



The **Summary of Benefits and Coverage (SBC)** document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, see [bluecrossma.org/coverage-info](https://bluecrossma.org/coverage-info). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](https://bluecrossma.org/sbcglossary) or call **1-800-424-0794** to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | \$750 member / \$1,500 family.                                                                                                                                                    | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                                      |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Preventive and prenatal care, most office visits, mental health visits, therapy visits, emergency transportation, emergency room, and <u>prescription drugs</u> .            | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                               | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$3,500 member / \$7,000 family.                                                                                                                                                  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                                                                                 | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the Member Service number on your ID card for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                               | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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<br>(You will pay the least)                            | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you visit a health care <u>provider's office or clinic</u> | Primary care visit to treat an injury or illness | \$30 / visit                                                      | Not covered                               | Family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, limited services clinic, multi-specialty <u>provider group</u> , or by a physician assistant or nurse practitioner designated as primary care; <u>cost share</u> waived for the first two diabetic PCP and / or <u>specialist</u> visits per calendar year; a telehealth <u>cost share</u> may be applicable |
|                                                               | <u>Specialist</u> visit                          | \$50 / visit; \$50 / chiropractor visit; \$50 / acupuncture visit | Not covered                               | Includes physician assistant or nurse practitioner designated as specialty care; <u>cost share</u> waived for the first two diabetic PCP and / or <u>specialist</u> visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable                                                                                                                                   |
|                                                               | <u>Preventive care/screening/immunization</u>    | No charge                                                         | Not covered                               | Limited to age-based schedule and / or frequency; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                                          |

| Common Medical Event                                                                                                                                                                                                      | Services You May Need                      | What You Will Pay                                                                                                                                                                                                                                                                                      |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                           |                                            | In-Network<br>(You will pay the least)                                                                                                                                                                                                                                                                 | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                    |
| If you have a test                                                                                                                                                                                                        | <u>Diagnostic test</u> (x-ray, blood work) | \$25                                                                                                                                                                                                                                                                                                   | Not covered                               | <u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required                                                                                                     |
|                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)               | \$75                                                                                                                                                                                                                                                                                                   | Not covered                               | <u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required                                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a> | Generic drugs                              | \$10 / retail or mail service supply for low-cost generic drugs; \$15 / retail or mail service supply for other generic drugs                                                                                                                                                                          | Not covered                               | Up to 30-day retail (90-day mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs                               |
|                                                                                                                                                                                                                           | Preferred brand drugs                      | \$45 / retail supply or \$90 / mail service supply                                                                                                                                                                                                                                                     | Not covered                               |                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                           | Non-preferred brand drugs                  | \$90 / retail supply or \$180 / mail service supply                                                                                                                                                                                                                                                    | Not covered                               |                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                           | <u>Specialty drugs</u>                     | \$10 / retail supply for low-cost generic drugs; \$15 / retail supply for other generic drugs; 20% <u>coinsurance</u> / retail supply for preferred brand <u>specialty drugs</u> ; 20% <u>coinsurance</u> / retail supply for non-preferred <u>specialty drugs</u> ; not covered / mail service supply | Not covered                               | Up to 30-day retail supply; when obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                               |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | In-Network<br>(You will pay the least)          | Out-of-Network<br>(You will pay the most)       |                                                                                                                                                                                                                                                                                |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | \$150 / admission                               | Not covered                                     | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services                                                                                                                                                                                        |
|                                                                           | Physician/surgeon fees                         | No charge                                       | Not covered                                     | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services                                                                                                                                                                                        |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$150 / visit; <u>deductible</u> does not apply | \$150 / visit; <u>deductible</u> does not apply | <u>Copayment</u> waived if admitted or for observation stay                                                                                                                                                                                                                    |
|                                                                           | <u>Emergency medical transportation</u>        | No charge                                       | No charge                                       | None                                                                                                                                                                                                                                                                           |
|                                                                           | <u>Urgent care</u>                             | \$50 / visit                                    | Not covered                                     | A telehealth <u>cost share</u> may be applicable                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                          | Not covered                                     | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services                                                                                                                                                                        |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                          | Not covered                                     | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services                                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | \$30 / visit                                    | Not covered                                     | A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services                                                                                                                                                                       |
|                                                                           | Inpatient services                             | 20% <u>coinsurance</u>                          | Not covered                                     | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services                                                                                                                                                                        |
| If you are pregnant                                                       | Office visits                                  | No charge                                       | Not covered                                     | <u>Deductible</u> applies first except for prenatal care; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable |
|                                                                           | Childbirth/delivery professional services      | 20% <u>coinsurance</u>                          | Not covered                                     |                                                                                                                                                                                                                                                                                |
|                                                                           | Childbirth/delivery facility services          | 20% <u>coinsurance</u>                          | Not covered                                     |                                                                                                                                                                                                                                                                                |

