



MASSACHUSETTS

## SUMMARY OF BENEFITS



# Dental Blue<sup>®</sup> Pediatric Essential Benefits

For members until the end of the calendar month  
in which they turn age 19

**Dental Blue<sup>®</sup>**  
*The right choice*



This policy includes coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

# Dental Blue Pediatric Essential Benefits

Preventive Benefit Group*	Basic Benefit Group*	Major Benefit Group*
<b>No Deductible</b>	<b>\$50 Per Member Plan-Year Deductible (No more than \$150 for Three or More Members)</b>	
<b>Full Coverage</b>	<b>75% Coverage</b>	<b>50% Coverage</b>
<b>\$350 Per Member (\$700 for Two or More Members) Plan-Year Out-of-Pocket Maximum</b>		
<p><b>Oral Exams</b></p> <ul style="list-style-type: none"> <li>• One complete initial oral exam per provider or location (including initial history and charting of teeth and supporting structures)</li> <li>• Periodic or routine oral exams; twice in a calendar year</li> <li>• Oral exams for a member under age three; twice in a calendar year</li> <li>• Limited oral exams; twice in a calendar year</li> </ul> <p><b>X-rays</b></p> <ul style="list-style-type: none"> <li>• Single tooth X-rays; no more than one per visit</li> <li>• Bitewing X-rays; twice in a calendar year</li> <li>• Full mouth X-rays; once in three calendar years per provider or location</li> <li>• Panoramic X-rays; once in three calendar years per provider or location</li> </ul> <p><b>Routine Dental Care</b></p> <ul style="list-style-type: none"> <li>• Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year</li> <li>• Fluoride treatments; once in 90 days</li> <li>• Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)</li> <li>• Space maintainers</li> </ul>	<p><b>Fillings</b></p> <ul style="list-style-type: none"> <li>• Amalgam (silver) fillings; one filling per tooth surface in 12 months</li> <li>• Composite resin (white) fillings; one filling per tooth surface in 12 months</li> </ul> <p><b>Root Canal Treatment</b></p> <ul style="list-style-type: none"> <li>• Root canals on permanent teeth; once per tooth</li> <li>• Vital pulpotomy</li> <li>• Retreatment of prior root canal on permanent teeth; once per tooth in 24 months</li> <li>• Root end surgery on permanent teeth; once per tooth</li> </ul> <p><b>Crowns</b></p> <ul style="list-style-type: none"> <li>• Prefabricated stainless steel crowns; once per tooth (primary and permanent)</li> </ul> <p><b>Gum Treatment</b></p> <ul style="list-style-type: none"> <li>• Periodontal scaling and root planing; once per quadrant in 36 months</li> <li>• Periodontal surgery; once per quadrant in 36 months</li> </ul> <p><b>Prosthetic Maintenance</b></p> <ul style="list-style-type: none"> <li>• Repair of partial or complete dentures and bridges; once in 12 months</li> <li>• Reline or rebase partial or complete dentures; once in 24 months</li> <li>• Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul> <p><b>Oral Surgery</b></p> <ul style="list-style-type: none"> <li>• Simple tooth extractions; once per tooth</li> <li>• Erupted or exposed root removal; once per tooth</li> <li>• Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>• Other necessary oral surgery</li> </ul> <p><b>Other Necessary Services</b></p> <ul style="list-style-type: none"> <li>• Dental care to relieve pain (palliative care)</li> <li>• General anesthesia for covered oral surgery</li> </ul>	<p><b>Crowns</b></p> <ul style="list-style-type: none"> <li>• Resin crowns; once per tooth in 60 months</li> <li>• Porcelain/ceramic crowns; once per tooth in 60 months</li> <li>• Porcelain fused to metal/high noble crowns; once per tooth in 60 months</li> </ul> <p><b>Tooth Replacement</b></p> <ul style="list-style-type: none"> <li>• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months</li> <li>• Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months</li> </ul> <p><b>Other Necessary Services</b></p> <ul style="list-style-type: none"> <li>• Occlusal guards when necessary; once in a calendar year</li> <li>• Fabrication of an athletic mouth guard</li> </ul>
		<p><b>Orthodontic Benefit Group*</b></p> <p><b>No Deductible</b></p> <p>Coverage is only provided for medically necessary orthodontic care and requires prior authorization before services are provided. After prior authorization, you have:</p> <p>50% coverage</p> <ul style="list-style-type: none"> <li>• Braces for a member who has a severe and handicapping malocclusion</li> <li>• Related orthodontic services for a member who qualifies</li> </ul>

\* In Massachusetts, benefits are only provided when covered services are furnished by a participating dentist.

Welcome to Dental Blue, a comprehensive dental plan that provides a wide range of benefits to meet your dental care needs.

## Your Dentist

Dental Blue offers an extensive network of dentists. Over 90 percent of dentists in Massachusetts and New Hampshire participate with Blue Cross Blue Shield of Massachusetts. Dentists who participate with Blue Cross Blue Shield of Rhode Island are also available to Dental Blue members.

If you already have a dentist and you want to know if she or he participates with Blue Cross Blue Shield of Massachusetts, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card.

If you would like help choosing a dentist, you can call the Physician Selection Service at **1-800-821-1388**. You can also access the online dental provider directory at [www.bluecrossma.com](http://www.bluecrossma.com).

## Your Benefits

The dental benefits your plan covers are subject to the plan-year deductible and coinsurance (if applicable), and out-of-pocket maximum amounts. The chart shows the percentage of costs your plan will pay for covered dental services. Many covered services have specific time limits.

