

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://coc.nebraskablue.com/E44Q6C3C> or by calling 1-888-592-8961.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	<p>In-network: \$4,000 individual / \$8,000 family</p> <p>Out-of-network: \$9,000 individual / \$18,000 family</p> <p>Does not apply to most preventive care or prescription drugs. Copayments and coinsurance don't count toward the deductible.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.</p>
Are there other deductibles for specific services?	<p>Yes.</p> <p>\$100 individual/\$200 family for prescription drugs.</p> <p>There are no other specific deductibles.</p>	<p>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.</p>
Is there an out-of-pocket limit on my expenses?	<p>Yes.</p> <p>In-network: \$6,500 individual / \$13,000 family</p> <p>Out-of-network: \$11,900 individual / \$23,800 family</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>

Questions: Call 1-888-592-8961 or visit us at www.nebraskablue.com If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://www.cms.gov/CCHIO/Resources/Files/Downloads/uniform-glossary-final.pdf> or call 1-888-592-8961 to request a copy.

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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 23, 2013 (corrected).

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit ?	None of the following are included: penalties, premiums, balance-billed charges, and services this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of in-network providers , see www.nebraskablue.com or call 1-888-592-8961	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 3 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for information about excluded services .



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	50% coinsurance	Some office services are subject to the deductible and coinsurance.
	Specialist visit	\$75 copay/visit	50% coinsurance	Allergy injections and serum: \$10 copay/visit. Benefits will vary based on the network provider type.
	Other practitioner office visit	Convenient care clinic: \$30 copay/visit	Convenient care clinic: 50% coinsurance	Some office services are subject to the deductible and coinsurance. Limitations on chiropractic services may apply. See Rehabilitation Services. Acupuncture is not covered.
		Chiropractic office visit: \$75 copay/visit	Chiropractic office visit: 50% coinsurance	
	Manipulations: 30% coinsurance	Manipulations: 50% coinsurance		
	Preventive care/screening/immunization	No charge for federally mandated preventive services.	50% coinsurance For immunizations for children up to age 7, the deductible is waived.	Age, gender and frequency limits may apply to some preventive services. Services other than those which are federally mandated may be subject to other cost share amounts.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Benefits will vary based on the place of service and provider type.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Prior certification may be required. Failure to obtain prior certification when required will result in denial of the claim.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.nebraskablue.com.</p>				<p>For all prescription drugs, out-of-pocket costs shown are per 30-day supply, retail and mail order. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for specialty drugs) by paying 3 copay amounts.</p> <p>Certain prescription drugs may require prior authorization.</p> <p>Mail order benefits are not available out of network.</p>
	Generic drugs	\$10/prescription	\$10/prescription plus 25% penalty	----- none -----
	Preferred brand drugs	\$40/prescription	\$40/prescription plus 25% penalty	----- none -----
	Non-preferred brand drugs	\$75/prescription	\$75/prescription plus 25% penalty	----- none -----
	Specialty drugs	\$100/prescription	Not covered	Retail and mail order: 30-day supply maximum. Designated pharmacy may apply.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	----- none -----
	Physician/surgeon fees	30% coinsurance	50% coinsurance	----- none -----

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need immediate medical attention	Emergency room services	\$250 copay/visit, then 30% coinsurance (deductible is waived)	Same as in-network level of benefits	Copay waived if admitted.
	Emergency medical transportation	\$100 copay per transport	Same as in-network level of benefits	Limitations may apply to air ambulance.
	Urgent care	\$45 copay/visit	50% coinsurance	Copay applies to urgent care facilities. Some urgent care services are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	----- none -----
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$30 copay/office visit Other outpatient services: 30% coinsurance	50% coinsurance	Some office services are subject to the deductible and coinsurance.
	Mental/behavioral health inpatient services	30% coinsurance	50% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Substance use disorder outpatient services	\$30 copay/office visit Other outpatient services: 30% coinsurance	50% coinsurance	Some office services are subject to the deductible and coinsurance.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	----- none -----
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	----- none -----
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	<p><i>Home health aide:</i> Limited to 60 days per calendar year.</p> <p><i>Skilled nursing in the home:</i> Prior certification required.</p> <p><i>Respiratory care:</i> Limited to 60 days per calendar year.</p>
	Rehabilitation services	30% coinsurance	50% coinsurance	<p><i>Outpatient physical, occupational, speech, physiotherapy:</i> Combined 60 session limit per calendar year.</p> <p><i>Manipulations and adjustments:</i> Combined 30 session limit per calendar year.</p> <p><i>Outpatient cardiac rehabilitation:</i> Combined 18 session limit per diagnosis for certain cardiac diagnoses.</p> <p><i>Outpatient pulmonary rehabilitation:</i> Combined 18 session limit per diagnosis for certain diagnoses and criteria. Prior certification required.</p> <p><i>Inpatient physical rehabilitation:</i> Must follow within 90 days of discharge from acute hospitalization. Prior certification required. Failure to obtain prior certification will result in denial of the claim.</p>

