### Important Questions | Answers | Why This Matters:

**What is the overall deductible?**
- $2,000 individual contract / $4,000 family contract.
- Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.

**Are there services covered before you meet your deductible?**
- Yes. Preventive care, prenatal care, preventive drugs.
- This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

**Are there other deductibles for specific services?**
- Yes. For pediatric essential dental, $50 member (no more than $150 for three or more eligible members per family). There are no other specific deductibles.
- You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

**What is the out-of-pocket limit for this plan?**
- For medical and prescription drug benefits, $6,700 member / $13,400 family; and for pediatric essential dental, $350 member (no more than $700 for two or more eligible members per family).
- The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

**What is not included in the out-of-pocket limit?**
- Premiums, balance-billing charges, and health care this plan doesn’t cover.
- Even though you pay these expenses, they don't count toward the out-of-pocket limit.

**Will you pay less if you use a network provider?**
- Yes. See [bluecrossma.com/findadoctor](http://bluecrossma.com/findadoctor) or call the Member Service number on your ID card for a list of network providers.
- This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

**Do you need a referral to see a specialist?**
- Yes.
- This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
### Common Medical Event

**Services You May Need**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 / visit</td>
<td>Not covered</td>
<td>Deductible applies first; a telehealth cost share may be applicable</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$60 / visit; $60 / chiropractor visit; $60 / acupuncture visit</td>
<td>Not covered</td>
<td>Deductible applies first; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$75 for x-rays and $60 for lab tests</td>
<td>Not covered</td>
<td>Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$500</td>
<td>Not covered</td>
<td>Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services</td>
</tr>
</tbody>
</table>

**All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network (You will pay the least)</td>
<td>Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$30 / retail supply or $60 / mail order supply</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at bluecrossma.org/medication</td>
<td>Preferred brand drugs</td>
<td>$60 / retail supply or $120 / mail order supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$105 / retail supply or $315 / mail order supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost share (generic, preferred, non-preferred)</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$500 / admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$300 / visit</td>
<td>$300 / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$60 / visit</td>
<td>$60 / visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$750 / admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$30 / visit</td>
<td>Deductible applies first; a telehealth cost share may be applicable; pre-authorization required for certain services</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$750 / admission</td>
<td>Deductible applies first; pre-authorization required for certain services</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Deductible applies first except for prenatal care; a telehealth cost share may be applicable; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); cost sharing does not apply for preventive services</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$750 / admission</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
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<td>----------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$60 / visit for outpatient services; $750 / admission for inpatient services</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$60 / visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$750 / admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network (You will pay the least)</td>
<td>What You Will Pay Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s glasses</td>
<td>35% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<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 foot care (only for patients with systemic circulatory disease)
- Routine eye care - adult (one exam every 24 months)
- Weight loss programs ($150 per calendar year per policy)
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact 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 a state exchange, you can contact your state’s marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member’s employer or organization that provides group health coverage to the member.)

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**: $2,000
- **Delivery fee copay**: $0
- **Facility fee copay**: $750
- **Diagnostic tests copay**: $60

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

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

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: $3,060

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

---

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

- **The plan’s overall deductible**: $2,000
- **Specialist visit copay**: $60
- **Primary care visit copay**: $30
- **Diagnostic tests copay**: $60

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><strong>Deductibles</strong></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$1,300</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20
- The total Joe would pay is: $3,280

---

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

- **The plan’s overall deductible**: $2,000
- **Specialist visit copay**: $60
- **Emergency room copay**: $300
- **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><strong>Deductibles</strong></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$300</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: $2,300

---

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

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.

<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, no deductible</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>25% coinsurance after deductible</td>
</tr>
<tr>
<td>Group 3: Major Restorative Services: tooth replacement, resin crowns, and occlusal guards</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member</td>
<td>50% coinsurance, no deductible</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-limite para manter a sua cobertura de saúde ou ajudar nos 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 Idantifikasyon w lan. 711).

Avi sa a gen Enfòmasyon Enpòtan ladann. Avi sa a gen enfòmasyon enpòtan osijè demann aplikasyon ou oswa pwoteksyon Blue Cross Blue Shield of Massachusetts bay. Ou gendwa bezwen aji 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 Idantifikasyon 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 chăm sóc y tế qua Blue Cross Blue Shield of Massachusetts. Quý vị có thể cần có hành động trước thời hạn nhất định để duy trì dịch vụ hoặc được 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/دير: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف: "TTY": 711).

