Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, call 1-800-310-2835 or visit <u>healthnewengland.org</u> and sign into the Member Portal. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call 1-800-310-2835 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual coverage: \$3,600 individual. Family coverage: \$3,600 individual / \$7,200 family	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. 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> .
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	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</u> <u>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> .
Are there other deductibles for specific services?	Yes. \$50 per child / \$150 per family for non-preventive pediatric dental services.	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</u> <u>limit</u> for this <u>plan</u> ?	Medical, prescription drugs & chiropractic services: \$6,650 individual / \$13,300 family. Pediatric dental: \$350 child / \$700 family. Total: \$7,000 individual / \$14,000 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.
What is not included in the out-of-pocket limit?	Your <u>cost-sharing</u> for benefits that are not <u>Essential Health</u> <u>Benefits</u> under national health care reform, <u>premiums</u> , health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>healthnewengland.org</u> or call 1-800-310-2835 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</u> charge 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.

2021-SG-SL-FRXK5-CH20NLF-Grp&non-Grp

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$100 <u>copay</u> /visit	Not covered	None
If you visit a health care provider's office or clinic	Specialist visit	\$150 copay/visit \$20 copay/visit for chiropractor. \$20 copay/visit for acupuncture.	Not covered	Acupuncture limited to 12 visits per calendar year.
	Preventive care/screening/ immunization	No charge <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	Radiology: \$140 <u>copay</u> Lab: \$55 <u>copay</u>	Not covered	None
If you have a test	Imaging (CT/PET scans, MRIs)	\$1,000 <u>copay</u> (maximum 3 <u>copays</u> per year)	Not covered	Includes CT Scans, PET Scans, MRIs, MRAs and Nuclear Cardiac Imaging. Prior approval is required.
If you need drugs to	Tier 1 (Generic drugs)	\$30 retail <u>copay</u> , \$60 mail order <u>copay</u> /prescription.	Not covered	Covers up to a 20 day supply (retail), up to
treat your illness or condition  More information about prescription drug coverage is available at www.hnedirect.com/Form	Tier 2 (Brand/Formulary drugs)	\$150 retail <u>copay</u> , \$300 mail order <u>copay</u> /prescription.	Not covered	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order). Prior approval is required for some <u>prescription drugs</u> . Without prior approval, a drug may not be
	Tier 3 (Brand/Non-formulary drugs)	\$225 retail <u>copay</u> , \$675 mail order <u>copay</u> /prescription.	Not covered	covered.
ularyLookup/Default.aspx	Specialty drugs	Copay depends on drug tier.	Not covered	Prior approval is required for some prescription drugs. Without prior approval, a

		What You \		
Common Medical Event	Services You May Need	In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				drug may not be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <u>copay</u>	Not covered	Prior approval is required for some services. This <u>copay</u> is based on the type of service. To find out if this <u>copay</u> applies to a specific procedure, please contact Health New England Member Services at 1-800-310-2835.
	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	\$1,750 <u>copay</u> /visit	\$1,750 <u>copay</u> /visit	None
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	For ground ambulance services from out-of- plan <u>providers</u> , only ambulance transport and mileage are covered. Ancillary supplies or services (such as ECG tracing, drugs, intubation and measuring of oxygen in the blood) will not be covered if billed as separate line items.
	<u>Urgent care</u>	\$150 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,000 copay/admission	Not covered	60 days per calendar year limit for inpatient rehabilitation. 100 days per calendar year limit for skilled nursing facility care.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral	Outpatient services	\$100 <u>copay</u> /visit	Not covered	Prior approval is required for some services.
health, or substance abuse services	Inpatient services	\$2,000 <u>copay</u> /admission	Not covered	Prior approval is required.
	Office visits	No charge <u>Deductible</u> does not apply.	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service, deductible and copays may apply.
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$2,000 <u>copay</u> /admission	Not covered	Coverage for child is limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30

What You Will Pay				
Common Medical Event	Services You May Need	In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				days of date of birth.
	Home health care	No charge	Not covered	Prior approval is required.
	Rehabilitation services	\$150 <u>copay</u> /visit per treatment type	Not covered	Limited to 60 visits per calendar year for physical or occupational therapy. Prior approval is required for speech therapy after the initial evaluation.
If you need help recovering or have other special health needs	Habilitation services	\$150 <u>copay</u> /visit per treatment type	Not covered	Early intervention services are covered for children from birth to age 3. Applied Behavioral Analysis (ABA) to treat autism spectrum disorders is covered with prior approval. Copays do not apply to early intervention and ABA services.
	Skilled nursing care	No charge	Not covered	Skilled nursing services in the home. Prior approval is required.
	Durable medical equipment	20% coinsurance	Not covered	Prior approval is required.
	Hospice services	No charge	Not covered	Prior approval is required.
If your child needs dental or eye care	Children's eye exam	No charge for routine exams.  Deductible does not apply.	Not covered except for children under age 19. For children under age 19 you will pay charges in excess of a \$28 reimbursement.	Routine exams limited to one per calendar year. Routine exams for children under age 19 will be covered at no charge only if done by a provider participating with Health New England's children's vision care provider EyeMed.
	Children's glasses	No charge for 1 pair with a "Collection" frame; or \$150 allowance + 20% off expense beyond allowance.	Not covered except for children under age 19. For children under age 19 you will pay expenses beyond allowed amounts. Allowed amounts depend on types of frames and lenses.	For children under age 19. Limited to one pair per calendar year. In-plan providers are providers participating with Health New England's children's vision care provider EyeMed.
	Children's dental check-up	No charge	20% coinsurance	For children under age 19. Out-of-plan dentists may also bill you for the difference between their charge and Health New

		What You Will Pay		
Common Medical Event	Services You May Need	In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				England's contracted dental network's allowed amount.

