BlueCross® BlueShield®

SUMMARY OF BENEFITS

# HMO BLUE NEW ENGLAND $3,000 DEDUCTIBLE

## WITH HOSPITAL CHOICE COST SHARING

Plan-Year Deductible: $3,000/$6,000
Effective on anniversary dates on or after January 1, 2023
for Individuals and Small Groups


## UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

**Sign in**

Download the app, or create an account at **bluecrossma.org.**

## Where you get care can impact what you pay for care.

**This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.**
As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in this Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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.

# YOUR CARE

**Your Primary Care Provider (PCP)**
When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**; consult Find a Doctor at **bluecrossma.com/findadoctor**; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school the doctor attended, and whether there are languages other than English spoken in the office.

**Referrals**
Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see an HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate.

**Your Cost Share**
This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain services at or by "higher cost share hospitals," including inpatient admissions, outpatient day surgery, and some other hospital outpatient services. See the chart for your cost share.

*Note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your PCP refers you.*

**Higher Cost Share Hospitals**
Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- **Baystate Medical Center**
- **Boston Children's Hospital**
- **Brigham and Women's Hospital**
- **Cape Cod Hospital**
- **Dana-Farber Cancer Institute**
- **Fairview Hospital**
- **Massachusetts General Hospital**
- **UMass Memorial Medical Center**

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

*Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.*

**Your Deductible**
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$3,000** per member (or **$6,000** per family).

**Your Out-of-Pocket Maximum**
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is **$8,750** per member (or **$17,500** per family).

**Emergency Room Services**
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

**Telehealth Services**
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

**Your Virtual Care Team**
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **For outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your subscriber certificate, or call the Member Service number on your ID card.

**Service Area**
The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

**When Outside the Service Area**
If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your subscriber certificate for more information.

**Dependent Benefits**
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your subscriber certificate (and riders, if any) for exact coverage details.

| Covered Services | Your Cost |
|---|---|
| **Preventive Care** | |
| Well-child care exams | **Nothing**, no deductible |
| Routine adult physical exams, including related tests | **Nothing**, no deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | **Nothing**, no deductible |
| Routine hearing exams, including routine tests | **Nothing**, no deductible |
| Hearing aids (up to $2,000 per ear every 36 months) | **All charges beyond the maximum**, no deductible |
| Routine vision exams<br>(one every 24 months, except one every 12 months until the end of the month a member turns age 19) | **Nothing**, no deductible |
| Vision supplies (one set of prescription lenses and/or frames or contact lenses per calendar year until the end of the month a member turns age 19) | **35% coinsurance** after deductible |
| Family planning services—office visits | **Nothing**, no deductible |
| **Outpatient Care** | |
| Emergency room visits | **$500** per visit after deductible<br>(copayment waived if admitted or for observation stay) |
| Office or health center visits, when performed by:<br>• Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | **$30** per visit, no deductible<br>**$55** per visit, no deductible |
| Mental health or substance use treatment | **$30** per visit, no deductible |
| Outpatient telehealth services<br>• With a covered provider<br>• With the designated telehealth vendor | Same as in-person visit<br>**$30** per visit, no deductible |
| Diabetic management services (first two visits per calendar year*) | **Nothing**, no deductible |
| Chiropractors' office visits | **$55** per visit, no deductible |
| Acupuncture visits (up to 12 visits per calendar year) | **$55** per visit, no deductible |
| Short-term rehabilitation therapy—physical and occupational<br>(up to 60 visits for rehabilitation services and 60 visits for habilitation services per calendar year**)<br>• At other hospitals or by other covered providers<br>• At or by in-network higher cost share hospitals | <br>**$50** per visit after deductible<br>**$90** per visit after deductible |
| Speech, hearing, and language disorder treatment—speech therapy<br>• At other hospitals or by other covered providers<br>• At or by in-network higher cost share hospitals | <br>**$50** per visit after deductible<br>**$90** per visit after deductible |
| Diagnostic X-rays<br>• At other hospitals or by other covered providers<br>• At or by in-network higher cost share hospitals | <br>**$40** per service date after deductible<br>**$140** per service date after deductible |
| Diagnostic lab tests<br>• At other hospitals or by other covered providers<br>• At or by in-network higher cost share hospitals | <br>**$35** per service date after deductible<br>**$70** per service date after deductible |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests<br>• At other hospitals or by other covered providers<br>• At or by in-network higher cost share hospitals | <br>**$500** per category per service date after deductible<br>**$950** per category per service date after deductible |
| Home health care and hospice services | **Nothing**, no deductible |
| Oxygen and equipment for its administration | **Nothing** after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | **20% coinsurance** after deductible*** |
| Prosthetic devices | **20% coinsurance** after deductible |
| Surgery and related anesthesia in an office or health center, when performed by:<br>• Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | <br>**$30** per visit†, no deductible<br>**$55** per visit†, no deductible |
| Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit<br>• At other general hospitals or by other covered providers<br>• At or by in-network higher cost share hospitals | <br>**$500** per admission after deductible<br>**$1,500** per admission after deductible |

* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, or diabetic foot care.
** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
*** Cost share waived for one breast pump per birth, including supplies.
† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

| Covered Services | Your Cost |
|---|---|
| **Inpatient Care (including maternity care) in:** | |
| • Other general hospitals (as many days as medically necessary)<br>• In-network higher cost share hospitals (as many days as medically necessary) | $500 per admission after deductible<br>$1,500 per admission after deductible |
| Chronic disease hospital care (as many days as medically necessary) | $500 per admission after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | $500 per admission after deductible |
| Rehabilitation hospital care (up to 60 days per calendar year) | Nothing after deductible |
| Skilled nursing facility care (up to 100 days per calendar year) | Nothing after deductible |
| **Prescription Drug Benefits*** | |
| At designated non-specialty retail pharmacies<br>(up to a 30-day formulary supply for each prescription or refill)** | No deductible<br>$10 for Tier 1***<br>$45 for Tier 2***<br>$175 for Tier 3†<br>$225 for Tier 4† |
| Through the designated mail service pharmacy<br>(up to a 90-day formulary supply for each prescription or refill)** | No deductible<br>$20 for Tier 1***<br>$90 for Tier 2***<br>$350 for Tier 3†<br>$675 for Tier 4† |
| Specialty drugs when obtained from a designated specialty pharmacy<br>(up to a 30-day formulary supply for each prescription or refill) | No deductible<br>$10 for Tier 1<br>$45 for Tier 2<br>50% coinsurance for Tier 5 (maximum of $350)†<br>50% coinsurance for Tier 6 (maximum of $500)† |

* Generally, Tier 1 refers to preferred generic drugs; Tier 2 refers to non-preferred generic drugs; Tier 3 refers to preferred brand-name drugs; Tier 4 refers to non-preferred brand-name drugs; Tier 5 refers to preferred brand-name specialty drugs; Tier 6 refers to non-preferred brand-name specialty drugs. Your pharmacy coverage includes the Mail Order with Retail Choice Program that requires you to take action. For a complete description of the program refer to your subscriber certificate and riders. To find out which maintenance drugs are part of the program, call the Member Service number on your ID card, or visit our website at bluecrossma.org/90daymeds.

** Cost share may be waived or reduced for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

*** Cost share waived for select generic drugs that treat depression, cholesterol, diabetes, heart, and high blood pressure. For a list of these drugs, contact Blue Cross Blue Shield of Massachusetts or visit bluecrossma.org/medication.

† If you choose to buy a brand-name drug where allowed by state law, instead of a generic drug equivalent (if available), your out-of-pocket costs will be more. For these covered brand-name drugs, your cost share will include the generic drug cost share as well as all costs that are in excess of the allowed charge for the generic drug equivalent. All costs that you pay for these covered drugs will count toward your out-of-pocket maximum.

| **Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-262-BLUE (2583) to learn about discounts, savings, resources, and special programs available to you, like those listed below.** | |
|---|---|
| Wellness Participation Program<br>Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your subscriber certificate for details.) | $150 per calendar year per policy |
| Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your subscriber certificate for details.) | $150 per calendar year per policy |

**24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.**

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-262-BLUE (2583), or visit us online at bluecrossma.org. Interested in our Medicare Plans? Visit bluecrossma.com/medicare.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.


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MASSACHUSETTS

# 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.

You must meet a plan-year deductible for certain covered dental services. Your deductible is **$50** per member (no more than **$150** for three or more members enrolled under the same family membership).

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and coinsurance for covered dental services. Your out-of-pocket maximum is **$350** per member (no more than **$700** for two or more members enrolled under the same family membership).

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

| Pediatric Essential Dental Benefits* | Your Cost In-Network** |
|---|---|
| **Group 1: Preventive and Diagnostic Services:** oral exams, X-rays, and routine dental care | Nothing, no deductible |
| **Group 2: Basic Restorative Services:** fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance | 25% coinsurance after deductible |
| **Group 3: Major Restorative Services:** tooth replacement, resin crowns, and occlusal guards | 50% coinsurance after deductible |
| **Orthodontic Services:** medically necessary orthodontic care pre-authorized for a qualified member | 50% coinsurance, no deductible |

* 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.


