



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. 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 or call 1-888-753-6615 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | \$250 member in-network; \$500 member out-of-network. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. In-network preventive and prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, therapy visits; emergency room. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | Yes. For pediatric essential dental, \$50 member (no more than \$150 for three or more eligible members per family). There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | For medical benefits, \$5,000 member / \$10,000 family; for <u>prescription drug</u> benefits, \$1,000 member / \$2,000 family; and for pediatric essential dental, \$350 member (no more than \$700 for two or more eligible members per 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. |
| What is not included in the <u>out-of-pocket limit</u>? | <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> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See bluecrossma.com/findadoctor 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | 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 (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable |
| | <u>Specialist</u> visit | \$25 / visit; \$25 / chiropractor visit; \$25 / acupuncture visit | 20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit | <u>Deductible</u> applies first for out-of-network; 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 | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; 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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> may be required |
| | Imaging (CT/PET scans, MRIs) | \$25 | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication | Generic drugs | \$20 / retail supply or \$40 / mail service supply for low-cost generic drugs; \$40 / retail supply or \$80 / 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 | \$60 / retail supply or \$120 / mail service supply | Not covered | |
| | Non-preferred brand drugs | \$120 / retail supply or \$360 / mail service supply | Not covered | |
| | <u>Specialty drugs</u> | Applicable <u>cost share</u> (generic, preferred, non-preferred) | Not covered | 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 |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| If you need immediate medical attention | <u>Emergency room care</u> | \$100 / visit; <u>deductible</u> does not apply | \$100 / 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 | <u>Deductible</u> applies first |
| | <u>Urgent care</u> | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <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 | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | Inpatient services | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services |
| If you are pregnant | Office visits | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <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 | No charge | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | No charge | 20% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| | <u>Rehabilitation services</u> | \$25 / visit for outpatient services; No charge for inpatient services | 20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services | <u>Deductible</u> applies first except for in-network outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, <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> | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to 60 visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); <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>pre-authorization</u> may be required for certain services |
| | <u>Skilled nursing care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required |
| | <u>Durable medical equipment</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies |
| | <u>Hospice services</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|--|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to one exam every 12 months until the end of the month a member turns age 19 |
| | Children's glasses | 35% <u>coinsurance</u> | 55% <u>coinsurance</u> | <u>Deductible</u> applies first; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 19 |
| | Children's dental check-up | No charge | Not covered | Limited to twice per calendar year until the end of the month a member turns age 19 |

Excluded Services & Other Covered Services:

| | | |
|---|--|--|
| Services Your <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>.) | | |
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Long-term care | <ul style="list-style-type: none"> • Private-duty nursing |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | |
| <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • Infertility treatment • Non-emergency care when traveling outside the U.S. • Routine eye care - adult (one exam every 24 months) | <ul style="list-style-type: none"> • Routine foot care (only for patients with systemic circulatory disease) • Weight loss programs (\$150 per calendar year per policy) |

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 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).

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.

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> | \$250 |
| ■ <u>Delivery fee copay</u> | \$0 |
| ■ <u>Facility fee copay</u> | \$0 |
| ■ <u>Diagnostic tests copay</u> | \$0 |

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$0 |

| <u>What isn't covered</u> | |
|-----------------------------------|--------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$320 |

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> | \$250 |
| ■ <u>Specialist</u> visit <u>copay</u> | \$25 |
| ■ <u>Primary care</u> visit <u>copay</u> | \$25 |
| ■ <u>Diagnostic tests</u> <u>copay</u> | \$0 |

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost sharing</u> | |
|---------------------|---------|
| <u>Deductibles</u> | \$100 |
| <u>Copayments</u> | \$1,200 |
| <u>Coinsurance</u> | \$0 |

| <u>What isn't covered</u> | |
|-----------------------------------|----------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,320 |

Mia's Simple Fracture (in-network emergency room visit and follow-up care)

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist</u> visit <u>copay</u> | \$25 |
| ■ <u>Emergency room</u> <u>copay</u> | \$100 |
| ■ <u>Ambulance services</u> <u>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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |

| <u>What isn't covered</u> | |
|-----------------------------------|--------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$450 |

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.



PEDIATRIC ESSENTIAL DENTAL BENEFITS

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

This separate dental policy covers pediatric essential dental benefits for members until the end of the calendar month in which they turn age 19 as required by federal law.



You must meet a plan-year deductible for certain covered dental services. Your deductible is **\$50** per member (no more than **\$150** for three or more members enrolled under the same family membership).

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and coinsurance for covered dental services. Your out-of-pocket maximum is **\$350** per member (no more than **\$700** for two or more members enrolled under the same family membership).

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor or call the Member Service number on your ID card.

| Pediatric Essential Dental Benefits* | Your Cost In-Network** |
|---|----------------------------------|
| Group 1: Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care | Nothing, no deductible |
| Group 2: Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance | 25% coinsurance after deductible |
| Group 3: Major Restorative Services: tooth replacement, resin crowns, and occlusal guards | 50% coinsurance after deductible |
| Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member | 50% coinsurance, no deductible |

* All covered services are limited to members until the end of the month they turn age 19, and may be subject to an age-based schedule or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.
** There are no out-of-network benefits for dental services.

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/العربية:

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. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (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).