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/NZ5G8MWC. 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 or call 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family In-Network: $850/$1,700 Out-of-Network: $1,700/$3,400	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 policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes, preventive care, prescription drugs, and provider office services.	This plan covers some items and services even if you haven't yet met the annual 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,750/$11,500 Out-of-Network: $11,500/$23,000	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.
What is not included in the out-of-pocket limit?	Premium, balance billed charges, penalties, denial for failure to obtain preauthorization and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.NebraskaBlue.com/find-a-doctor or call 1-844-201-0763 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay 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 (a balance bill). 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drugs, may require preauthorization. Failure to obtain preauthorization will result in denial of the claim.

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 the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	Some office services may be subject to deductible and/or coinsurance. Preauthorization may be required.
	Specialist visit	$55 copay/visit	40% coinsurance	Some office services may be subject to deductible and/or coinsurance. Preauthorization may be required.
	Preventive care/screening/ immunization	No charge for federally mandated services.	40% coinsurance. For immunizations for children up to age 7, the deductible is waived.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preauthorization may be required.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition		For all prescription drugs, 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 specialty drugs) by paying 5 copay amounts. Home delivery benefits are not available out-of-network. The following cost-shares apply only when obtaining drugs through a pharmacy.		
	Generic drugs	25% coinsurance, deductible waived	25% coinsurance, deductible waived plus 25% penalty	In and Out-of-network: $10 minimum / $40 maximum per prescription Preauthorization may be required.
	Preferred brand drugs	25% coinsurance, deductible waived	25% coinsurance, deductible waived plus 25% penalty	In and Out-of-network: $50 minimum / $100 maximum per prescription Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at https://coc.NebraskaBlue.com/NZ5G8MWC

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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 the most)	
More information about prescription drug coverage is available at www.nebraskablue.com	Non-preferred brand drugs	50% coinsurance, deductible waived	50% coinsurance, deductible waived plus 25% penalty	In and Out-of-network: $75 minimum / $150 maximum per prescription Preauthorization may be required.
	Specialty drugs	25% coinsurance, deductible waived	Not covered	In-network: $125 minimum / $250 maximum per prescription Retail and home delivery: 30-day supply maximum. Designated pharmacy may apply. Preauthorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	$85 copay/visit, then deductible and 20% coinsurance	Same cost shares as in-network provider	Copay waived if admitted. Preauthorization may be required.
	Emergency medical transportation	20% coinsurance	Same cost shares as in-network provider	Limitations may apply to air ambulance.
	Urgent care	$55 copay/visit, then deductible and 20% coinsurance	40% coinsurance	Copay applies to urgent care facilities. Some urgent care services may be subject to the deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Preauthorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No charge Other Outpatient Services: 20% coinsurance	40% coinsurance	Preauthorization may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at https://coc.NebraskaBlue.com/NZ5G8MWC

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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 the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Copay may apply for visit to determine pregnancy. Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. Preauthorization may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	See pregnancy office visits limit. Preauthorization may be required.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	See pregnancy office visits limit. Preauthorization may be required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	*Home health aide:* 60 days per calendar year. *Skilled nursing in the home:* Limited to 8 hours per day. *Respiratory care:* 60 days per calendar year. Preauthorization may be required.
	Rehabilitation services	Outpatient therapy: 20% coinsurance Manipulations: 20% coinsurance Other services: 20% coinsurance	Outpatient therapy: 40% coinsurance Manipulations: 40% coinsurance Other services: 40% coinsurance	*Outpatient physical, occupational, speech, physiotherapy*: Combined 60 session limit per calendar year. *Manipulations and adjustments*: Combined 30 session limit per calendar year. *Outpatient cardiac rehabilitation*: Combined 18 session limit per diagnosis. *Outpatient pulmonary rehabilitation*: Combined 18 session limit per diagnosis for certain diagnoses and criteria. Preauthorization may be required.
	Habilitation services	Outpatient therapy: 20% coinsurance Other services: 20% coinsurance	Outpatient therapy: 40% coinsurance Other services: 40% coinsurance	See the *Rehabilitation services* and *If you have a hospital stay* sections. Educational services are not covered. Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at https://coc.NebraskaBlue.com/NZ5G8MWC

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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 the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	*In the home:* See the Home health care section. *Skilled nursing care:* Limited to 60 days per calendar year. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental or purchase, whichever is least costly. Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Visual acuity tests are covered under the preventive services benefit. No coverage for eye exams.
	Children's glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
	Children's dental check-up	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: 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)

