                                   | \$0                                                                            |
| Tier 2: Generic                      | \$12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$7                                                                               | \$36                                                                                   | \$0                                                                            |
| Tier 3: Preferred Brand              | 20%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 20%                                                                               | 20%                                                                                    | 20%                                                                            |
| Tier 4: Non-Preferred Drug           | 30%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 30%                                                                               | 30%                                                                                    | 30%                                                                            |
| Tier 5: Specialty Tier               | 31%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31%                                                                               | Not offered                                                                            | Not offered                                                                    |
| Phase 3: Catastrophic Coverage Stage | <p>You won't pay more than \$35 for a 31-day supply and no more than \$105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier. You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay \$0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your <i>Evidence of Coverage</i>. You can also see our plan's pharmacy directory at our website <a href="http://www.bcbsm.com/pharmaciesmedicare">www.bcbsm.com/pharmaciesmedicare</a>. For the most current information about covered drugs visit (<a href="http://www.bcbsm.com/formularymedicare">www.bcbsm.com/formularymedicare</a>).</p> |                                                                                   |                                                                                        |                                                                                |

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **[www.bcbsm.com/medicare](http://www.bcbsm.com/medicare)**.

*Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.*

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**[www.bcbsm.com/pharmaciesmedicare](http://www.bcbsm.com/pharmaciesmedicare)**).

You can see the most complete and current information about which drugs are covered on our website (**[www.bcbsm.com/formularymedicare](http://www.bcbsm.com/formularymedicare)**).

For more information, please call us at the phone number below or visit us at [www.bcbsm.com/medicare](http://www.bcbsm.com/medicare).

If you are not a member of this plan, call toll-free 1-888-563-3307. TTY users should call 711.

If you are a member of this plan, call toll-free 1-877-241-2583. TTY users should call 711. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language.

## Medicare PLUS Blue<sup>SM</sup> PPO



Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

# Scope of Sales Appointment Confirmation Form



The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephone sales meeting to ensure understanding of what will be discussed between the agent and the Medicare member (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his or her authorized representative.

**Please initial beside the products you want the agent to discuss.**

(Refer to the following page for product descriptions.)

Stand-alone Medicare prescription drug plans (Part D)

Medicare Advantage plans (Part C)

Dental/vision/hearing products

Ancillary products (not Medicare-affiliated)

Medicare supplement (Medigap) products

**By signing the form, you agree to meet with a sales agent to discuss the products you initialed above.**

The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work for the federal government. This individual may also be paid based on your enrollment in a plan. **Signing this form doesn't obligate you to enroll in a plan, affect your current or future enrollment status, or automatically enroll you in a Medicare plan.**

| Member or authorized representative signature and signature date            |                                 |
|-----------------------------------------------------------------------------|---------------------------------|
| Signature                                                                   | Signature date                  |
| If you are the authorized representative, please sign above and print below |                                 |
| Representative name                                                         | Your relationship to the member |
| To be completed by agent                                                    |                                 |
| Agent name                                                                  | Agent phone                     |
| Member name                                                                 | Member phone                    |
| Member address                                                              |                                 |
| Initial method of contact (indicate here if member was a walk-in)           |                                 |
| Agent signature                                                             |                                 |
| Plans represented by agent during meeting                                   | Date appointment completed      |

Scope of Appointment documentation is subject to CMS record retention requirements.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Stand-alone Medicare prescription drug plans (Part D)</b>                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Medicare Prescription Drug Plan (PDP)</b> – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare cost plans, some Medicare private fee-for-service plans and Medicare medical savings account plans.                                                                                                                                                                                                              |
| <b>Medicare Advantage plans (Part C)</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Medicare health maintenance organization (HMO)</b> – A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).                                                                                                                                |
| <b>Medicare preferred provider organization (PPO) plan</b> – A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.                                                                                                                            |
| <b>Medicare private fee-for-service (PFFS) plan</b> – A Medicare Advantage plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan’s payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers. |
| <b>Medicare special needs plan (SNP)</b> – A Medicare Advantage plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who live in nursing homes, and people who have certain chronic medical conditions.                                                                                                                         |
| <b>Dental/vision/hearing products</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.                                                                                                                                                                                                                                                                                          |
| <b>Ancillary products</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Critical illness and accident insurance</b> – Plans offering coverage for consumers who have been diagnosed with a specific illness on a predetermined list. These plans are not affiliated or connected to Medicare.                                                                                                                                                                                                                                         |
| <b>Hospital indemnity insurance</b> – Plans that offer coverage each day you are hospitalized, up to a designated number of days. These plans are not affiliated with or connected to Medicare.                                                                                                                                                                                                                                                                  |
| <b>Travel insurance</b> – Plans offering additional benefits for consumers who travel outside the United States. These plans are not affiliated or connected to Medicare.                                                                                                                                                                                                                                                                                        |
| <b>Medicare supplement (Medigap) products</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Plans offering a supplemental policy to fill “gaps” in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.                                                                        |

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.



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## IMPORTANT INFORMATION:

### 2025 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



#### Blue Cross Blue Shield of Michigan - H9572

For 2025, Blue Cross Blue Shield of Michigan - H9572 received the following Star Ratings from Medicare:

**Overall Star Rating:** ★★★★★  
**Health Services Rating:** ★★★★★  
**Drug Services Rating:** ★★★★★

#### Medicare PLUS Blue<sup>SM</sup> PPO



Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Every year, Medicare evaluates plans based on a 5-star rating system.

#### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

The number of stars show how well a plan performs.

