The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan.</u> The SBC shows you how you and the <u>plan would</u> share the cost for covered health care services. NOTE: Information about the cost of this <u>plan (called the premium)</u> 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/B32AAO3N. For general definitions of common terms, such as <u>allowed amount, balance billing</u>, <u>coinsurance</u>, <u>copayment, deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-721-2583 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family In-Network: \$1,500/\$3,000 Out-of-Network: \$3,000/\$6,000	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 deductible?	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</u> services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan?</u>	Individual/Family In-Network: \$5,250/\$10,500 Out-of-Network: \$10,500/\$21,000	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> ?	Premium, balance billed charges, penalties, denial for failure to obtain certification and services this plan 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 network provider?	Yes. See www.nebraskablue.com/find-a-doctor or call 1-877-721-2583 for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the 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 for the difference between the provider's charge and what your <u>plan pays</u> (a balance bill). Be aware, your <u>network provider might use an out-of-network provider for some services (such as lab work). Check with your <u>provider before you get services</u>.</u></u>
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 $\underline{copayment}$ and $\underline{coinsurance}$ costs shown in this chart are after your overall $\underline{deductible}$ has been met, if a $\underline{deductible}$ applies.

			u Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	40% coinsurance	Some office services may be subject to deductible and/or coinsurance.	
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	40% coinsurance	Some office services may be subject to deductible and/or coinsurance.	
	Preventive care/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% coinsurance	<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> .	
		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> .			
If you need drugs to treat your illness or condition	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 prescription drug coverage is available at www.nebraskablue.com		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	



		What You Will Pay		00verage 1 enou. 7/112017 0/31/2010
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay	Limitations, Exceptions, & Other Important Information
	Specialty drugs	25% <u>coinsurance</u> , <u>deductible</u> waived	50% <u>coinsurance</u> , <u>deductible</u> waived	In-network: \$60 minimum / \$120 maximum per prescription Out-of-network: \$170 minimum / \$340 maximum per prescription Retail and mail order: 30-day supply maximum. Designated pharmacy may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% coinsurance	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Emergency room care	\$75 <u>copay</u> /visit, then <u>deductible</u> and 20% <u>coinsurance</u>	Same cost shares as in-network provider	<u>Copay</u> waived if admitted.
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	Same cost shares as in-network provider	Limitations may apply to air ambulance.
	Urgent care	\$50 <u>copay</u> /visit, then <u>deductible</u> and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Copay applies to urgent care facilities. Some urgent care services are subject to the deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you needmental 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% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.

Educators Health Alliance



BlueCross BlueShield Nebraska		Educators Health Alliance		Coverage Period: 9/1/2017 - 8/31/2018	
		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay	Limitations, Exceptions, & Other Important Information	
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	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Home health aide: 60 days per calendar year. Skilled nursing in the home: Limited to 8 hours per day. Prior certification required. Respiratory care: 60 days per calendar year.	
	Rehabilitation services	Outpatient therapy: 20% coinsurance Manipulations: 20% coinsurance Other services: 20% coinsurance	Outpatient therapy: 40% <u>coinsurance</u> Manipulations: 40% <u>coinsurance</u> Other services: 40% <u>coinsurance</u>	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. Prior certification required. Inpatient physical rehabilitation: Must follow 90 days of discharge from acute hospitalization. Prior certification required. Failure to obtain prior certification will result in denial of the claim.	
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	See the <u>Rehabilitation services</u> and <i>If you have</i> a hospital stay sections. Educational services are not covered.	



		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	In the home: See the Home health care section. Skilled nursing care: Limited to 60 days per calendar year. Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Durable medical equipment	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> .
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior certification 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	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 <u>plan</u> document.)

Chiropractic care
 Non-emergency care when traveling outside the US

Educators Health Alliance

Coverage Period: 9/1/2017 - 8/31/2018

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 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>www.nebraskablue.com</u>, the Nebraska Department of Insurance at 1-877-564-7323 or <u>www.doi.ne.gov</u>, for group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.doi.gov/ebsa/healthreform</u>, your employer's human resources or employee benefits department.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have <u>Minimum Essential Coverage</u> for a month under this <u>plan</u> 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, kwiijigo holne' 1-888-592-8961.



