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</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>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, <u>www.nebraskablue.com</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.cciio.cms.gov</u> or call 1-888-592-8961 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family <u>In-Network</u> : \$1,550/\$3,100 <u>Out-of-Network</u> : \$1,950/\$3,900	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 and prescription</u> drugs.	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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
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</u> <u>limit f</u> or this <u>plan?</u>	<u>In-Network</u> : \$4,050/\$8,100 <u>Out-of-Network</u> : \$8,100/\$9,700	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>Deductible</u> , <u>premium</u> , <u>balance</u> <u>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 <u>www.nebraskablue.com/find-a-doctor</u> or call 1-888-592-8961 for a list of <u>network</u> <u>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</u> <u>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 t</u> o see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral.</u>



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

		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 the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	45% coinsurance	None
If you visit a health care <u>provider's office</u> or clinic	<u>Specialist</u> visit	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Preventive care/screening/ immunization	No charge for federally mandated services.	No charge. For immunizations for children up to age 7.	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)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	Prior certification may be required. Failure to obtain prior certification when required will result in denial of the claim.
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	No coverage for prescription drugs.
	Preferred brand drugs	Not covered	Not covered	No coverage for prescription drugs.
More information about prescription drug coverage is available at www.nebraskablue.com	Non-preferred brand drugs	Not covered	Not covered	No coverage for prescription drugs.
	Specialty drugs	Not covered	Not covered	No coverage for prescription drugs.
If you haveoutpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None

BlueCross BlueShield Nebraska		University of Nebraska		Coverage Period: 1/1/2018 - 12/31/2018	
		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	
	Emergency room care	30% <u>coinsurance</u>	Same cost shares as in-network provider_	None	
If you need immediate medical attention	Emergency medical_ transportation_	30% <u>coinsurance</u>	Same cost shares as in-network provider_	Limitations may apply to air ambulance.	
	<u>Urgent care</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	Prior certification required. Failure to obtain prior certification will result in denial of the claim.	
	Physician/surgeon fee	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None	
If you needmental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None	
	Inpatient services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	Prior certification required. Failure to obtain prior certification will result in denial of the claim.	
If you are pregnant	Office visits	30% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <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	30% <u>coinsurance</u>	45% coinsurance	See pregnancy office visits limit.	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	See pregnancy office visits limit.	
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	45% <u>coinsurance</u>	<i>Skilled nursing in the home: <u>Prior certification</u> required.</i>	

BlueCross Blue Nebraska	ueShield	University of Nebraska		Coverage Period: 1/1/2018 - 12/31/2018
Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	ou Will Pay Out-of-Network Provider (You will pay	Limitations, Exceptions, & Other Important Information
	Rehabilitation services.	Outpatient therapy, including manipulations: 30% <u>coinsurance</u> Other services: 30% <u>coinsurance</u>	Outpatient therapy, including manipulations: 45% <u>coinsurance</u> Other services: 45% <u>coinsurance</u>	Outpatient physical, occupational, speech, physiotherapy and chiropractic manipulations and adjustments: Combined 60 session limit per calendar year. Outpatient cardiac rehabilitation: Combined 18 session limit per diagnosis. Outpatient pulmonary rehabilitation: Combined 36 session limit per diagnosis for certain diagnoses and criteria. <u>Prior certification</u> required. Inpatient physical rehabilitation: <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .
	Habilitation services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	See the <u>Rehabilitation services</u> and <i>If you have</i> a hospital stay sections. Educational services are not covered.
	Skilled nursing care	30% <u>coinsurance</u>	45% <u>coinsurance</u>	<i>In the home:</i> See the <u>Home health care</u> section. <u><i>Skilled nursing care:</i></u> Limited to 30 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> .
	Durable medical equipment	30% <u>coinsurance</u>	45% <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	30% <u>coinsurance</u>	45% <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.

BlueCross Blue Nebraska	eShield	University of Nebraska		Coverage Period: 1/1/2018 - 12/31/2018	
Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay	Limitations, Exceptions, & Other Important Information	
	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 Ge	enerally Does NOT Cover (Ch	eck your policy or plan docume	ent for more information and a l	ist of any other <u>excluded services</u> .)	
Acupuncture	Acupuncture Glasses (children) Private-duty nursing			vate-duty nursing	
Bariatric surgery		Hearing aids Rou		utine eye care (adults)	
Cosmetic surgery		Infertility treatment Rou		outine eye care (children)	
Dental care (adults)		Long-term care Rou		putine foot care	
Dental care (children)		Prescription drugs We		eight 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 transmission 	3 .		



University of Nebraska

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: 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, 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 1-888-592-8960 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.dol.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./No.

