


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, <https://coc.nebraskablue.com/3O8MATDJ>. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-721-2583 to request a copy.

| Important Questions   | Answers   | Why this Matters:   |
|---|---|---|
| What is the overall <u>deductible</u> ?                             | Individual/Family<br><u>In-Network</u> : \$600/\$1,200<br><u>Out-of-Network</u> : \$1,200/\$2,400   | 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 policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes, <u>preventive care</u> , <u>prescription drugs</u> , and <u>provider</u> office services.  | This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                       |
| Are there other <u>deductibles</u> for specific services?           | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Individual/Family<br><u>In-Network</u> : \$4,350/\$8,700<br><u>Out-of-Network</u> : \$8,700/\$17,400  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premium</u> , <u>balance billed</u> charges, penalties, denial for failure to obtain certification and services this <u>plan</u> doesn't cover.                  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.nebraskablue.com/find-a-doctor">www.nebraskablue.com/find-a-doctor</a> or call 1-877-721-2583 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 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 (a balance bill). 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |

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

| Common Medical Event  | Services You May Need   | What You Will Pay                                 |   | Limitations, Exceptions, & Other Important Information  |
|---|---|---|---|---|
|   |   | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(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  | \$30 <u>copay</u> /visit                          | 40% <u>coinsurance</u>  | Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> .  |
|   | <u>Specialist</u> visit   | \$50 <u>copay</u> /visit                          | 40% <u>coinsurance</u>  | Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> .  |
|   | <u>Preventive care</u> /screening/immunization  | No charge for federally mandated services.        | 40% <u>coinsurance</u> . For immunizations for children up to age 7, the <u>deductible</u> is waived. | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed 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)  | 20% <u>coinsurance</u>                            | 40% <u>coinsurance</u>  | None  |
|   | Imaging (CT/PET scans, MRIs)  | 20% <u>coinsurance</u>                            | 40% <u>coinsurance</u>  | <u>Prior certification</u> may be required. Failure to obtain <u>prior certification</u> when required will result in denial of the <u>claim</u> .                                      |
| If you need drugs to treat your illness or condition  | For all <u>prescription drugs</u> , out-of-pocket costs shown are per 30-day supply. If allowed by your prescription, up to a 180-day supply may be obtained at one time (except for <u>specialty drugs</u> ) by paying 5 <u>copay</u> amounts. Certain <u>prescription drugs</u> may require <u>prior certification</u> . Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> . Mail order benefits are not available <u>out-of-network</u> . |   |   |   |
|   | Generic drugs   | 25% <u>coinsurance</u> , <u>deductible</u> waived | 25% <u>coinsurance</u> , <u>deductible</u> waived plus 25% penalty                                    | In and <u>Out-of-network</u> : \$5 minimum / \$25 maximum per prescription  |
|   | Preferred brand drugs   | 25% <u>coinsurance</u> , <u>deductible</u> waived | 25% <u>coinsurance</u> , <u>deductible</u> waived plus 25% penalty                                    | In and <u>Out-of-network</u> : \$40 minimum / \$80 maximum per prescription   |
| More information about <u>prescription drug coverage</u> is available at <a href="http://www.nebraskablue.com">www.nebraskablue.com</a> . | Non-preferred brand drugs   | 50% <u>coinsurance</u> , <u>deductible</u> waived | 50% <u>coinsurance</u> , <u>deductible</u> waived plus 25% penalty                                    | In and <u>Out-of-network</u> : \$70 minimum / \$110 maximum per prescription  |

