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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 member / $6,000 family in-network; $6,000 member / $13,000 family out-of-network.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care; generic prescription 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, $6,000 member / $12,000 family in-network and $7,850 member / $15,700 family out-of-network; 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	30% coinsurance	50% coinsurance	Deductible applies first; a telehealth cost share may be applicable
	Specialist visit	30% coinsurance; 30% coinsurance / chiropractor visit; 30% coinsurance / acupuncture visit	50% coinsurance; 50% coinsurance / chiropractor visit; 50% coinsurance / acupuncture visit	Deductible applies first; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; 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)	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization may be required

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	$25 / retail supply or $50 / mail order supply	$50 / retail supply and all charges for mail order	Deductible applies first except for generic 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	$45 / retail supply or $90 / mail order supply	$90 / retail supply and all charges for mail order	
	Non-preferred brand drugs	$90 / retail supply or $270 / mail order supply	$180 / retail supply and all charges for mail order	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first except for generic drugs; when obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	In-network deductible applies first for in-network and out-of-network services
	Emergency medical transportation	30% coinsurance	30% coinsurance	In-network deductible applies first for in-network and out-of-network services
	Urgent care	30% coinsurance	50% coinsurance	Deductible applies first; a telehealth cost share may be applicable

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 a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Deductible applies first; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge for prenatal care; 30% coinsurance for postnatal care	20% coinsurance for prenatal care; 50% coinsurance for postnatal care	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network 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	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	

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	30% coinsurance	50% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	30% coinsurance for outpatient services; 30% coinsurance for inpatient services	50% coinsurance for outpatient services; 50% coinsurance for inpatient services	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	30% coinsurance	50% coinsurance	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); cost share 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	30% coinsurance	50% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	30% coinsurance	50% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
	Hospice services	30% coinsurance	50% coinsurance	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	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 12 months until the end of the month a member turns age 19
	Children's glasses	35% coinsurance	55% coinsurance	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
- 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
- Non-emergency care when traveling outside the U.S.
- 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: 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**	**$3,000**
■ **Delivery fee coinsurance**	**30%**
■ **Facility fee coinsurance**	**30%**
■ **Diagnostic tests coinsurance**	**30%**

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	$3,000
Copayments	$10
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,970**

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

■ **The plan's overall deductible**	**$3,000**
■ **Specialist visit coinsurance**	**30%**
■ **Primary care visit coinsurance**	**30%**
■ **Diagnostic tests coinsurance**	**30%**

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	$3,000
Copayments	$700
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,790**

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

■ **The plan's overall deductible**	**$3,000**
■ **Specialist visit coinsurance**	**30%**
■ **Emergency room coinsurance**	**30%**
■ **Ambulance services coinsurance**	**30%**

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	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

MASSACHUSETTS

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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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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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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MASSACHUSETTS

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**).

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 Idantitifkasyon 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 Idantitifkasyon w lan. **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**).

Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc phạm vi bao trả thông qua Blue Cross Blue Shield of Massachusetts. Quý vị có thể cần có hành động trước thời hạn nhất định để duy trì phạm vi bao trả y tế 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**).

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**).

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/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**).

يتضمن هذا الإشعار معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة حول استخدامك أو تغطيتك من خلال شركة Blue Cross Blue Shield of Massachusetts. قد تحتاج إلى اتخاذ إجراءً ما بحلول مواعيد نهائية معينة للاحتفاظ بتغطيتك الصحية أو لتلقي المساعدة فيما يتعلق بالتكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون أيّ تكلفة. 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**)។

កំណត់សម្គាល់នេះមានព័ត៌មានសំខាន់។ កំណត់សម្គាល់នេះមានព័ត៌មានសំខាន់អំពីការដាក់ពាក្យរបស់អ្នក ឬការគ្របដណ្តប់តាមរយៈ Blue Cross Blue Shield នៃ Massachusetts។ អ្នកអាចត្រូវការចាត់វិធានការត្រឹមកាលបរិច្ឆេទផុតកំណត់ជាក់លាក់នានាដើម្បីរក្សាការគ្របដណ្តប់របស់អ្នក ឬដើម្បីទទួលបានជំនួយជាមួយថ្លៃចំណាយផ្សេងៗ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ និងជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ 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**).

Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou votre couverture avec Blue Cross Blue Shield of Massachusetts. Il se peut que vous deviez réagir avant certaines dates limites pour conserver votre couverture santé ou recevoir une assistance concernant vos frais. Vous êtes en droit d'obtenir gratuitement les présentes informations et une assistance dans votre langue. 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**).

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 ottenere 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**).

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.

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 취하셔야 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 κάλυψή 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 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**).

इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में Blue Cross Blue Shield of Massachusetts **के माध्यम से आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी है। अपना स्वास्थ्य कवरेज बनाए रखने या लागतों में मदद पाने के लिए आपको कुछ निश्चित समय-सीमाओं के अंदर कदम उठाने की आवश्यकता हो सकती है। आपके पास यह जानकारी एवं मदद अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्य सेवा 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**).

આ નોટિસમાં મહત્ત્વની માહિતી છે. આ નોટિસમાં Blue Cross Blue Shield of Massachusetts મારફતે તમારી અરજી કે કવચ વિશે મહત્ત્વની માહિતી છે. તમને તમારું આરોગ્ય કવચ ચાલુ રાખવા કે ખર્ચાઓમાં મદદ માટે ચોક્કસ અંતિમ તારીખો સુધીમાં કાર્યવાહી કરવાની જરૂર પડી શકે. તમને તમારી ભાષામાં આ માહિતી અને મદદ વિના મૂલ્યે મેળવવાનો અધિકાર 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**).

Ang Paunawang ito ay naglalaman ng Mahalagang Impormasyon. Ang paunawang ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa Blue Cross Blue Shield of Massachusetts. Maaaring kailanganin mong magsagawa ng mga pagkilos na aabot sa mga deadline upang mapanatili ang iyong pagkakasaklaw sa kalusugan o upang matulungan ka sa iyong mga gastusin. Karapatan mong matanggap ang impormasyong ito at matulungan ka sa iyong wika nang libre. 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**）。

この通知には重要な情報が記載されています。この通知にはBlue Cross Blue Shield of Massachusettsでのあなたの申請や保険についての重要な情報が記載されています。健康保険を維持する、または費用について支援を受けるには、期限日までに行動を起こす必要があります。あなたは母国語で、この情報を入手し、支援を受ける権利があり、それについて費用はかかりません。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**).

Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder zur Abdeckung durch Blue Cross Blue Shield of Massachusetts. Sie müssen unter Umständen innerhalb gewisser Fristen bestimmte Handlungen ergreifen, damit Ihr Gesundheitsschutz bestehen bleibt oder Sie Kostenunterstützung erhalten. Sie sind berechtigt, diese Informationen sowie kostenlos Hilfe in Ihrer Muttersprache zu erhalten. 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**).

این اطلاعی حاوی اطلاعات ممی است. این اطلاعی حاوی اطلاعات ممی دربار درخواست شما یا پوشش شما از طریق Blue Cross Blue Shield of Massachusetts است. ممکن است لازم باشد ک برای حفظ پوشش درمانی یا کمک ای مالی، اقدامات لازم را تا ملت ای مشخص شد انجام دید. شما حق دارید ک این اطلاعات و رانمایی را ب زبان خود و ب صورت رایگان دریافت کنید. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍເງິນ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກຕາມໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນສຳຄັນກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫລື ປະກັນສັງຄົມໂດຍລວມຂອງອົງການ Blue Cross Blue Shield ຂອງ Massachusetts. ທ່ານອາດຈະຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານໄວ້ ຫຼື ເພື່ອຮັບເອົາການຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ໄດ້ຮັບການຊ່ວຍເຫຼືອດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກຕາມໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

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

Díí bee ééhózinígí t'áá íiyiisí baa ákonínízin doo. Díí bee ééhózninígí éí díí ninaaltsoos Blue Cross Blue Shield of Massachusetts bii' bee naa'áháyánígí éí bídeet'i' dóó baa ákonínízin dooleeł. Díí ła' áadoo iiłkaahí díí naah'é'él'íníí bee ná'ahoot'i'įgį bídadéít'i' dóó łahdóó ná bik'é ni'doolyéełgo át'é. Díí bee ééhózinígí nich'į' íishjání áalzindoogo éí bee náhaz'ą dóó t'áá ninizaad k'ehjí t'áá jíík'e bee niká' a'doowoł. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíijį' béésh bee hodíílnih (TTY: **711**).

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