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# Limited, Regional and Tiered Network Plans: Choosing the Health Plan That's Right for You

## Health Insurance & Provider Networks

Massachusetts health insurers now offer lower-cost health insurance plan options with limited, regional and tiered networks. This guide can help you get the information you need to understand these options and make an informed decision.

Many insurers have different health plans with different provider networks. A doctor or hospital may be in the provider network of one plan but not in another, *even though the same insurer sells both health plans*.

The provider network determines the doctors and hospitals the health plan will cover for non-emergency care. Some health plans will not cover services you receive from providers that are outside the network without approval, while others will have you pay higher out-of-pocket costs if you go out of network. Your choice of health plan and provider network will determine your premium and out-of-pocket costs. You may be able to save money on your premium if you choose a network with more limits on the doctors and hospitals that are covered.

It is important for you to know the provider network for any plan you are considering. Insurers have brand names for their plans and networks. Make sure you know the brand names so that you can find out if your provider is part of that specific plan. You can find the provider directory on the health insurer's website or you can ask for a paper copy of the directory. Also, use the directory to make sure that the particular location used by your provider is included in the network. Be sure to call the insurance carrier if you have any questions about whether a provider is in a network.

State law now requires insurers to label any limited network as:

- Limited Provider Network
- Regional Provider Network
- Tiered Provider Network

Remember, once you buy a health plan, **you cannot switch plans until it is up for renewal**, so think about your options and health care needs carefully.

## Why Choose a Health Plan with a Limited Network?

Buying a product with some type of limited network allows you to have similar coverage and quality care at a cost that is lower than that of other plans offered by the same insurer.

## What Does a Network's Size have to do with Cost?

Limited networks can lower health insurance premiums. They allow insurers to reduce costs by limiting the group of health care providers to those that offer quality care at lowers costs compared to higher-cost providers.


**A provider or health care facility may leave a network or might be assigned to a different tier in a tiered provider network. Find out how often and when the network changes - and how you can check a provider's status.**

## Types of Provider Networks

You should know that all network plans licensed in Massachusetts have a full range of quality health services and providers. Choosing a limited network does not mean that you will have to settle for lower quality care. Insurers may offer plans that use a combination of the network designs described below, and it is important for you to read your plan description to learn the rules of each network.

**General Provider Network Plans** give you the widest choice of providers. This may be a good option for you if you are willing to pay more for a wider choice of providers.

**Limited Provider Network Plans** have a network that is smaller than the insurer's general network, but cost less. This may be a good option for you if the limited network includes the providers that you plan to use and you do not need the option to visit providers outside the network.

**Regional Provider Network Plans** have a network that is limited to a specific geographic region, and usually cost less than a general network. This may be a good option for you if you live or work in a region that the network covers and you do not need the option of visiting providers in other areas.

**Tiered Provider Network Plans** assign providers to different levels (tiers) based on the insurer's decision of the relative value of the provider's cost and quality. Your share of the cost will depend on the provider's tier. With this plan, you can save money by choosing providers in a lower-cost tier.

| **Choosing the Right Network: Key Questions to Ask** | **General Network** | **Limited Network** | **Regional Network** | **Tiered Network** |
|---|---|---|---|---|
| Are the providers and facilities that you use listed in the insurer's network directory?<br><br>*-The insurer will have a directory that lists the providers in each of its networks. Check to see that the hospital, primary care provider and specialists you want to see or might be referred to your provider are specifically listed for the services you use at the locations you want.* | √ | √ | √ | √ |
| Are you willing to change providers or facilities in order to pay a lower premium?<br><br>*-If you are able to switch to providers that are in a limited network you may be able to get lower premiums. Remember that if you want to see a provider that is not listed in the network, you may need to pay higher out-of-pocket costs or you may not have coverage at all for those providers.* | | √ | √ | √ |
| Are you willing to limit yourself to providers and facilities near your home or work?<br><br>*-If you don't need the option of traveling to hospitals in another area for your care, you may be able to get lower premiums. Remember that care at an out-of-network provider or hospital may not be covered, or you may need to pay more for your share.* | | √ | √ | |
| Are you willing to choose a plan in which you pay more or less out of pocket depending on the tier to which your provider is assigned?<br><br>*- Do you want a broad network, and are you willing to pay a larger share of the expense for some hospitals and doctors? Remember, this could end up being more than what you may save in premium.* | | | | √ |

## Important Things to Remember

Know the brand name of the network plan you choose – and be sure the providers you want are in that network plan.