★★★★★ EXCELLENT  
★★★★☆ ABOVE AVERAGE  
★★★☆☆ AVERAGE  
★★☆☆☆ BELOW AVERAGE  
★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

#### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

#### Questions about this plan?

Contact Blue Cross Blue Shield of Michigan 7 days a week from 8:00 a.m. to 9:00 p.m. Eastern time at 888-563-3307 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time. Current members please call 877-241-2583 (toll-free) or 711 (TTY).

Blue Cross Blue Shield of Michigan is a PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Michigan depends on contract renewal.



## Notice of Availability

**English:** Call the phone number on the back of your member ID card to reach a complimentary interpreter who speaks English or to receive additional support you may need.

**Spanish:** Llame al número de teléfono que aparece en el reverso de su tarjeta de identificación de miembro para comunicarse de forma gratuita con un intérprete que hable español o para recibir apoyo adicional que pueda necesitar.

**Arabic:** اتصل برقم الهاتف الموجود على ظهر بطاقة هوية عضويتك للوصول إلى مترجم مجاني يتحدث باللغة العربية أو لتلقي المزيد من الدعم الذي قد تحتاجه.

**Chinese Mandarin:** 拨打您的会员 ID 卡背面的电话号码，即可联系一位会说普通话的免费翻译，或获取您可能需要的其他支持。

**Albanian:** Telefononi në numrin e telefonit që gjendet në anën e pasme të kartës suaj të anëtarësisë për t'u lidhur me një interpret pa pagesë që flet shqip ose për të marrë mbështetje shtesë që mund t'ju nevojitet.

**German:** Rufen Sie die Telefonnummer auf der Rückseite Ihres Mitgliedsausweises an, um einen kostenlosen Dolmetscher zu finden, der Deutsch spricht, oder um weitere Unterstützung zu erhalten.

**Amharic:** አማርኛ ከአሚናገር ነጻ ተርጓሚ ጋር ለመገናኘት ወይም ሊያስፈልግዎ የሚችል ተጨማሪ ድጋፍ ለማግኘት ከአባል መታወቂያ ካርድዎ ጀርባ ያለው ስልክ ቁጥር ላይ ይደውሉ።

**Bengali:** বিনামূল্যে বাংলা ভাষায় কথা বলতে পারেন এমন একজন সহায়ক দোভাষীর সাথে যোগাযোগ করতে অথবা আপনার প্রয়োজনীয় অতিরিক্ত সহায়তা পেতে আপনার মেম্বারশিপ ID কার্ডের পিছনে দেওয়া ফোন নম্বরে কল করুন।

**French:** Appelez le numéro de téléphone figurant au dos de votre carte d'adhérent pour joindre un interprète gratuit qui parle français ou pour bénéficier d'un soutien supplémentaire dont vous pourriez avoir besoin.

**Hindi:** किसी ऐसे मानार्थ (कंप्लीमेंटरी) दुभाषिए से संपर्क करने के लिए जो हिंदी बोलता हो या ऐसी अतिरिक्त सहायता प्राप्त करने के लिए जिसकी आपको आवश्यकता हो सकती है, आपके सदस्य ID कार्ड के पीछे दिए गए फ़ोन नंबर पर कॉल करें।

**Korean:** 가입자 ID 카드 뒷면의 전화번호로 전화를 주시면 한국어 무료 통역사와 연결하시거나 필요한 추가 지원을 받으실 수 있습니다.

**Polish:** Zadzwoń pod numer telefonu znajdujący się z tyłu karty członkowskiej, aby skontaktować się z nieodpłatnym tłumaczem posługującym się językiem polskim lub aby – w razie potrzeby – uzyskać dodatkową pomoc.

**Telugu:** తెలుగు మాట్లాడే ఉచిత ఇంటర్ప్రెటీటర్తో కనెక్ట్ కావడానికి లేదా మీకు అవసరం కాగల అదనపు మద్దతును పొందడానికి మీ మెంబర్ ID కార్డు వెనుక ఉండే ఫోన్ నెంబర్ కు కాల్ చేయండి.

**Vietnamese:** Xin gọi số điện thoại ghi ở mặt sau thẻ ID thành viên của quý vị để kết nối với một thông dịch viên tiếng Việt miễn phí hoặc để được hỗ trợ thêm nếu quý vị cần

**Pennsylvania Dutch:** Call der Number as uff die hinnitusch Seit vun dei Member ID Card is fer schwetze mit en Interpreter as Deitsch schwetzt odder fer ennichi Hilf griege as du brauchsch. Des zellt dich nix koschde.

**Tagalog:** Tumawag sa numero ng telepono sa likod ng member ID card mo para makipag-ugnayan sa isang walang bayad na interpreter na nagsasalita ng Tagalog o para makatanggap ng karagdagang suporta na maaaring kailanganin mo.



**Blue Cross  
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Blue Care Network**  
of Michigan

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## **Discrimination is against the law**

Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 1-877-469-2583 or, if you're 65 or older, call 1-888-563-3307, TTY: 711.

## **Here's how you can file a civil rights complaint**

If you believe that Blue Cross Blue Shield of Michigan, Blue Care Network or our vendors have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator  
600 E. Lafayette Blvd., MC 1302  
Detroit, MI 48226  
Phone: 1-888-605-6461, TTY: 711  
Fax: 1-866-559-0578  
Email: [CivilRights@bcbsm.com](mailto:CivilRights@bcbsm.com)

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website 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, SW, Room 509F, HHH Building  
Washington, D.C. 20201  
Phone: 1-800-368-1019, TDD: 1-800-537-7697  
Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: <https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/>.