| Common Medical Event  | Services You May Need                          | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | In-Network Provider (You will pay the least)                                | Out-of-Network Provider (You will pay)            |  |
|   | <u>Specialty drugs</u>                         | 25% <u>coinsurance</u> , <u>deductible</u> waived                           | 50% <u>coinsurance</u> , <u>deductible</u> waived | <p><u>In-network</u>:<br/>\$60 minimum / \$120 maximum per prescription</p> <p><u>Out-of-network</u>:<br/>\$170 minimum / \$340 maximum per prescription</p> <p>Retail and mail order: 30-day supply maximum. Designated pharmacy may apply.</p> |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>                            | None   |
|   | Physician/surgeon fees                         | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>                            | None   |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$75 <u>copay</u> /visit, then <u>deductible</u> and 20% <u>coinsurance</u> | Same cost shares as <u>in-network provider</u>    | <u>Copay</u> waived if admitted.   |
|   | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>  | Same cost shares as <u>in-network provider</u>    | Limitations may apply to air ambulance.  |
|   | <u>Urgent care</u>                             | \$50 <u>copay</u> /visit, then <u>deductible</u> and 20% <u>coinsurance</u> | 40% <u>coinsurance</u>                            | <u>Copay</u> applies to <u>urgent care</u> facilities. Some <u>urgent care</u> services are subject to the <u>deductible</u> and <u>coinsurance</u> .  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>                            | <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .  |
|   | Physician/surgeon fee                          | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>                            | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>                            | None   |
|   | Inpatient services                             | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>                            | <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .  |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider (You will pay)   |  |
| If you are pregnant  | Office visits                             | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <u>Copay</u> may apply for visit to determine pregnancy. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copay</u> , <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC.  |
|  | Childbirth/delivery professional services | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | See pregnancy office visits limit.   |
|  | Childbirth/delivery facility services     | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | See pregnancy office visits limit.   |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <u>Home health aide</u> : 60 days per calendar year. <u>Skilled nursing in the home</u> : Limited to 8 hours per day. <u>Prior certification</u> required. <u>Respiratory care</u> : 60 days per calendar year.  |
|  | <u>Rehabilitation services</u>            | Outpatient therapy:<br>20% <u>coinsurance</u><br>Manipulations:<br>20% <u>coinsurance</u><br>Other services:<br>20% <u>coinsurance</u> | Outpatient therapy:<br>40% <u>coinsurance</u><br>Manipulations:<br>40% <u>coinsurance</u><br>Other services:<br>40% <u>coinsurance</u> | <u>Outpatient physical, occupational, speech, physiotherapy</u> : Combined 60 session limit per calendar year.<br><u>Manipulations and adjustments</u> : Combined 30 session limit per calendar year.<br><u>Outpatient cardiac rehabilitation</u> : Combined 18 session limit per diagnosis.<br><u>Outpatient pulmonary rehabilitation</u> : Combined 18 session limit per diagnosis for certain diagnoses and criteria. <u>Prior certification</u> required.<br><u>Inpatient physical rehabilitation</u> : Must follow 90 days of discharge from acute <u>hospitalization</u> . <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> . |
|  | <u>Habilitation services</u>              | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | See the <u>Rehabilitation services</u> and <u>If you have a hospital stay</u> sections. Educational services are not covered.  |

| Common Medical Event                   | Services You May Need            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------------|--|--|--|
|  |                                  | In-Network Provider (You will pay the least)                                 | Out-of-Network Provider (You will pay)                                       |  |
|  | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <i>In the home:</i> See the <u>Home health care</u> section. <u>Skilled nursing care</u> : Limited to 60 days per calendar year. <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> . |
|  | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | Rental or purchase, whichever is least costly. <u>Prior certification</u> may be required. Failure to obtain <u>prior certification</u> when required will result in denial of the <u>claim</u> .  |
|  | <u>Hospice services</u>          | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <u>Prior certification</u> required.   |
| If your child needs dental or eye care | Children's eye exam              | Not covered  | Not covered  | Visual acuity tests are covered under the <u>preventive services</u> benefit. No coverage for eye exams.   |
|  | Children's glasses               | Lenses:<br>Not covered<br>Frames:<br>Not covered<br>Contacts:<br>Not covered | Lenses:<br>Not covered<br>Frames:<br>Not covered<br>Contacts:<br>Not covered | No coverage for glasses.   |
|  | Children's dental check-up       | Not covered  | Not covered  | No coverage for dental check-up.   |

### 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.)

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

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

- Chiropractic care
- Non-emergency care when traveling outside the US

**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: Blue Cross and Blue Shield of Nebraska at 1-877-721-2583 or visit [www.nebraskablue.com](http://www.nebraskablue.com); 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](http://www.dol.gov/ebsa/healthreform); for non-federal governmental group health plans, 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); or your employer's human resources department. 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.

**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: Blue Cross and Blue Shield of Nebraska at 1-877-721-2583 or visit [www.nebraskablue.com](http://www.nebraskablue.com), the Nebraska Department of Insurance at 1-877-564-7323 or [www.doi.ne.gov](http://www.doi.ne.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](http://www.dol.gov/ebsa/healthreform), your employer's human resources or employee benefits department.

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, 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.

#### Language Access Services:

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

如果需要中文的帮助, 请拨打这个号码 1-888-592-8961.

