### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,000 person / $2,000 family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, office visits, chiropractic care &amp; prescription drugs are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $50 per child for non-preventive pediatric dental services.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical, prescription drugs &amp; chiropractic care $4,650 person / $9,300 family. Pediatric dental: $350 child / $700 family. Total: $5,000 person / $10,000 family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Your cost-sharing for benefits that are not Essential Health Benefits under national health care reform, premiums, health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. Visit healthnewengland.org or call 1-800-310-2835 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why This Matters:</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Plan Provider (You will pay the least)</td>
<td>Out-of-Plan Provider (You will pay the most)</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>$25 copay/visit. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 copay/visit. $20 copay/visit for chiropractor. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Radiology: $25 copay. Lab: $25 copay.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$200 copay (maximum 3 copays per year)</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 (Generic drugs)</td>
<td>$20 retail copay. $40 mail order copay/prescription. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Brand/Formulary drugs)</td>
<td>$40 retail copay. $80 mail order copay/prescription. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Brand/Non-formulary drugs)</td>
<td>$60 retail copay. $180 mail order copay/prescription. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Plan Provider</td>
<td>Out-of-Plan Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Copay depends on drug tier. Deductible does not apply.</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$250 copay/day</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$150 copay/visit</td>
<td>$150 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>$100 copay/member/day</td>
<td>$100 copay/member/day</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$45 copay/visit. Deductible does not apply.</td>
<td>Not covered</td>
<td>Deductible may apply to some office services.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 copay/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 copay/visit. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>$500 copay/admission</td>
<td>Not covered</td>
<td>Prior approval is required for some services.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

Prior approval is required for some prescription drugs. Without prior approval, a drug may not be covered.

Prior approval is required for some services. This copay is based on the type of service. To find out if this copay applies to a specific procedure, please contact Health New England Member Services at 1-800-310-2835.

For ground ambulance services from out-of-plan providers, 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.

60 days per calendar year limit for inpatient rehabilitation. 100 days per calendar year limit for skilled nursing facility care.

Cost sharing does not apply for preventive services. Depending on the type of service, deductible and copays may apply.
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Plan Provider (You will pay the least)</th>
<th>Out-of-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$500 copay/admission</td>
<td>Not covered</td>
<td>Coverage for child is limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Prior approval is required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$45 copay/visit per treatment type. Deductible does not apply.</td>
<td>Not covered</td>
<td>Limited to 60 visits per calendar year for physical or occupational therapy. Prior approval is required for speech therapy after the initial evaluation.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$45 copay/visit per treatment type. Deductible does not apply.</td>
<td>Not covered</td>
<td>Early intervention services covered for children from birth to age 3 with no member cost sharing.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Prior approval is required.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Prior approval is required.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
<td>Prior approval is required.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge for routine exams. Deductible does not apply.</td>
<td>Not covered except for children under age 19. For children under age 19 you will pay charges in excess of a $28 reimbursement.</td>
<td>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.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>No charge for 1 pair with a “Collection” frame; or $150 allowance + 20% off expense beyond allowance.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>For children under age 19. Out-of-plan dentists may also bill you for the difference between their charge and Health New England’s contracted dental network’s allowed amount.</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
</tr>
<tr>
<td>• Dental Care (Adult) (except for the limited services specified in your plan materials)</td>
</tr>
<tr>
<td>• Long Term Care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private Duty Nursing</td>
</tr>
<tr>
<td>• Routine Foot Care (Routine foot care is covered if you have diabetes)</td>
</tr>
<tr>
<td>• Weight Loss Programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric Surgery (requires prior approval)</td>
</tr>
<tr>
<td>• Chiropractic Care</td>
</tr>
<tr>
<td>• Hearing Aids (limited to members age 21 and under, $2,000 per hearing aid per ear each 36 months)</td>
</tr>
<tr>
<td>• Infertility Treatment (requires prior approval)</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
</tbody>
</table>

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**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: (if you are insured through a group plan) 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); (if you are not insured through a group plan) the Massachusetts Division of Insurance at 877-563-4467, or doicss.mailbox@state.ma.us, or [http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/](http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](http://www.mass.gov/). For more information about the [Marketplace](http://www.mass.gov/), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**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: the Massachusetts Division of Insurance at 877-563-4467, or doicss.mailbox@state.ma.us, or [http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/](http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/); or (if you are insured through a group plan) you can 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
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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](http://www.mass.gov/).  

