The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see bluecrossma.org/connector. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-262-BLUE (2583) to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For prescription drug benefits, $250 member / $500 family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Medical benefits, premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge; No charge / chiropractor visit; No charge / acupuncture visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$1 / retail supply or $2 / mail service supply</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a></td>
<td>Preferred brand drugs</td>
<td>$3.65 / retail supply or $7.30 / mail service supply</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$3.65 / retail supply or $7.30 / mail service supply</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost share (generic, preferred, non-preferred)</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): No charge</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): No charge</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>In-Network (You will pay the least): No charge Out-of-Network (You will pay the most): Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No charge for outpatient services; No charge for inpatient services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Abortion
- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)
Your Rights to Continue Coverage:
If you have Individual health insurance:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-472-2689 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

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

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

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

**Peg is Having a Baby**  
(9 months of in-network prenatal care and a hospital delivery)

- The plan’s overall deductible: $0
- Delivery fee copay: $0
- Facility fee copay: $0
- Diagnostic tests copay: $0

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

The total Peg would pay is: $60

---

**Managing Joe’s Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $0
- Specialist visit copay: $0
- Primary care visit copay: $0
- Diagnostic tests copay: $0

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

**Total Example Cost**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $20

The total Joe would pay is: $220

---

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

- The plan’s overall deductible: $0
- Specialist visit copay: $0
- Emergency room copay: $0
- Ambulance services copay: $0

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

The total Mia would pay is: $0

---

The plan would be responsible for the other costs of these EXAMPLE covered services.

* Registered Marks of the Blue Cross and Blue Shield Association. © 2024 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.
**PEDIATRIC ESSENTIAL DENTAL BENEFITS**

Your health plan coverage includes a dental policy that covers pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

This separate dental policy covers pediatric essential dental benefits for members until the end of the calendar month in which they turn age 19 as required by federal law.

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at [bluecrossma.com/findadoctor](http://bluecrossma.com/findadoctor) or call the Member Service number on your ID card.

<table>
<thead>
<tr>
<th>Pediatric Essential Dental Benefits*</th>
<th>Your Cost In-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1: Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care</td>
<td>Nothing</td>
</tr>
<tr>
<td>Group 2: Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance</td>
<td>Nothing</td>
</tr>
<tr>
<td>Group 3: Major Restorative Services: tooth replacement, resin crowns, and occlusal guards</td>
<td>Nothing</td>
</tr>
<tr>
<td>Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member</td>
<td>Nothing</td>
</tr>
</tbody>
</table>

* All covered services are limited to members until the end of the month they turn age 19, and may be subject to an age-based schedule or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.

** There are no out-of-network benefits for dental services.
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

**BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:**

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.
Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Este aviso tiene información importante. Este aviso tiene información importante sobre su solicitud o su cobertura de Blue Cross Blue Shield of Massachusetts. Es posible que deba tomar medidas antes de ciertas fechas límite para mantener su cobertura médica o recibir ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su idioma de manera gratuita. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Este Aviso contém Informação Importante. Este aviso contém informação importante acerca do seu pedido ou cobertura através da Blue Cross Blue Shield of Massachusetts. Poderá ter de agir em função de determinadas datas-límite para manter a sua cobertura de saúde ou ajudar aos custos. Tem o direito de obter esta informação e auxílio no seu idioma, sem qualquer custo. Telefone para o Serviço aos Membros, através do número no seu cartão ID (TTY: 711).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：711）。

此通知包含重要信息。此通知包含有关您通过 Blue Cross Blue Shield of Massachusetts 提交的申请或享有的承保服务的重要信息。您可能需要在特定截止日期前采取行动，以保持您的健康保险，或获得费用相关的帮助。您有权免费获得这些信息，及以您的语言提供的帮助。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：711）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang, gratis ap disponib pou ou. Rele nimewo Sèvis Manm nan ki sou kat Idantitifikasyon w lan (711).

