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.com/connector](http://bluecrossma.com/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.com/sbcglossary](http://bluecrossma.com/sbcglossary) or call 1-800-262-BLUE (2583) to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,000 member / $2,000 family.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, prenatal care, prescription drugs, most office visits, mental health visits, and therapy visits.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$4,650 member / $9,300 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the Member Service number on your ID card for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network (You will pay the least)</th>
<th>Out-of-Network (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 / visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 / visit; $45 / chiropractor visit; $45 / acupuncture visit</td>
<td>Not covered</td>
<td>Limited to 12 acupuncture visits per calendar year</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>GYN exam limited to one exam per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$25</td>
<td>Not covered</td>
<td>Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$200</td>
<td>Not covered</td>
<td>Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$20 / retail supply or $40 / mail order supply</td>
<td>Not covered</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$40 / retail supply or $80 / mail order supply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 / retail supply or $180 / mail order supply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost share (generic, preferred, non-preferred)</td>
<td>Not covered</td>
<td>When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs</td>
</tr>
</tbody>
</table>

*All information is subject to change. Visit the Blue Cross Blue Shield of Massachusetts website for the most current information.*

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**Important Note:**

For more information about prescription drug coverage, visit [bluecrossma.com/medications](http://bluecrossma.com/medications).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>In-Network (You will pay the least) $250 / admission&lt;br&gt;Out-of-Network (You will pay the most) Not covered</td>
<td>Deductible applies first; pre-authorization required for certain services</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$150 / visit</td>
<td>$150 / visit&lt;br&gt;Deductible applies first; copayment waived if admitted or for observation stay</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge&lt;br&gt;Deductible applies first</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$45 / visit</td>
<td>$45 / visit&lt;br&gt;Out-of-network coverage limited to out of service area</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 / admission</td>
<td>Not covered&lt;br&gt;Deductible applies first; pre-authorization required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered&lt;br&gt;Deductible applies first; pre-authorization required</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$25 / visit</td>
<td>Not covered&lt;br&gt;Pre-authorization required for certain services</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$500 / admission</td>
<td>Not covered&lt;br&gt;Deductible applies first; pre-authorization required for certain services</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$500 / admission</td>
<td>Not covered&lt;br&gt;Deductible applies first for childbirth/delivery facility services; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network (You will pay the least)</td>
<td>Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$45 / visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$45 / visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$500 / admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>35% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

#### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Abortion
- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)
Your Rights to Continue Coverage:

If you have Individual health insurance:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

OR

If you have Group health coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state’s marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member’s employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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]
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's Type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow-up care)</td>
</tr>
<tr>
<td>■ The plan's overall deductible</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>■ Delivery fee copay</td>
<td>$0</td>
<td>$45</td>
</tr>
<tr>
<td>■ Facility fee copay</td>
<td>$500</td>
<td>$25</td>
</tr>
<tr>
<td>■ Diagnostic tests copay</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist office visits (pre-natal care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Example Cost</td>
<td>$12,800</td>
<td>$7,400</td>
</tr>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
<td>$2,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$1,660</td>
<td></td>
</tr>
<tr>
<td>What isn't covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan would be responsible for the other costs of these EXAMPLE covered services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Registered Marks of the Blue Cross and Blue Shield Association. © 2020 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
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.
Your health plan coverage includes a dental policy that covers pediatric dental services as required under the federal Patient Protection and Affordable Care Act.
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.
Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Este aviso tiene información importante. Este aviso tiene información importante sobre su solicitud o su cobertura de Blue Cross Blue Shield of Massachusetts. Es posible que deba tomar medidas antes de ciertas fechas límite para mantener su cobertura médica o recibir ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su idioma de manera gratuita. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Este Aviso contém Informação Importante. Este aviso contém informação importante acerca do seu pedido ou cobertura através da Blue Cross Blue Shield of Massachusetts. Poderá ter de agir em função de determinadas datas-limite para manter a sua cobertura de saúde ou ajudar os 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 Idantifikasiyèn 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 Idantitifikasyon w lan. 711).


Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc phạm vi bảo trì qua Blue Cross Blue Shield of Massachusetts. Quý vị có thể cần có hành động trước thời hạn để duy trì phạm vi bảo trì y tế hoặc được trợ giúp về phí tiền. 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 Hỗ trợ 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 (телефон: 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 (телефон: 711).

Arabic/عربية: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز التلفون الصوتي للصم والبكم: 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 نهاية ميزة الاحتفاظ بتفاصيل هذه المعلومات بما يتعلق بالتكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز التلفون الصوتي للصم والبكم: 711).

Mon-Khmer, Cambodian/កម្ពុជា: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរបើអ្នកអាចរកបានសបរារ់អ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្ណ្ណ សរាគា េ្លៃួនរ្រស់អ្នក (TTY: 711)។

Blue Cross Blue Shield of Massachusetts គឺជាទំនើបក្រុមទូរស័ព្ទការបម្លែម្េត្រ់តាមរយៈ Blue Cross Blue Shield នៃ Massachusetts។ Blue Cross Blue Shield សម្រាប់សរុបក្រុមទូរស័ព្ទបៅម្េនៃការបម្លែម្េត្រ់តាមរយៈ Blue Cross Blue Shield of Massachusetts និងជំនួយជាភាសាខ្មែរបាន (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).


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 취하시어야 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 κάλυψη σας μέσω της Blue Cross Blue Shield of Massachusetts. Μπορεί να χρειαστεί να προβείτε σε συγκεκριμένες ενέργειες σε συγκεκριμένες προθεσμίες, ώστε να διατηρήσετε την κάλυψη της υγείας σας ή να βοηθήσετε στο θέμα του κόστους. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και τη βοήθεια στη γλώσσα σας χωρίς κόστος. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

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

Hindi/हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो भाषा सहायता सेवाओं, आप के लिए निश्चित उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वै.ई.: 711). इस नोटिस में महत्त्वपूर्ण जानकारी है। इस नोटिस में Blue Cross Blue Shield of Massachusetts के माध्यम से आपके आवेदन या कवरेज के बारे में महत्त्वपूर्ण जानकारी है। आपके स्वास्थ्य कवरेज बनाए रखने या लागतों में मदद पाने के लिए आपको कुछ निर्देश अन्य संस्थाओं के अंतर्गत कदम उठाने की आवश्यकता हो सकती है। आपके पास यह जानकारी एवं मदद आपकी भाषा में निश्चित पाने का अधिकार है। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वै.ई.: 711).
Congratulations: If you are a Blue Cross Blue Shield of Massachusetts subscriber, you have access to free language assistance services. Call Member Service at the number on your ID Card (TTY: 711).

This notice contains important information.

This notice contains important information about your application or coverage through Blue Cross Blue Shield of Massachusetts. You may need to take certain actions within specific deadlines to maintain your health coverage or to receive financial support. You have the right to receive these information and assistance in your native language for free. Call Member Service at the number on your ID Card (TTY: 711).

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