Blue Cross Blue Shield of Massachusetts يتضمن هذا الإشعار معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة حول استعدادك أو تخطيتك من خلال شركة Blue Cross Blue Shield of Massachusetts قد تحتاج إلى اتخاذ إجراء ما يحلو موفقية نهاية ممتعة للاحتفاظ ببطاقة الطاقة الصحية أو لتلقي المساعدة فيما يتعلق بالتكلفة. يمكن لمكتب التحقيق لك الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم: "TTY": 711).

Mon-Khmer, Cambodian/ចងក្រដាលខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (TTY: 711)។


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).

Il presente avviso contiene informazioni importanti. Il presente avviso contiene informazioni importanti riguardanti la vostra domanda o copertura Blue Cross Blue Shield of Massachusetts. Potrebbe essere necessario agire entro precisi termini per non perdere la copertura sanitaria o garantire assistenza con i costi. Avete diritto a ricevere gratuitamente queste informazioni e assistenza nella vostra lingua. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).


본 통지서에는 중요한 정보가 담겨 있습니다. 본 통지서에는 Blue Cross Blue Shield of Massachusetts를 통한 귀하의 가입 신청 또는 보험보장에 관한 중요한 정보가 담겨 있습니다. 귀하께서는 특정 마감 기한까지 조치를 취하여 계속 건강 보험 적용을 받거나 비용 지원을 받으실 수 있습니다. 귀하는 무료로 본 정보를 입수하고 귀하의 모국어로 지원을 받으실 수 있는 권리가 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).

Η παρούσα κοινοποίηση περιέχει σημαντικές πληροφορίες. Η παρούσα κοινοποίηση περιέχει σημαντικές πληροφορίες σχετικά με την αίτηση ή την κάλυψη σας μέσω της Blue Cross Blue Shield of Massachusetts. Μπορεί να χρειαστεί να προβείτε σε συγκεκριμένες ενέργειες σε συγκεκριμένες προθεσμίες, ώστε να διατηρήσετε την κάλυψη της υγείας σας ή να βοηθήσετε στο θέμα του κόστους. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και τη βοήθεια στη γλώσσα σας χωρίς κόστος. 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).

To powiadomienie zawiera ważne informacje. To powiadomienie zawiera ważne informacje na temat złożonego wniosku lub ochrony ubezpieczeniowej zapewnianej przez Blue Cross Blue Shield of Massachusetts. Konieczne może być podjęcie pewnych działań w określonych terminach, by utrzymać ochronę ubezpieczeniową lub uzyskać pomoc w pokryciu kosztów. Ubezpieczonemu przysługuje prawo do uzyskania tych informacji i pomocy w jego języku bez żadnych kosztów. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

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

इस नोटिस में महत्त्वपूर्ण जानकारी है। इस नोटिस में Blue Cross Blue Shield of Massachusetts के माध्यम से आपके आवेदन या कार्यों के बारे में महत्त्वपूर्ण जानकारी है। अपना स्वास्थ्य कवरेज बनाए रखने या लागतों में मदद पाने के लिए आपको कुछ निष्पादन समय-सीमाओं के अंदर कदम उठाने की आवश्यकता हो सकती है। आपके पास यह जीवनकारी एवं मदद अपनी भाषा में निष्पादन पाने का अधिकार है। 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 ભયાષયાકીય સહયોગ સેવા મૂળે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ 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）。


Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Lao/Phasaleueua: Thue ielasidao, lao tha sae Phasaleueua, thiab phana phasaleueua xaisiub속이가 투안 thiab lao meelow khydrub siup. Pha sob lao phana phasaleueua xaisiub속이가 투안 thiab lao meelow khydrub siup (TTY: 711).

Navajo/Dine' Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Díí Diné, k’ehjí yánilt’i’go saad bee yát’i’ éi t’aajít’í’é bee nikà’á’doowolgo bee náhaz’á. Díí bee anítaáhíí nínaaltsoos bine’déé’ nóomba biká’ígiíí’ bée sh bee hodiílnih (TTY: 711).