Avi sa a gen Enfòmasyon Enpòtan ladann. Avi sa a gen enfòmasyon enpòtan osi jè demann aplikasyon ou oswa pwoteksyon Blue Cross Blue Shield of Massachusetts bay. Ou gendwa bezwen ajen anvan sèten dat limit pou kenbe pwoteksyon asirans ou oswa pou ede ak depans yo. Ou gen dwa jwenn enfòmasyon sa a ak asistans nan lang ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifikasyon w lan (711).


Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc hỗ trợ y tế hoặc bảo hiểm y tế hoặc trợ giúp về phí tổn. Quý vị có quyền được nhận thông tin này và được trợ giúp bằng ngôn ngữ của quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: 711).

В этом уведомлении содержится важная информация. В этом уведомлении содержится важная информация о Вашем заявлении на страхование или страховке при участии компании Blue Cross Blue Shield of Massachusetts. Чтобы сохранить медицинскую страховку или получить помощь в связи с какими-то выплатами, Вам может потребоваться предпринять какие-то действия к определенному сроку. У Вас есть право на бесплатные услуги переводчика для получения этой информации. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: 711).

Arabic/د: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف: 711).

يتضمن هذا الإشعار معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة حول استعدادك أو تخطيطك من خلال شركة Blue Cross Blue Shield of Massachusetts قد تحتاج إلى اتخاذ إجراء ما بحلول مواعيد نهاية مميتة للحفاظ على بقاءك الصحي والانتظام في التغطية الصحية فيما يتعلق بالتكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف: 711).

Mon-Khmer, Cambodian/ការជូនដំណ ឹ ង៖ ប្រសិនប្រើអ្នកនិយាយភាសាខ្មែរបសវាជំនួយភាសាឃើតគិតថ្លៃ គឺអាចរកបានសបរា្រ់អ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្ (TTY: 711)។

Blue Cross Blue Shield of Massachusetts រានសិទ្ិទទួេបានព័ត៌រានបនះនិងជំនួយជាភាសាក្រមតិបនះតាមរយៈថន (TTY: 711)។


Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.
Gujarati/ગુજરાતી:
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભયાષયાકી્ સહયા્તયા સેવયાઓ વવનયા મૂલ્૦ ઉપલબ્ધ છે. તમારી આઈડી કાડ પર આપેલ નંબર પર Member Service ને કૉલ કરો (TTY: 711).


Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: 711）。


Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک‌هایی ب‌صورت رایگان در اختیار شما قرار می‌گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

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ເອງ/ພາສາລາວ: ທ່ານເຈົ້າມີຈ່າຍແວນເປັນນີ້, ມີການບັນທືກສາດທັງຊດການສາມາດຕ່າງໆໃນໄລຍະເລີຍ. ມີການບັນທືກສາມາດທັງຊດການສາມາດຕ່າງໆໃນໄລຍະເລີຍໃຊ້ເພດທ່ານນີ້ (TTY: 711).

ລາວ/ພາສາລາວ: ຄວາມໃສ່ເຈົ້າມີຈ່າຍແວນເປັນນີ້, ມີການບັນທືກສາມາດທັງຊດການສາມາດຕ່າງໆໃນໄລຍະເລີຍ. ມີການບັນທືກສາມາດທັງຊດການສາມາດຕ່າງໆໃນໄລຍະເລີຍໃຊ້ເພດທ່ານນີ້ (TTY: 711).


Díí bee éehóziníí á’i’íyí’ísí baa ákonínízíí díí. Díí bee éehóziníííí éí díí ninaaltsoos Blue Cross Blue Shield of Massachusetts bii’ bee naa’áháyánígí éí bidee’t’i’ dóó baa ákonínízíí dooleel. Díí la’ áadoo ilkaahí díí naah’é’él’íníí bee ná’ahoot’i’í’gi’ bidadé’t’i’ dóó lâhdóó ná bik’é ni’doolyéésgo át’e. Díí bee éehóziníííí nich’i’ íshjáníi álziphíígo éí bee náhaz’á dóó t’áá ninizaad k’ehjí t’áá jíkk’ee bee níka’a’ doowol. Díí bee anítahíííí ninaaltsoos bine’dée’ nóomba bik’á’gii’í bée sh bee hodíílnih (TTY: 711).