This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com/connector or by calling **1-800-262-BLUE (2583)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,750** member / **$5,500** family. Does not apply to preventive care, prenatal care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, for prescription drugs, **$250** member / **$500** 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.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,800** member / **$13,600** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call **1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
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
	Specialist visit	$40 / visit	Not covered	Deductible applies first
	Other practitioner office visit	$40 / chiropractor visit	Not covered	Deductible applies first
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	$50 / lab tests; $175 / x-rays	Not covered	Deductible applies first; copayment applies per category of test / day
	Imaging (CT/PET scans, MRIs)	$1,000	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	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com/medications.	Generic drugs	$25 / retail supply or $50 / mail service supply	Not covered	Deductible applies first; up to 30-day retail (90-day mail service) supply; certain cost share may be waived for some covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$75 / retail supply or $150 / mail service supply	Not covered	Deductible applies first; up to 30-day retail (90-day mail service) supply; certain cost share may be waived for some covered drugs and supplies; pre-authorization required for certain drugs
	Non-preferred brand drugs	$100 / retail supply or $300 / mail service supply	Not covered	Deductible applies first; up to 30-day retail (90-day mail service) supply; certain cost share may be waived for some covered drugs and supplies; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; 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)	$750 / 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 services	$500 / visit	$500 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$40 / visit	$40 / visit	Deductible applies first; out-of-network coverage limited to out of service area

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 / admission	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fee	No charge	Not covered	Deductible applies first; pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 / visit	Not covered	Deductible applies first; pre-authorization required for certain services
	Mental/Behavioral health inpatient services	$1,000 / admission	Not covered	Deductible applies first; pre-authorization required
	Substance use disorder outpatient services	$25 / visit	Not covered	Deductible applies first; pre-authorization required for certain services
	Substance use disorder inpatient services	$1,000 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Deductible applies first for postnatal care
	Delivery and all inpatient services	$1,000 / admission and no charge for delivery	Not covered	Deductible applies first

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
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	$40 / visit	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	$40 / visit	Not covered	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; pre-authorization may be required for certain services
	Skilled nursing care	$1,000 / admission	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 service	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every 12 months until the end of the month a member turns age 19
	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
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery	• Dental care (adult) • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Abortion • 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 (three months in qualified program(s) per contract per calendar year)

Your Rights to Continue Coverage:

If you have Individual health insurance:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

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). You may also contact your state insurance department at www.mass.gov/doi.

OR

If you have Group health coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jíikeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,750
- **Patient pays** $3,790

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,770
Copays	$870
Coinsurance	$0
Limits or exclusions	$150
Total	**$3,790**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $160
- **Patient pays** $5,240

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,400
Copays	$3,760
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,240**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-262-BLUE (2583)** or visit us at www.bluecrossma.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-800-262-BLUE (2583)** to request a copy.

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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.

158485MB
55-0647 (2/16)

MASSACHUSETTS

Pediatric Dental

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

158474MB 55-0613 (2/16)

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**.

164264M 55-1487 (8/16)

MASSACHUSETTS

Translation Resources
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/λληνικά: 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 निःशुल्क 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 éézhónígí t'áá íiyiisí baa ákonínízin doo. Díí bee éézhóznínígí 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'doolyéégo át'é. Díí bee éézhónígí 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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