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                      |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network<br>(You will pay the least)                                                 | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | No charge                                                                              | Not covered                               | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services                                                                                                                                                                                                                                                                                         |
|                                                                | <u>Rehabilitation services</u>   | \$50 / visit for outpatient services;<br>20% <u>coinsurance</u> for inpatient services | Not covered                               | <u>Deductible</u> applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, Down syndrome, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
|                                                                | <u>Habilitation services</u>     | \$50 / visit                                                                           | Not covered                               | Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable                                                                                                                                                                   |
|                                                                | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                                                                 | Not covered                               | <u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required                                                                                                                                                                                                                                                                       |
|                                                                | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                                                                 | Not covered                               | <u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies                                                                                                                                                                                                                                                                     |
|                                                                | <u>Hospice services</u>          | No charge                                                                              | Not covered                               | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services                                                                                                                                                                                                                                                                                         |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                                                              | Not covered                               | Limited to one exam every 24 months                                                                                                                                                                                                                                                                                                                                             |
|                                                                | Children's glasses               | Not covered                                                                            | Not covered                               | None                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                | Children's dental check-up       | No charge for members with a cleft palate / cleft lip condition                        | Not covered                               | Limited to members under age 18                                                                                                                                                                                                                                                                                                                                                 |

**Excluded Services & Other Covered Services:**

|                                                                                                                                                                                                                                            |                                                                                                                                                                                                                         |                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>                                                               |                                                                                                                                                                                                                         |                                                                                                             |
| <ul style="list-style-type: none"><li>• Children's glasses</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>                                                                                                              | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>                                                                                           | <ul style="list-style-type: none"><li>• Private-duty nursing</li></ul>                                      |
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>                                                                                                 |                                                                                                                                                                                                                         |                                                                                                             |
| <ul style="list-style-type: none"><li>• Acupuncture (12 visits per calendar year)</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Routine eye care - adult (one exam every 24 months)</li><li>• Routine foot care (only for patients with systemic circulatory disease)</li></ul> | <ul style="list-style-type: none"><li>• Weight loss programs (\$150 per calendar year per policy)</li></ul> |

**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](http://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](http://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](http://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](http://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](http://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](http://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 <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Delivery fee coinsurance</u>             | 20%   |
| ■ <u>Facility fee coinsurance</u>             | 20%   |
| ■ <u>Diagnostic tests copay</u>               | \$25  |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost sharing</u> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$750   |
| <u>Copayments</u>   | \$100   |
| <u>Coinsurance</u>  | \$1,700 |

*What isn't covered*

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,610</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Specialist visit copay</u>               | \$50  |
| ■ <u>Primary care visit copay</u>             | \$30  |
| ■ <u>Diagnostic tests copay</u>               | \$25  |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost sharing</u> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$100   |
| <u>Copayments</u>   | \$1,500 |
| <u>Coinsurance</u>  | \$0     |

*What isn't covered*

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,620</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Specialist visit copay</u>               | \$50  |
| ■ <u>Emergency room copay</u>                 | \$150 |
| ■ <u>Ambulance services copay</u>             | \$0   |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$0   |
| <u>Copayments</u>   | \$400 |
| <u>Coinsurance</u>  | \$0   |

*What isn't covered*

|                                   |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$400</b> |

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

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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.

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, 25 Technology Place, Hingham, MA 02043; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **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**; 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**.

## PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

**Chinese/简体中文:** 注意: 如果您讲中文, 我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部 (TTY 号码: **711**)。

**Haitian Creole/Kreyòl Ayisyen:** ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: **711**).

**Vietnamese/Tiếng Việt:** LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

**Russian/Русский:** ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

**Arabic/عربي:**

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. 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**)។

**French/Français:** ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

**Italian/Italiano:** ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

**Korean/한국어:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

**Greek/Ελληνικά:** ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

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

**Hindi/हिंदी:** ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

**Gujarati/ગુજરાતી:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને 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).

**Japanese/日本語:** お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: 711)。

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

**Persian/پارسیان:**

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

**Lao/ພາສາລາວ:** ຂໍຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowolgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dée' nóomba biká'ígíjij' béésh bee hodíílnih (TTY: 711).