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
	Habilitation services	30% coinsurance	50% coinsurance	<p><i>Outpatient physical, occupational, speech, physiotherapy:</i> Combined 60 session limit per calendar year</p> <p>Educational services are not covered.</p> <p>Additional limitations and exclusions may apply.</p>
	Skilled nursing care	30% coinsurance	50% coinsurance	<p><i>In the home:</i> See the <i>Home health care</i> section.</p> <p><i>Skilled nursing facility stay:</i> Limited to 60 days per calendar year. Prior certification required. Failure to obtain prior certification will result in denial of the claim.</p>
	Durable medical equipment	30% coinsurance	50% coinsurance	Rental or purchase, whichever is least costly. Rental shall not exceed the cost of purchasing. Prior certification is required for subsequent purchases of durable medical equipment.
	Hospice service	30% coinsurance	50% coinsurance	Prior certification required.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If your child needs dental or eye care	Eye exam	No charge	Not covered	<p>Visual acuity tests are covered under the preventive services benefit.</p> <p>Eye exam limited to 1 per calendar year.</p> <p>Pediatric vision services are limited to covered persons up to age 19.</p> <p>Certain vision services may require prior authorization.</p> <p>Additional vision services may be available when medically necessary.</p>
	Glasses	<p>Lenses: Not covered</p> <p>Frames: Not covered</p> <p>Contacts: Not covered</p>	<p>Lenses: Not covered</p> <p>Frames: Not covered</p> <p>Contacts: Not covered</p>	No coverage for glasses.
	Dental check-up	Preventive, Simple and Complex Restorative services: Not covered	Preventive, Simple and Complex Restorative services: Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adults)
- Dental care (children)
- Glasses (children)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the US
- Routine eye care (adults)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your employer's human resources or employee benefits department. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Blue Cross and Blue Shield of Nebraska at 1-888-592-8961 or visit www.nebraskablue.com.
- The Nebraska Department of Insurance at 1-877-564-7323 or www.doi.nebraska.gov.
- For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Your employer's human resources or employee benefits department.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-592-8961.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8961.

如果需要中文的帮助, 请拨打这个号码 1-888-592-8961.

Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-592-8961.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan Pays: \$1,740**
- **Patient Pays: \$5,800**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventative	\$40
Total	\$7,540

Patient Pays:

Deductibles	\$4,900
Copays	\$0
Coinsurance	\$700
Limits or exclusions	\$200
Total	\$5,800

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan Pays: \$3,400**
- **Patient Pays: \$2,000**

Sample Care Costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory Tests	\$100
Vaccines, other preventative	\$100
Total	\$5,400

Patient Pays:

Deductibles	\$400
Copays	\$1,600
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$2,000

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call 1-888-592-8961 or visit us at www.nebraskablue.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf> or call 1-888-592-8961 to request a copy.

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Federally Required Notices

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNE:

- 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 Customer Service at (800) 991-5840.

If you believe that BCBSNE 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: Manager, Corporate Compliance, P.O. Box 3248, Omaha, NE 68180-0001, Toll Free (800) 991-5840, Fax 402-392-4130, civilrights@nebraskablue.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION*: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840.

*This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدكم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

French (Europe)

ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance-santé ou bénéficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l'assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