Understand the ways your share of the costs can vary – co-payments, co-insurance or deductibles can be higher or lower depending on the provider and the tier the provider is in.

MASSACHUSETTS

DISCLOSURE

# FOR MEMBERS ENROLLED IN A GROUP HEALTH PLAN CONTINUITY OF CARE ACCESS FOR CANCER AND PEDIATRIC FACILITIES

## If You Are Enrolled in a Group Health Plan with a Tiered or Limited Network

You may be eligible for continuity of care coverage when you enroll in a tiered or limited network plan and you are receiving an active course of care for a serious illness that you began before your effective date in the health plan. This means that under certain conditions, the cost-share amount you pay for covered services furnished at a comprehensive cancer or pediatric facility will be a lower cost-share amount than you would normally pay for services at that facility. To be eligible for this coverage, you must meet all of the following conditions:

## TO BE ELIGIBLE FOR THIS COVERAGE, YOU MUST MEET ALL OF THE FOLLOWING CONDITIONS:

- You are a member enrolled in a group health plan through your employer.
- You began an active course of care for a serious illness (such as cancer or cystic fibrosis) at a **comprehensive cancer or pediatric facility** before your effective date in the tiered or limited network plan. **Comprehensive cancer or pediatric facility** means: Dana-Farber Cancer Institute, Boston Children's Hospital, Shriners Hospitals for Children (Boston and Springfield), Floating Hospital for Children at Tufts Medical Center, Nashoba Valley Medical Center, and Massachusetts Eye and Ear Infirmary.
- You are enrolled in a tiered provider network plan and you would normally pay the highest cost-share amount for covered services furnished at the **comprehensive cancer or pediatric facility** where you are receiving your care; or you are enrolled in a limited or tiered provider network and the **comprehensive cancer or pediatric facility** is not in the health plan's network.
- Your active course of care, if it were disrupted, would cause you an undue hardship. This means, for example, a disruption could endanger your life, or cause you suffering or pain, or result in a substantial change to your treatment plan.

If you meet all of the conditions stated and your active course of care began on or after May 1, 2012, you are eligible for this coverage until the end of the 12-month period that starts on the **subscriber's effective date** in a tiered or limited network plan, **but only when** your group offers you a choice to enroll only in a tiered or limited network plan in which your **comprehensive cancer or pediatric facility** is not part of the health plan's network or, for a tiered network plan, it is at the highest cost share level; and your care is not available from another provider in the health plan's network.

If you are enrolled in a tiered network plan and **Blue Cross Blue Shield** determines you are eligible for this coverage, your cost-share amount will be at the second highest cost-share level when the **comprehensive cancer or pediatric facility** is at the highest cost-share level. Or, your cost-share amount will be at the lowest cost-share level when the comprehensive cancer or pediatric facility is not part of the health plan's network. If **Blue Cross Blue Shield** determines you are not eligible for this coverage, you must pay the cost-share amount you would normally pay for covered services furnished at a **comprehensive cancer or pediatric facility.**

If you are enrolled in a limited network plan and **Blue Cross Blue Shield** determines you are eligible for this coverage, your cost share amount for covered services will be the same that would apply to a comparable network provider. If **Blue Cross Blue Shield** determines you are not eligible for this coverage, no benefits will be provided.

If you think you are eligible for this coverage, you or your health care provider must send a completed continuity of care form to **Blue Cross Blue Shield**. You can get a copy of this form by calling member service at the toll-free phone number shown on your ID card. Or, visit MyBlue, and in the Tools and Resources menu, select Forms and Brochures. Then click Health Plans—Miscellaneous and download the Continuity of Care Form for Plans That Include a Tiered or Limited Provider Network.


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MASSACHUSETTS

# NONDISCRIMINATION NOTICE

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**.


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# PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

**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**).

**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**).

**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**）。

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

**Vietnamese/Tiếng Việt:** LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

**Russian/Русский:** ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

**Arabic/ةيبر:**

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

**French/Français:** ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

**Italian/Italiano:** ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

**Korean/한국어:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

**Greek/Ελληνικά:** ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

**Polish/Polski:** UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

**Hindi/हिंदी:** ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

**Gujarati/ગુજરાતી:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

**Tagalog/Tagalog:** PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (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**）。

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

**Persian/پارسیان:**
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji̧' béésh bee hodíílnih (TTY: **711**).


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