**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
What is the overall deductible? | $1,000 member / $2,000 family. Does not apply to in-network preventive and prenatal care, most office visits, therapy visits, mental health visits; prescription drugs, emergency room. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.

Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

Is there an out-of-pocket limit on my expenses? | Yes. For medical benefits, $1,500 member / $3,000 family in-network and $3,000 member / $6,000 family out-of-network; and for prescription drug benefits, $1,000 member / $2,000 family in-network. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

Does this plan use a network of providers? | Yes. See [www.bluecrossma.com/findadoctor](http://www.bluecrossma.com/findadoctor) or call 1-800-821-1388 for a list of preferred providers. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

Do I need a referral to see a specialist? | No. | You can see the specialist you choose without permission from this plan.

Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 6. See your policy or plan document for additional information about excluded services.

Questions: Call 1-888-456-1351 or visit us at [www.bluecrossma.com](http://www.bluecrossma.com). If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bluecrossma.com/sbcglossary](http://www.bluecrossma.com/sbcglossary) or call 1-888-456-1351 to request a copy.
• **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

• **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider’s charge if it is less than the **allowed amount**) for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider’s charge), your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.

• The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

• This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$30 / chiropractor visit</td>
<td>20% coinsurance / chiropractor visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 / retail supply or $20 ($10 for value drugs) / mail service supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$25 / retail supply or $50 ($25 for value drugs) / mail service supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$45 / retail supply or $90 / mail service supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost share (generic, preferred, non-preferred)</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 / visit</td>
<td>$100 / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.bluecrossma.com/medications.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>abuse needs</td>
<td></td>
<td></td>
<td>Deductible applies first for out-of-network; pre-authorization required for certain services</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible applies first for in-network postnatal care and out-of-network prenatal and postnatal care</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td>Deductible applies first</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</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>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$30 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Eye exam</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>No charge for members with a cleft palate / cleft lip condition</td>
<td>20% coinsurance for members with a cleft palate / cleft lip condition</td>
</tr>
</tbody>
</table>

**Limitations & Exceptions**

- Deductible applies first; pre-authorization required
- Deductible applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
- Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
- Deductible applies first; limited to 100 days per calendar year; pre-authorization required
- Deductible applies first; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
- Deductible applies first
- Deductible applies first for out-of-network; limited to one exam per calendar year
- Limited to members under age 18; deductible applies first for out-of-network

--- none ---
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Children's glasses</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Routine eye care - adult (one exam per calendar year)</td>
</tr>
<tr>
<td>• Routine foot care (only for patients with systemic circulatory disease)</td>
</tr>
<tr>
<td>• Weight loss programs ($150 per calendar year per policy)</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member’s employer or organization that provides group health coverage to the member. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Assistance
To obtain language assistance, please call the toll-free Member Service number on your ID card.
SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.
CHINESE (中文): 如您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼
NAVAJO (Dine): Dineʼehjí shikaʼ aʼdowoł ninizingo, kwojí hodiiʼné tʼáá jiiʼeh bée sh beeʼ haneʼjí Tʼáá dooléʼé binaʼisdiʼkidgo yeehááʼadoojah éí binumber bee néehoʼdolzin biniyé naanitinííí bikiááʼ doo.

Disclaimer:
This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(normal delivery)</strong></td>
<td><strong>(routine maintenance of a well-controlled condition)</strong></td>
</tr>
</tbody>
</table>

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,370
- **Patient pays:** $1,170

**Sample care costs:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copays</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,170</strong></td>
</tr>
</tbody>
</table>

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,010
- **Patient pays:** $1,390

**Sample care costs:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$140</td>
</tr>
<tr>
<td>Copays</td>
<td>$1,170</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,390</strong></td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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Questions: Call 1-888-456-1351 or visit us at [www.bluecrossma.com](http://www.bluecrossma.com).

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bluecrossma.com/sbcglossary](http://www.bluecrossma.com/sbcglossary) or call 1-888-456-1351 to request a copy.
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, 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).

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).


Arabic/ةيب: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الاتصال والكم (TTY: 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណើរ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ បានប្រើប្រាស់ម៉ាសាំុំបង្ហាញព័ត៌មាន ភាសាខ្មែរៈហិរញ្ញវត្ថុភាពធម្មតានេះម៉ោង រួមបញ្ចូលទំហំនៃយូរ (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).


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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निष्ठुरक उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाइ.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતો હો, તો તમારી ભાષા સહાયતા સેવાઓ દ્વારા મૂમ્પ્ય ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપણે નંબર પર મંડીલી સેવાઓ ને કોલને આપશો (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）。