* For more information about limitations and exceptions, see the plan or policy document at https://coc.NebraskaBlue.com/NZ5G8MWC

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- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adults)
- Routine eye care (children)
- Voluntary Abortion (except to safeguard the life of the woman or due to a sexual assault (rape) or incest)
- 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
- Hearing aids
- Non-emergency care when traveling outside the US
- Routine foot care

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 1-844-201-0763 or visit 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; 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; 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 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 1-844-201-0763 or visit www.NebraskaBlue.com, the Nebraska Department of Insurance at 1-877-564-7323 or 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, your employer's human resources or employee benefits department.

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.

* For more information about limitations and exceptions, see the plan or policy document at https://coc.NebraskaBlue.com/NZ5G8MWC

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Language Access Services:

Para obtener asistencia en Español, llame al 1-844-201-0763.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-201-0763.

如果需要中文的帮助，请拨打这个号码 1-844-201-0763.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-201-0763.

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

* For more information about limitations and exceptions, see the plan or policy document at https://coc.NebraskaBlue.com/NZ5G8MWC

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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	**$850**
Specialist copay	**$55**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$850
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,210**

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

The plan's overall deductible	**$850**
Specialist copay	**$55**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,270**

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

The plan's overall deductible	**$850**
Specialist copay	**$55**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$850
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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

Non-discrimination and Translation Notice

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, TTY 711 between 7:30 a.m. to 6 p.m., Central time, Monday through Friday.

If you believe that Blue Cross and Blue Shield of Nebraska 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
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
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 of 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 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
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
For quick processing, use the OCR online portal to file a complaint.

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 تساعدهم 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
ဟ်သူဉ်ဟ်သး–တၢ်ဘိးဘဉ်သ့ဉ်ညါဆဲၤ ဘဉ်သ့ဉ်သ့ဉ် ကဆိဉ်ဒီးတ၊်ဂ့ၢ်တ၊်ကျိၤလ၊ အရူဒိဉ်ဘဉ်ယး နလံာ်ပတံထိဉ်တ၊် မ့တမ့၊် တ၊်ဆုဉ်ကိၤသးန့ဉ်လီၤ.
ကွၢ်ယု မ့ၢ်နံၤမ့ၢ်သိအရူဒိဉ်လ၊ လံာ်ဘိးဘဉ်သ့ဉ်ညါဆံၤအပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ် နကဘဉ် ဟံးဂ့ၢ်ဝီလ၊ မ့ၢ်နံၤလၢခံကတ၊်လ၊ တ၊်ဟ်ပနှိဉ်နှၤ်နှၤ လၢနကဟ့ဉ်နတ၊်အိဉ်ဆူဉ်အိဉ်ရူ တ၊်ဘူးတ၊်လဲတဖဉ် မ့တမ့၊် မၤန့ၢ်တ၊်မၤစၢၤလ၊ တ၊်ပူၤလိၤလဲတဖဉ်နှဉ်လီၤ.
နၤ မ့တမ့၊် ပှၤတဂၤဂၤလ၊ နမၤစၢၤမ့၊်အိဉ်ဒီးတ၊်သံကွၢ်အယိ. နအိဉ်ဒီးတ၊်ခွဲးတ၊်ယာ်လ၊ ကမၤန့ၢ်တ၊်မၤစၢၤဒီးတ၊်ဂ့ၢ်တ၊်ကျိၤလ၊ နကျိာ်လ၊ တလၢာ်ဘူဉ်လၢာ်စ့ၤဘဉ်နှဉ်လီၤ.
လၢနကကတိၤတ၊်ဒီး ပှၤကျိးထံတ၊်အဂိၢ်. ကိး1-800-991-5840.တက့ၢ်.

Korean
주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish
ئاگاداری
ڕەنگە ئەم ئاگاداریە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەروارە سەرەکیەکانی ناو ئەم ئاگاداریە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کرداریک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێڕێک، پەیوەندی بە 18009915840. بکە.

Lao
ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ.
ຈົ່ງຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄຳຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ,
ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali
ध्यानाकर्षण: यो सूचनामा तपाईंको निवेदन वा कभरेजको बारेमा महत्वपूर्ण 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 नि:शुल्क 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.

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.