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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, kwiijigo 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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>	\$1,550
Specialist coinsurance	30%
Hospital (facility) <u>coinsurance</u>	30%
Other coinsurance	30%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,800

In this example, Peg would pay:

Cost Sharing		
Deductibles	\$1,700	
Copayments	\$0	
Coinsurance	\$2,500	
What isn't covered		
Limits or exclusions	\$80	
The total Peg would pay is	\$4,280	

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>	\$1,550
Specialist coinsurance	30%
Hospital (facility) <u>coinsurance</u>	30%
Other coinsurance	30%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (*including disease education*) <u>Diagnostic tests (*blood work*)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter</u>)

Total Example Cost	\$7,400
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lr	this example, Joe would pay:	
	Cost Sharing	
	Deductibles	\$1,000
	<u>Copayments</u>	\$0
	<u>Coinsurance</u>	\$0
	What isn't covered	
	Limits or exclusions	\$6,200
	The total Joe would pay is	\$7,200

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

The <u>plan's</u> overall <u>deductible</u>	\$1,550
Specialist coinsurance	30%
Hospital (facility) <u>coinsurance</u>	30%
Other coinsurance	30%

This EXAMPLE event includes services like: <u>Emergency room care (including medical</u> <u>supplies)</u> <u>Diagnostic test (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy)</u>

Total Example Cost	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$1,550
<u>Copayments</u>	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,650

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 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

تتبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار . قد يلز مك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلةً، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفور يين، اتصل بر قم 1-800-950-5840

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 یا طرح پوشش بیماتان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم بآشد تا موحد مقرر ی اقدام کنید تا پوشش بیمه در مانیتان حفظ شود یا هزینه های در مانی را در یافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخور دار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. بر ای صحبت کردن با یک مترجم، با شماره 1-800-991 تماس بگ بد

French (Europe)

ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiguées. 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。

Karen

ဟ်သူဉ်ဟ်သး–တာ်ဘိုးဘဉ်သူဉ်သါအံၤ ဘဉ်သူဉ်သူဉ် ကအိဉ်ဒီးတဂ်ုတ်ကြိုးလ၊ အရှုဒိဉ်ဘဉ်ယး နယ်ာ်ပတံထီဉ်တာ် မူတမွှာ် တာ်အုဉ်ကီးသးနှဉ်လီၤ. ကွာ်ယှ မှု၊နုံးမှု၊သီအရှုဒ်ဉ်လ၊ လံဉ်ဘိုးဘဉ်သှဉ်ညါအုံးအပူးတက္နါ. ဘိဉ်သှဉ်သှဉ် နကဘဉ် ဟံးဂုံစီလ၊ မု၊ံနံးလ၊ခံကတၢၤဴလ၊ တါဟ်ပနီဉ်နှု၊နား လ၊နကဟ္ဉ်ခုတါအိဉ်ဆူဉ်အိုဉ်ချ တါဘူးတါလဲတဖဉ် မတမ့၊ မာန္နါတါမာစားလ၊ တါမွာလီးလဲတဖဉ်နူဉ်လီး. ຊາ ຍຸວາຍຸໂ ບາວກາດາເວາ ຊຍາຍາຍຸໂສ້ວິຊຶ່າອາໂລກິງສາພິ, ຊສີວິຊຶ່າອາໂຊ່າອາໂພວິເບ ກອບຊູໂອກີຍາຍາເຊື່າອາໂກົງໂດກິຊາດໃດ ຊາ

လၢနကကတိၤတာ်နီး ပူးကိုးထံတာ်အင်္ဂါ, ကိုး1-800-991-5840.တက်.

Korean

주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.

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

Kurdish

ئاگادار ی

ر هنگه نُه م ناگادار یه ز انباری گرنگی نتیدا بنیت دهر بار دی داو اکاری یان روو مانکر دنهکهت به دوای به روار ه سهر مکیهکانی ناو نهم ناگاداریه بگهری الموانهیه پنویست بکات له هاهندیک دوا و اده کردار یک بکامیت بز ناموهی روومانی تاهندروستیت بامردهوام بیّت یان یارماشی بز تیچووهکانت دهست بخامیت نامگاه تو یان کامسیّک که تو یارماشی دهدهیت پرسیاری همیه، تو مافی دهسکهوتنی یارمهتی و زانیاریت به زمانی خوت بن بهرامبهر همیه بو قسه کردن لهگال و هرگذریک، پهیوهندی به 18009915840. يكه

<u>Lao</u> ສິງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໜັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ. ຈົ່ງຊອກຫາວັນທີ່ທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກ່ຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄຳຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົງໂທຫາເບີ 1-800-991-5840.

Nepali

ध्यानाकर्षणः यो सूचनामा तपाईंको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईंको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईंले निश्चित समयसीमा भित्र कारबाही लिनुपर्न हुनसक्छ। तपाईं वा तपाईंले सहायता गरेका कसैसँग जिजासाहरू छन भने तपाईसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्न अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नहोस।

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 cân hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nêu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyên 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.