Japanese

ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840.まで電話をおかけください。

Karen

တံသ့ၣ်တံသး- တံဘိးတံသ့ၣ်ညါအံၤ/တံသ့ၣ်သ့ၣ်/ကအိၣ်ဒီးတံဂံၢ်တံကျိၤလၢ/အရဒိၣ်တံသး/နလံၢ်တံတံတံတံ/မ့တမ့/တံအုၣ်ကံၤသးန့ၣ်လီၤ.
ကွံၤလု/မ့ၢ်နံၤမ့ၢ်သီအရဒိၣ်လၢ/လံၢ်ဘိးတံသ့ၣ်ညါအံၤအပူၤတက့ၢ်.
တံသ့ၣ်သ့ၣ်/နကတံၣ်/တံးဂံၢ်ဝီလၢ/မ့ၢ်နံၤလၢခံကတံၢ်လၢ/တံၢ်တံၣ်နီၣ်န့ၣ်/လၢနကတံၣ်နတံၢ်အိၣ်အုၣ်အိၣ်ချ့/တံၢ်ဘူးတံၢ်လဲတမ့ၣ်/မ့တမ့/မၤန့ၢ်တံၢ်မၤစၢၤလၢ/
တံၢ်ပူၤလီၤလဲတမ့ၣ်န့ၣ်လီၤ. /နၤ/မ့တမ့/ပုၤတက့ၢ်လၢ/နမၤစၢၤမ့ၢ်အိၣ်ဒီးတံသံကွံၤအလီၤ./နအိၣ်ဒီး
တံၢ်ခူးတံၢ်ယံၤလၢ/ကမၤန့ၢ်တံၢ်မၤစၢၤဒီးတံဂံၢ်တံကျိၤလၢ/နကျိၣ်လၢ/တလံၢ်ဘူၣ်လၢဂံၢ်စ့ၤတံၣ်န့ၣ်လီၤ. /လၢနကကတံၢ်တံၢ်ဒီး/ပုၤကျိးထံတံၢ်အဂီၢ်./ကိး 1-800-991-5840.တက့ၢ်.

Korean

주의: 본고지에는 해당신청서또는 적용범위에 대한 중요한 정보가 있을 수 있습니다.
본고지의 주요날짜를 찾으십시오. 해당건강보험을 유지하거나 비용을 지원받는 특정기한까지 조치를 취
하여야 합니다. 본인 자신이나 본인이 돕고 있는 누군가가 질문이 있다면 무료로 모국어로 된 도움과 정보를
얻을 수 있는 권리가 있습니다. 통역사와 통화하려면 1-800-991-5840. 번으로 전화하십시오.

Kurdish

ئاڭگاداری

رهنڭه ئهم ئاڭگاداریه زانیاری گرنگی تیدا بئیت دهر باره دی داواکاری یان روومآکر دنه کهمت به دوای بهرواره سهر دهکیه کانی ناو ئهم ئاڭگاداریه
بگهر ئی لهوانیه بئویست بکات له ههندیک دوا واده کرداریک بکهمت بو ئهوه دی روومآئی تهندروستیت بهر دوام بئیت یان یارماتی بو
تیجوو دهکانت دهست بخهمت نهگهر تو یان کهسیک که تو یارماتی دهدهیت پرسیری ههیه، تو مافی دهسکهوتنی یارماتی و زانیاریت به
زمانی خۆت بی بهرامبه ههیه بو فسهکردن لهگهڵ وهرگێرێک، په یه دندی به 18009915840 بکه.

Lao

ສາມ ການສະບັບ ຄວນເອົາໃຈໃສ່ : ຄວນ ການສະບັບ ບັນ
ຫາດລະມ ຂ ມ ນທ ສໍາຄ ນກ ບົວກ ບການສະໜ ກ ຫ
ການຄ ມຄອງສ ຂະພາບຂອງທ ານ. ຈ ງຸຊກຫາວ ນທ ທ ສໍາຄ ນໃນຄວ ງການສະບັບ ບັນ
ທ ານຫາດລະຕ ອງດ າເນ ນການໃນຂອບເຂດເວລາໃດໜ ງ
ເພ ອຮ ກສາການຄ ມຄອງດ ານສ ຂະພາບຂອງທ ານ ຫ
ໄດ ຮ ບການຊ ວຍເຫ ສທາງດ ານງ ບປະມານ. ຖ າຫາກທ ານ
ຫ ບ ກຄ ນທ ທ ານກໍລ ງຸຊ ວຍເຫ ສຢ ນ ນ
ມ ຄໍາຖາມ, ທ ານມ ສ ດໄດ ຮ ບການຊ ວຍເຫ ສ ແລະ
ໄດ ຮ ບຂ ມ ນທ ບ ນພາສາຂອງທ ານ ໃດຍບ ສອຍຄ າໃຊ້ ຈ າຍ.
ຕ ອງການລ ມກ ບນາຍແປພາສາ, ຈ ງໂທຫາເບ 1-800-991-5840.

Nepali

ध्यानाकर्षणः यो सूचनामा तपाईंको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य
मितिहरू हेर्नुहोस्। तपाईंको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईंले निश्चित समयसीमा भित्र कारबाही
लिनुपर्ने हुनसक्छ। तपाईं वा तपाईंले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा निःशुल्क
सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840. मा कल गर्नुहोस्।

Oromo

HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa’ee iyyata keetii yookaan waa’ee tajaajiloota
qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta’an ilaali. Tajaajila fayyaa kee itti fufsiisuuf
guyyoota murtaa’an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala.
Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan
dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Farsi

توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمهتان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرر اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

Russian

ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Spanish (Mexico)

ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Vietnamese

CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.