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

Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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:



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 plan's overall deductible \$600
- Specialist copay \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

| <u>Cost Sharing</u>         |         |
|-----------------------------|---------|
| <u>Deductibles</u>          | \$800   |
| <u>Copayments</u>           | \$30    |
| <u>Coinsurance</u>          | \$2,300 |
| <u>What isn't covered</u>   |         |
| Limits or <u>exclusions</u> | \$60    |
| The total Peg would pay is  | \$3,190 |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$600
- Specialist copay \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

| <u>Cost Sharing</u>         |         |
|-----------------------------|---------|
| <u>Deductibles</u>          | \$300   |
| <u>Copayments</u>           | \$200   |
| <u>Coinsurance</u>          | \$2,400 |
| <u>What isn't covered</u>   |         |
| Limits or <u>exclusions</u> | \$200   |
| The total Joe would pay is  | \$3,100 |

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

- The plan's overall deductible \$600
- Specialist copay \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

| <u>Cost Sharing</u>         |       |
|-----------------------------|-------|
| <u>Deductibles</u>          | \$600 |
| <u>Copayments</u>           | \$100 |
| <u>Coinsurance</u>          | \$200 |
| <u>What isn't covered</u>   |       |
| Limits or <u>exclusions</u> | \$0   |
| The total Mia would pay is  | \$900 |

The plan would be responsible for the other costs of the EXAMPLE covered services.

## 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](mailto: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>.

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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。

#### 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.

#### 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.



**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 مقرری 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.

**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.

**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**

ဟံသုၣ်ဟံသး-တံဘိးဘၣ်သုၣ်ညါအံၤ ဘၣ်သုၣ်သုၣ် ကအိၣ်ဒီးတံဂံၢ်တံဂီၢ်လၢ အရ့ဒိၣ်ဘၣ်သး နလံၣ်ပတံၣ်တံၢ် မတမ့ၢ် တံၢ်အုၣ်ဂီၢ်သးန့ၣ်လီၤ. က့ၢ်ယု မ့ၢ်န့ၢ်အရ့ဒိၣ်လၢ လံၣ်ဘိးဘၣ်သုၣ်ညါအံၤပုၤတက့ၢ်. ဘၣ်သုၣ်သုၣ် နကဘၣ် ဟံးဂံၢ်လီၤ မ့ၢ်န့ၢ်လၢခံကတၢ်လၢ တံၢ်ဟံပနီၣ်န့ၢ်န့ၢ် လၢနကဟ့ၣ်နတံၢ်အိၣ်ဆုၣ်အိၣ်ချ့ တံၢ်ဘူးတံၢ်လဲတဖၣ် မတမ့ၢ် မၤန့ၢ်တံၢ်မၤတၢ်လၢ တံၢ်ပုၤလီၤလဲတပၣ်န့ၣ်လီၤ. န့ၢ် မတမ့ၢ် ပုၤတကၤလၢ နမၤတၢ်မ့ၢ်အိၣ်ဒီးတံၢ်သံက့ၢ်အယံ, နအိၣ်ဒီးတံၢ်ခွဲးတံၢ်ယံလၢ ကမၤန့ၢ်တံၢ်မၤတၢ်ဒီးတံၢ်ဂံၢ်တံၢ်ဂီၢ်လၢ နက့ၢ်လၢ တလၢဘၣ်သုၣ်လၢတံၢ်ဘၣ်န့ၣ်လီၤ. လၢနကကတံၢ်တံၢ်ဒီး ပုၤက့ၢ်ထံတံၢ်အဂီၢ်, ဂံၢ်:1-800-991-5840.တက့ၢ်.

**Korean**

주의: 본 고지에는 해당 신청서 또는 적용범위에 대한 중요한 정보가 있을 수 있습니다. 본 고지의 주요 날짜를 찾으십시오. 해당 건강보험을 유지하거나 비용을 지원받는 특정 기한까지 조치를 취하셔야 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**

ئاگاداری  
ڕهنگه ئهم ئاگاداری به زانیاری گرنهنگی تێدا بێت دهرباره داواکاری یان رووماکێر دهنهکمهت. بهداوای بهر واره سههر دهکێهکاتی ناو ئهم ئاگاداریه بگهڕێ. ئهوهانییه بپووست بکات له ههمنێک دوا واده کرداریک بکهمیت بۆ ئهوهی روومانی تهندهروستنی بهر دوام بێت یان یارماتی بۆ تێچوووهکانت دهست بخهیت. ئهنگه ئو یان کهمیک که تو یارماتی ددهیت پرساری ههمیه، تو مافی دهسکوتنی یارماتی و زانیاریت به زمانی خۆت بێ بهر امبار ههمیه. بۆ سههرکردن لهگهڵ وهرگهڕێک، پهیوهندی به 18009915840.

**Lao**

ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ. ຈົ່ງອອກຫາວັນທີ່ສໍາຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດໍາເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄໍາຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 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 गर्न 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.

**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.

**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.