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/coverage-info**.
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.

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, certain value drugs, and 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/.
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 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.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit	Not covered	Deductible applies first; cost share waived for the first two diabetic PCP and / or specialist visits per calendar year; a telehealth cost share may be applicable
	Specialist visit	$45 / visit; $45 / chiropractor visit; $45 / acupuncture visit	Not covered	Deductible applies first; cost share waived for the first two diabetic PCP and / or specialist visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	$40	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$250	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 ($10 for value drugs) / mail order supply for low-cost generic drugs; $45 / retail supply or $90 ($45 for value drugs) / mail order supply for other generic drugs	Not covered	Deductible applies first except for preventive drugs and certain value drugs; up to 30-day retail (90-day mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$175 / retail supply or $350 ($175 for value drugs) / mail order supply	Not covered	
	Non-preferred brand drugs	$250 / retail supply or $750 / mail order supply	Not covered	
	Specialty drugs	$10 / retail supply for specialty preferred generic drugs; $45 / retail supply for specialty non-preferred generic drugs; 50% coinsurance / retail supply for specialty preferred brand drugs; 50% coinsurance / retail supply for specialty non-preferred brand drugs; not covered / mail order supply	Not covered	Deductible applies first; up to 30-day retail supply; when obtained from a designated specialty pharmacy; specialty preferred brand drug coinsurance limited to $350 per supply; specialty non-preferred brand drug coinsurance limited to $500 per supply; pre-authorization required for certain drugs

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$250 / visit	$250 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$45 / visit	$45 / visit	Deductible applies first; out-of-network coverage limited to out of service area; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit	Not covered	Deductible applies first; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$250 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 / admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$45 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$45 / visit	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); copayment and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization may be required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months until the end of the month a member turns age 19
	Children's glasses	35% coinsurance	Not covered	Deductible applies first; limited to 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
	Children's dental check-up	No charge	Not covered	Limited to twice per calendar year until the end of the month a member turns age 19

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).

OR

If you have Group health 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**	**$250**
■ **Diagnostic tests copay**	**$40**

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:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

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**	**$45**
■ **Primary care visit copay**	**$25**
■ **Diagnostic tests copay**	**$40**

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:

Cost Sharing	
Deductibles	$2,000
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,320**

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

■ **The plan's overall deductible**	**$2,000**
■ **Specialist visit copay**	**$45**
■ **Emergency room copay**	**$250**
■ **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:

Cost Sharing	
Deductibles	$2,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

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MCC COMPLIANCE

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.

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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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This health plan includes a limited provider network called HMO Blue Select. It provides access to a network that is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. In this plan, members have access to network benefits only from the providers in the HMO Blue Select network. For help in finding which providers are included in the HMO Blue Select network, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.com/findadoctor** and search for HMO Blue Select.

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55-1362 (6/21)

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? *-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? *-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? *-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? *- 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.

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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។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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'ígíiji' béésh bee hodíílnih (TTY: **711**).

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