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most you could pay during a plan year for deductible and coinsurance for covered services. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. The out-of-pocket maximum is **\$350** per member (or **\$700** for two or more members). Costs that do not count towards your out-of-pocket maximum are premiums, any balance-billed charges, all dental services for members who are not eligible for pediatric essential dental benefits, and all services that this policy does not cover.

## Pre-Treatment Estimates and Prior Authorizations

If your dentist expects that your treatment will involve covered services that will cost more than \$250, Blue Cross Blue Shield recommends that your dentist send a copy of the “treatment plan” to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service.

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

If your dentist has determined you will need a service that requires prior authorization, she or he must request approval for those services to be covered before services are provided. Prior authorization services that are done without obtaining approval may not be covered.

You will be responsible for all charges for services that are not approved or are done without prior authorization.

## Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures, and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure.

You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

## How Dentists Are Paid

### Participating Dentists

Dentists that participate with Blue Cross Blue Shield of Massachusetts or Blue Cross Blue Shield of Rhode Island accept the lesser of either the dentist’s actual charge or the allowed charge as payment in full for covered services. You pay only your deductible and coinsurance (if applicable).

In Massachusetts, benefits are only provided when covered services are furnished by a participating dentist.

### Dentists Outside of Massachusetts

Benefits for covered services by a dentist outside of Massachusetts are provided based on the dentist’s actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist’s actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable).

## How Orthodontic Benefits Are Paid

Orthodontic benefits are available on or after your effective date. Coverage is only provided for medically necessary orthodontic services and requires prior authorization before services are provided. Orthodontic benefits are calculated using the allowed charge for the orthodontic procedure. You may be responsible for the deductible, coinsurance (if applicable), and any difference between the Blue Cross Blue Shield payment and the dentist’s actual charge. See your plan description (and riders, if any) for exact coverage details.

## When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan. Dental benefits are provided for members until the end of the calendar month in which they turn age 19.

## If You Have to File a Claim

Participating dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Blue Cross Blue Shield of Massachusetts Medical ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive emergency care in Massachusetts by a non-participating dentist because a participating dentist was not available, you may have to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service. After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, see your plan description for instructions on how to file a grievance.

## Other Information

Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

**Questions?** Call The Commonwealth Health Connector at **1-877-MA-ENROLL**.

You can also visit [www.mahealthconnector.org](http://www.mahealthconnector.org) or [www.bluecrossma.com/getblue](http://www.bluecrossma.com/getblue) for more information.

**Limitations and Exclusions.** These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.





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# 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 [civilrightscordinator@bcbsma.com](mailto:civilrightscordinator@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](http://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](http://hhs.gov).



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## 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 Idantifikasyon w lan. **711**).

**Avi sa a gen Enfòmasyon Enpòtan ladann.** Avi sa a gen enfòmasyon enpòtan osijè demann aplikasyon ou oswa pwoteksyon Blue Cross Blue Shield of Massachusetts bay. Ou gendwa bezwen ajì anvan sèten dat limit pou kenbe pwoteksyon asirans ou oswa pou ede ak depans yo. Ou gen dwa jwenn enfòmasyon sa a ak asistans nan lang ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan. **711**).

**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/عربي:**

انتباه: إذا كنت تتحدث اللغة العربية، ف تتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (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 إجراء ما بحلول مواعيد نهائية معينة للاحتفاظ بتغطيتك الصحية أو لتلقي المساعدة فيما يتعلق بالتكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

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

កំណត់សម្គាល់នេះមានព័ត៌មានសំខាន់ៗ។ កំណត់សម្គាល់នេះមានព័ត៌មានសំខាន់ៗអំពីការដាក់ពាក្យ របស់អ្នក ឬការគ្របដណ្តប់តាមរយៈ Blue Cross Blue Shield នៃ Massachusetts។ អ្នកអាចត្រូវ ការចាត់វិធានការត្រឹមកាលបរិច្ឆេទផុតកំណត់ជាក់លាក់នានាដើម្បីរក្សាការគ្របដណ្តប់របស់ អ្នក 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 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 नि:शुल्क 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 કોલ કરો (TTY: 711).

**આ નોટિસમાં મહત્વની માહિતી છે.** આ નોટિસમાં Blue Cross Blue Shield of Massachusetts મારફતે તમારી અરજી કે કવર વિશે મહત્વની માહિતી છે. તમને તમારું આરોગ્ય કવર 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 કોલ 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 شماره تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

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

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

ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບການສະໜັກຂອງທ່ານ ຫລື ປະກັນສັງຄັມໂດຍລວມຂອງອົງການ Blue Cross Blue Shield ຂອງ Massachusetts. ທ່ານອາດຈະຕ້ອງດໍາ ດືນການຕາມກຳນົດເວລາສະເພາະ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານໄວ້ ຫຼື ເພື່ອຮັບເອົາການ ຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍ. 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'á. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjijí' béésh bee hodíílnih (TTY: 711).

Díí bee ééhózinígí t'áá íyíisi baa ákonínízin doo. Díí bee ééhózninígí éí díí ninaaltsoos Blue Cross Blue Shield of Massachusetts bii' bee naa'áháyánígí éí bídeet'i' dóo baa ákonínízin dooleet. Díí ła' áadoo iikaaahí díí naah'é'él'íníí bee ná'ahoot'i'ígí bídadéit'i' dóo łahdóo ná bik'é ni'doolyééłgo át'é. Díí bee ééhózinígí nich'í' íishjání áalzindoogo éí bee náhaz'á dóo t'áá ninizaad k'ehjí t'áá jíík'e bee níká'a'doowoł. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjijí' béésh bee hodíílnih (TTY: 711).