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 <u>plan's</u> overall <u>deductible</u>	\$1,500
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
Total Example Cost	Ψ12,000

In this example. Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
Copayments	\$30
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,990

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist copay	\$50
Hospital (facility) <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$2,400
What isn't covered	
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	\$1,500
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>	\$1,500
<u>Copayments</u>	\$100
Coinsurance	\$40
What isn't covered	
Limits or <u>exclusions</u>	\$0
The total Mia would pay is	\$1,640

The <u>plan</u> 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. 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 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 در خواست با طرح پوشش بیمه تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا مو حد مقر ری اقدام کنید تا یوشش بیمه در مانیتان حفظ شود یا هزینه های در مانی ر ا در یافت کنید. آگر شما یا فر دی دیگر که به او کمک می کنید، سؤالی دارید، از این حق بر خور دار هستید تا را هنمایی و اطلاعات را به صور ت رایگان به زبان خونتان دریافت کنید. بر ای صحیت کر دن با یک متر جم، با شماره 1-800-991

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 assurancesanté 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。

ပြာသူဉ်ဟိသႊ–တာ်ဘီးဘဉ်သူဉ်ညါအုံး ဘဉ်သူဉ်သှဉ် ကအိုဉ်ဒီးတာ်ဂျ်တာ်ကျိုးလာ အရှုဒိုဉ်ဘဉ်ယး နုလာပတံထီဉ်တာ် မှတမှာ် တာ်အုဉ်ကီးသးနှဉ်လီး. ကွာ်ယု မုန်းမုာ်သီအရှုဒိုဉ်လ၊ လိဉ်ဘိုးဘဉ်သူ့ဉ်ညါအုံးအပူးတက္ခ်ာ. ဘဉ်သှဉ်သှဉ် နကဘဉ် ဟုံးဂဂ်ဝီလ၊ မုဂ်နံးလာခံကတာဂ်လ၊ တါဟ်ပနီဉ်နှုံနား လာနကဟ္ဍာနတာအြိဉ်ဆူဉ်အိုချဲ့ တာ်ဘူးတဂ်လဲတဖဉ် မှတမှ၊ မာနှုံတာ်မာစားလ၊ တာ်ပူးလီးလဲတဖဉ်နှူဉ်လီးနှ

နာ၊ မှတမှု၊ ပူးတဂၤဂၤလ၊ နမာစားမှုါအိုဦးတြံသက္ခုအယိ, နအိုဦးတါနွဲးတါယာလ၊ ကမာနှုတ်မ်ာစားဦးတာဂြတ်ကြိုးလ၊ နကျိုာလ၊ တလာာဘျာဉ်လာခံစာသာနို့၌လီးန လາနကကတိုးတာဒီး ပူးကျိုးထံတာ်အင်္ဂါ, ကိုး1-800-991-5840.တက္၏.

Korean

주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.

본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신 이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려 면1-800-991-5840, 번으로전한하십시오.

Kurdish

ر ونگه نُهم نَاگادار په ز انیار ی گر نگی نیّدا بنِت دهر بار دی داو اکار ی پان ر و و مالّکر دنهکات بادو ای بادر و ار ه ساس هکیاکاتی ناو نُهم نَاگادار په بگاس ی لِلهو انهیه بیّو پست بکات له هاندنیک دوا و اده کر داریک بکامیت بق نامودی روومانی تامندروستیت بامردهوام بنیت بان بارمانتی بق نتیچووهکانت دهست بخامیت نامگام نق بیان کامستیک که نق بیارمانتی دەدەيت پر سيار ي هاميا، ئۇ مافى دەسكام تنى يار مامتى و ز انيار بيت به ز مانى خۇت بن بائر امبائر ، هاميه بۇ قسامكر دن لەگىلل و هرگير يك، پاييو هندى به . 18009915840

ຊຶ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ. ຈົ່ງຊອກຫາວັນທີ່ທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ ເພື່ອຮັກສຸາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າຫຼາກທ່ານ ຫຼືບຸກຸຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄໍາຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali

ध्यानाकर्षणः यो सूचनामा तपाईंको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्न्होस्। तपाईंको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हनसक्छ। तपाई वा तपाईले सहायता गरेका कसैसँग जिजासाहरू छन् भने तपाईसँग आफ्नो भाषामा निःश्ल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नुहोस्।

HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota gabaachuu 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.

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 thế 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.