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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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Specialist copay</strong></td>
<td><strong>Specialist copay</strong></td>
<td><strong>Specialist copay</strong></td>
</tr>
<tr>
<td>$45</td>
<td>$45</td>
<td>$45</td>
</tr>
<tr>
<td><strong>Hospital (facility) copay</strong></td>
<td><strong>Hospital (facility) copay</strong></td>
<td><strong>Hospital (facility) copay</strong></td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Other copays</strong></td>
<td><strong>Other copays</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>$20</td>
<td></td>
<td>20%</td>
</tr>
</tbody>
</table>

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** | $12,800 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th><strong>Deductibles</strong></th>
<th><strong>Copayments</strong></th>
<th><strong>Coinsurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$500</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions | $0 |

**The total Peg would pay is** | $1,500 |

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** | $7,400 |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th><strong>Deductibles</strong></th>
<th><strong>Copayments</strong></th>
<th><strong>Coinsurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$1,500</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions | $0 |

**The total Joe would pay is** | $1,600 |

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** | $1,900 |

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th><strong>Deductibles</strong></th>
<th><strong>Copayments</strong></th>
<th><strong>Coinsurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$400</td>
<td>$10</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions | $0 |

**The total Mia would pay is** | $1,410 |

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 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:
  - 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.


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.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>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)</td>
</tr>
<tr>
<td>Spanish</td>
<td>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)</td>
</tr>
<tr>
<td>Portuguese</td>
<td>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)</td>
</tr>
<tr>
<td>Chinese</td>
<td>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)</td>
</tr>
<tr>
<td>Language</td>
<td>Translation</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>French Creole</td>
<td>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)</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>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 hỏi viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. (TTY: 711).</td>
</tr>
<tr>
<td>Russian</td>
<td>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).</td>
</tr>
<tr>
<td>Arabic</td>
<td>يحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. لطلب مترجم، اتصل برقم العضو المجاني على بطاقة تعريف خلفية الصحية، ثم اضغط على 0. (TTY:711).</td>
</tr>
<tr>
<td>Mon-Khmer, Cambodian</td>
<td>អ្នកមានសិទ្ធិទ្ទ្ួួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយមិនអ្ស់ថ្លៃ។ ដាក់ឈ្មោះឈ្មោះអ្នកបកប្បបសូមទ្្ួូរស័ពទ្ដៅដលខឥតដដញថ្លៃសំរាប់សមាជិកប្លមានកត់ដៅកនុងប័ណ្ ណIDគំដរាងសខភាពរបស់អ្នករួដួដ ដួើដយ ដួ 0។ (TTY:711).</td>
</tr>
<tr>
<td>French</td>
<td>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).</td>
</tr>
<tr>
<td>Italian</td>
<td>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).</td>
</tr>
<tr>
<td>Korean</td>
<td>귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID 카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711</td>
</tr>
<tr>
<td>Greek</td>
<td>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).</td>
</tr>
<tr>
<td>Polish</td>
<td>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).</td>
</tr>
<tr>
<td>Hindi</td>
<td>आप के पास अपनी भाषा में सहायता एवं जानकारी मुफ्त प्राप्त करने का अधिकार है। तुम्हारे के लिए अनुरोध करने के लिए, अपने हेल्थ प्लान ID कार्ड पर सुविदियो टॉल-फ्री नबर पर फोन करें, 0 दबाएं। TTY 711</td>
</tr>
<tr>
<td>Gujarati</td>
<td>તમારી સ્વાસ્થ્યના બિના મૂકાયે મદદ અને માહિતી મેશાળવાનો તમામ અધિકાર છે. દુભાવશયની બિનાતી કરવા માટે તમારા હેલ્થ પલાન ID કાર્ડ પર જાપાલામાં ટૉલ-ફ્રી નંબર પર ફોન કરો, અને 0 દબાવો. (TTY: 711).</td>
</tr>
<tr>
<td>Lao</td>
<td>setStateTbsetAlphabet = 'Laotext'; $maintext = 'เก็บเวบไซต์ด้วยระบบที่ได้จัดเก็บในระบบตัวเอง ณ มีต่างจ่ายด้วย. ผู้อื่น ผู้อื่นไม่ได้รับ, แต่ตัวแทนงานนี้ไม่ว่าจะเป็นที่ตั้งทางคณิตศาสตร์ หรือทางคณิตศาสตร์ใดๆ ที่มีระบบตัวเองที่ได้จัดเก็บในบ้านที่ตัวเองอยู่, รักษาตัวเอง 0. (TTY: 711).</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Albanian</td>
<td>Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. (TTY: 711).</td>
</tr>
<tr>
<td>Tagalog</td>
<td>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).</td>
</tr>
</tbody>
</table>