



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, call 1-800-310-2835 or visit [healthnewengland.org](http://healthnewengland.org) and sign into the Member Portal. 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-310-2835 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500 individual / \$1,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , office visits, labs, chiropractic care & <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,000 individual / \$12,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Your <a href="#">cost-sharing</a> for benefits that are not <a href="#">Essential Health Benefits</a> under national health care reform, <a href="#">premiums</a> , health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://healthnewengland.org">healthnewengland.org</a> or call 1-800-310-2835 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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-Plan Provider (You will pay the least)	Out-of-Plan Provider (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	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not covered	<u>Deductible</u> may apply to some office services.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit \$20 <u>copay</u> /visit for chiropractor. \$20 <u>copay</u> /visit for acupuncture. <u>Deductible</u> does not apply.	Not covered	<u>Deductible</u> may apply to some office services. Chiropractic care limited to 12 visits per calendar year. Acupuncture limited to 12 visits per calendar year.
	<u>Preventive care/screening</u> /immunization	No charge <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Radiology: No charge Lab: No charge <u>Deductible</u> does not apply to labs.	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <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 treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.hnedirect.com/FormularyLookup/Default.aspx">www.hnedirect.com/FormularyLookup/Default.aspx</a>	Tier 1 (Generic drugs)	\$20 retail <u>copay</u> , \$40 mail order <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	Covers up to a 30-day supply (retail); up to a 90 day supply (mail order). Mail order is not available for specialty drugs. Prior approval is required for some <u>prescription drugs</u> . Without prior approval, a drug may not be covered.
	Tier 2 (Brand/Formulary drugs)	\$50 retail <u>copay</u> , \$100 mail order <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	
	Tier 3 (Brand/Non-formulary drugs)	\$100 retail <u>copay</u> , \$300 mail order <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
	Tier 4 (Specialty/Formulary drugs)	\$150 retail <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
	Tier 5 (Specialty/Non-Formulary drugs)	\$250 retail <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Prior approval is required for some services.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$250 <u>copay</u> /visit <u>Deductible</u> does not apply.	None
	<a href="#">Emergency medical transportation</a>	\$100 <u>copay</u> per member per day	\$100 <u>copay</u> per member per day	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.
	<a href="#">Urgent care</a>	\$40 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not covered	<u>Deductible</u> may apply to some office services.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	60 days per calendar year limit for inpatient <u>rehabilitation</u> . 100 days per calendar year limit for <u>skilled nursing facility care</u> .
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not covered	Prior approval is required for some services.
	Inpatient services	No charge	Not covered	Prior approval is required.
<b>If you are pregnant</b>	Office visits	No charge <u>Deductible</u> does not apply.	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, deductible and <u>copays</u> may apply.
	Childbirth/delivery professional services	No charge <u>Deductible</u> does not apply.	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	Coverage for child is limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	Prior approval is required.
	<a href="#">Rehabilitation services</a>	\$40 <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.
	<a href="#">Habilitation services</a>	\$40 <u>copay</u> /visit per treatment type	Not covered	Early intervention services are covered for children from birth to age 3 with no member <u>cost sharing</u> . Applied Behavioral Analysis (ABA) to treat autism spectrum disorders is covered with no member cost sharing.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Skilled nursing services in the home. Prior approval is required.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u> <u>Deductible</u> does not apply	Not covered	Prior approval is required.
	<a href="#">Hospice services</a>	No charge <u>Deductible</u> does not apply.	Not covered	Prior approval is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Plan Provider (You will pay the least)	Out-of-Plan Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge for routine exams. <u>Deductible</u> does not apply.	Not covered	Routine exams limited to one per calendar year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

#### 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"> <li>Children's Dental Check-up</li> <li>Children's Glasses</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult) (except for the limited services specified in your plan materials)</li> <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> <li>Routine Foot Care (Routine foot care is covered if you have diabetes)</li> </ul>	
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"> <li>Abortion</li> <li>Acupuncture</li> <li>Bariatric Surgery (requires prior approval)</li> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (limited to members age 21 and under, \$2,000 per hearing aid per ear each 36 months, requires prior approval)</li> <li>Infertility Treatment (requires prior approval)</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Weight Loss Programs (reimbursement per calendar year :\$200 per individual up to \$400 per family)</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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). You can also contact your state insurance department. Massachusetts resident can contact The Massachusetts Division of Insurance at 877-563-4467, or [doicss.mailbox@state.ma.us](mailto:doicss.mailbox@state.ma.us), or <https://www.mass.gov/health-care>. 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. You may be able to buy individual coverage through your state's marketplace, if applicable. If you are a resident of Massachusetts, contact the Massachusetts Health Connector at [www.mahealthconnector.org](http://www.mahealthconnector.org).

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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](http://www.mass.gov/hpc/opp). You can also contact the Department of Labor's Employee Benefits

Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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](#).

*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 pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> <a href="#">copay</a>	\$40
■ Hospital (facility) <a href="#">copay</a>	\$0
■ Laboratory <a href="#">copay</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$530</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> <a href="#">copay</a>	\$40
■ Primary care visit <a href="#">copay</a>	\$20
■ Laboratory <a href="#">copay</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,200</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> <a href="#">copay</a>	\$40
■ Hospital ER (facility) <a href="#">copay</a>	\$250
■ Ambulance services <a href="#">copay</a>	\$100

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,020</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## 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 aids and language services to people with disabilities and whose primary language is not English to communicate effectively with us. We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (800) 310-2835 (TTY: 711). Someone who speaks your preferred language can help you.

This is a free service, which includes:

- **Qualified sign language interpreters**
- **Written information in other formats (large print, audio, accessible electronic formats, other formats)**
- **Qualified interpreters**
- **Information written in other languages**

If you need these services, you may also contact Susan O'Connor, Vice President and General Counsel, at One Monarch Place, Suite 1500, Springfield, MA 01104-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685.

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 at the above address, phone or fax, or via email to [ComplaintsAppeals@hne.com](mailto: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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, 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 <http://www.hhs.gov/ocr/office/file/index.html>.

*Reviewed: 12/13/2022*



## 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.

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)
German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Mitgliedsnummer an, die auf Ihrem Krankenversicherungsausweis aufgeführt ist, und drücken Sie die 0. (TTY: 711)
Japanese	あなたには、無料であなたの言語でヘルプと情報を得る権利があります。通訳を依頼するには、健康保険証に記載されているフリーダイヤルの会員番号に電話し、0を押してください。(TTY: 711)
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 số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 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	អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអ្វីថ្លៃ។ ដើម្បីប្រើសេវាសន្លឹកសម្លេងសម្រាប់សមាជិក បុរស ឬ ស្រី អ្នកគួរតែទូរស័ព្ទលេខកូដកូដសម្រាប់សមាជិក បុរស ឬ ស្រី លេខ ០១ (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	आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुआषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फोन 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 ટોલ-ફ્રી નંબર પર કોલ કરો અને 0 દબાવો. (TTY: 711).
Lao	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ, ໂທພຣິຫາຫມາຍເລກໂທລະສັບສາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ, 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).