#### **Excluded Services & Other Covered Services:**

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

- Cosmetic Surgery
- Dental Care (Adult) (except for the limited services specified in your plan materials)
- Long Term Care
- Non-emergency care when traveling outside the U.S.

- Private Duty Nursing
- Routine Foot Care (Routine foot care is covered if you have diabetes)

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

- Abortion
- Acupuncture
- Bariatric Surgery (requires prior approval)
- Chiropractic Care

- Hearing Aids (limited to members age 21 and under, \$2,000 per hearing aid per ear each 36 months, requires prior approval)
- Infertility Treatment (requires prior approval)
- Routine eye care (Adult)
- Weight Loss Programs (reimbursement per calendar year :\$200 per individual up to \$400 per family)

## **Your Rights to Continue Coverage:**

If you have Individual health insurance: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Massachusetts Division of Insurance at 877-563-4467, or <a href="mailbox@state.ma.us">doi:css.mailbox@state.ma.us</a>, or <a href="https://www.mass.gov/health-care">https://www.mass.gov/health-care</a>. 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 <a href="www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596. For information on buying individual coverage through the state marketplace, contact the Massachusetts Health Connector at <a href="www.mahealthconnector.org">www.mahealthconnector.org</a>.

If you have Group health insurance 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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the Department of Health Insurance at 877-563-4467, or <a href="wdo.dol.gov/ebsa/healthreform">dol.gov/ebsa/healthreform</a> and the Department of Health Insurance department. Massachusetts resident can contact The Massachusetts Division of Insurance at 877-563-4467, or <a href="wdo.dol.gov/ebsa/healthreform">dol.gov/ebsa/healthreform</a> and the Department of Health Insurance at 877-563-4467, or <a href="wdo.dol.gov/ebsa/healthreform">w

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact Member Services at the number on your plan ID Card or your plan sponsor (usually the employer or organization that provides your health insurance). Or you can contact the Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp. If you have group health insurance coverage you can also contact the

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>.

## 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? Group plans: Yes Individual policies: Not Applicable

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.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

# Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$3,600
■ Specialist copay	\$150
■ Hospital (facility) copay	\$2,000
Laboratory copay	\$55

#### 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:		
Cost Sharing		
<u>Deductibles</u>	\$3,600	
Copayments	\$2,000	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Peg would pay is	\$5,600	

# Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,600
■ Specialist copay	\$150
Primary care visit copay	\$100
Laboratory <u>copay</u>	\$55

### This EXAMPLE event includes services like:

<u>Primary care physician</u> 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:		
Cost Sharing		
<u>Deductibles</u>	\$2,200	
Copayments	\$400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$2,600	

# **Mia's Simple Fracture**

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

■ The plan's overall deductible	\$3,600
■ Specialist copay	\$150
■ Hospital ER (facility) copay	\$1,750
Ambulance services copay	\$0

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$2,800	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

### Notice Informing Individuals of Nondiscrimination and Accessibility

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health New England does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### Health New England:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - Information written in other languages

If you need these services, contact Susan O'Connor, Vice President and General Counsel.

If you believe that Health New England has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Susan O'Connor, Vice President and General Counsel, One Monarch Place, Suite 1500, Springfield, MA 01104-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685 or ComplaintsAppeals@hne.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Susan O'Connor, Vice President and General Counsel 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 electronically through the Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.

## **Multi-Language Services**

We're here to help you. We can give you information in other formats and different languages. All translation services are free to members. If you have questions regarding this document please call the toll-free member phone number listed on your health plan ID card, (TTY:711), Monday through Friday, 8:00 a.m.-6:00 p.m.

Last reviewed: 7/31/2019

English	You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. (TTY: 711)
Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. (TTY: 711)
Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. (TTY: 711)

Chinese	
Chinese	│ 您有權免費以您使用的語言獲得幫助和訊息。如需口譯員,請撥打您的保健計劃 ID 卡上列出的免費會員電話號碼
	,按 0。(TTY: 711)
French Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. (TTY: 711)
Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi sô điể In thoa Ii miễn phí dành cho hô Ii viên được nêu trên the ID chương trình ba Io hiểm y tê I của quý vị, bấm sô I 0. (TTY: 711).
Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия (телетайп: 711)
Arabic	يحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. لطلب مترجم، اتصل برقم هاتف العضو المجاني على بطاقة تعريف خطتك الصحية، ثم اضغط على 0. (TTY:711)
Mon-Khmer, Cambodian	អ្នកមានសិទ្ធិទ្ទួួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអ្យ់ថ្លៃ។ ដ ើមបីដសនើស ំអ្នកបកប្រប សូមទុូរស័ពទដៅដលខឥតដេញថ្លៃសំរាប់សមាជិក ប លមានកត់ដៅកនុងប័ណ្ណ ID គំដរាងស ខភាពរបស់អ្នក រួេដ ើយេ េ 0។ (TTY: 711)
French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. (ATS: 711).
Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti (TTY: 711).
Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는
	귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. (TTY: 711).
Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. (TTY: 711).
Hindi	आंप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सुचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
Gujarati	તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયાની વિનંતી કરવા માટે તમારા હેલ્થ પ્લાન ID કાર્ડ પર જણાવેલા ટૉલ- ફ્રી-નંબર પર કૉલ કરો અને 0 દબાવો. (TTY: 711).¤

Lao	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບ ່ມີຄ່າໃຊ້ຈ່າຍ. ເພຼື່ອຂ ຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສ າລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. (TTY: 711).
Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. (TTY: 711).
Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. (TTY: 711).