

 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, visit <http://home.commonspirit.org/employeecentral/mybenefits> or call (855) 475-4747 option 1. 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.healthcare.gov/sbc-glossary or call (855) 475-4747, option 1, to request a copy.


Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Enhanced Network <u>Provider</u> (CIN): \$0 individual /\$0 family per calendar year Out-of-Network <u>Provider</u> : \$6,000 individual /\$12,000 family per calendar year	Generally, you must pay all 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care, your drug costs, first colonoscopy and mammogram of the benefit period, ambulance services, <u>in-network</u> mental health/substance abuse, <u>in-network</u> office services, <u>preventive care</u> , and services subject to <u>copayments</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the deductible 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Enhanced Network <u>Provider</u> (CIN): \$4,000 individual /\$8,000 family per calendar year Out-of-Network (OON) <u>Provider</u> : \$12,000 individual /\$24,000 family per calendar year	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> ?	Premiums, pre-service review penalties, <u>balance-billed charges</u> , and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. Enhanced Network: Blueprint Health Network Primary Care Network . See www.NebraskaBlue.com/FindADoctor or call (844) 908.4534 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network . You will pay the most if you use an out-of-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing) . Be aware, your <u>network provider</u> might use an out-of-network <u>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 deductible has been met, if a deductible applies.


Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider/CIN (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	No charge for DPC providers only Not covered for all other providers	Not covered	Allergy injections, dialysis, labs/x-rays, surgery and second surgical opinions are covered with 15% <u>coinsurance</u> In-Network and 60% <u>coinsurance</u> Out-of-Network. All other primary care services MUST be provided by the Direct Primary Care.
	<u>Specialist</u> visit	\$30 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Applies to Non-PCP <u>provider</u> types. Chiropractic services apply <u>deductible</u> and <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply Out-of-network coverage for preventive care covered only when unavailable from the Direct Primary Care provider.	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer Summary Plan Description for details. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive <u>coinsurance</u> on first mammogram and colonoscopy of the benefit period.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.

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


Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider/CIN (You will pay the least)	Out-of- Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at www.cap-rx.com. For specialty prescriptions, go to www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy.</p>	Generic drugs	CommonSpirit Health Pharmacy: \$5 <u>copay</u> Other retail: \$10 copay Home delivery: \$12.50 <u>copay</u> <u>Deductible</u> does not apply	Retail: 60% <u>coinsurance</u> <u>Deductible</u> does not apply Home delivery: N/A	<p>Covers up to a 30-day supply from an in-network retail pharmacy or a 90-day supply from a home delivery pharmacy.</p> <p>If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name <u>coinsurance</u> plus the difference between the generic and brand-name.</p> <p>Maintenance medications must be filled for a 90-day supply using a CommonSpirit Health-owned pharmacy or the CommonSpirit Health home delivery pharmacy.</p> <p>Any combination of diabetic supplies and insulin purchased at a <u>network</u> pharmacy within six days of the fills are subject to one copayment or the applicable coinsurance amount for the insulin. Additional <u>copayment</u> / <u>coinsurance</u> amounts will apply to any combination of supplies purchased separately from the above mentioned insulin purchase criteria.</p> <p>Specialty prescriptions must be processed through the CommonSpirit Health Specialty Pharmacy. If the CommonSpirit Health Specialty Pharmacy can't fill your medication, your prescription will be routed to the Capital Rx Specialty Pharmacy partner please call (844) 306.6254.</p>
	Preferred brand drugs	CommonSpirit Health Pharmacy: 15% <u>coinsurance</u> \$20 min/\$55 max Other retail: 30% <u>coinsurance</u> \$40 min/\$110 max Home delivery: 15% <u>coinsurance</u> \$50 min/\$87.50 max <u>Deductible</u> does not apply	Retail: 60% <u>coinsurance</u> <u>Deductible</u> does not apply Home delivery: N/A	
	Non-preferred brand drugs	CommonSpirit Health Pharmacy: 25% <u>coinsurance</u> \$32.50 min/\$80 max Other retail: 50% <u>coinsurance</u> \$65 min/\$160 max Home delivery: 25% <u>coinsurance</u> \$80 min/\$162.50 max <u>Deductible</u> does not apply	Retail: 60% <u>coinsurance</u> <u>Deductible</u> does not apply Home delivery: N/A	
	<u>Specialty drugs</u>	Refer to above costs	Refer to above costs	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider/CIN (You will pay the least)	Out-of- Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Waive <u>coinsurance</u> on first colonoscopy of the benefit period.
	Physician/surgeon fees	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined <u>Deductible</u> does not apply	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined <u>Deductible</u> does not apply	50% <u>coinsurance</u> applies to non-emergency medical services. For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	<u>Emergency medical transportation</u>	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	Ambulance services received from an <u>out-of-network provider</u> may balance bill the difference in the billed amount and the allowed amount.
	<u>Urgent care</u>	\$50 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	\$75 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Reduction for failure to pre-certify out-of-network services is \$500 per admission.
	Physician/surgeon fees	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider/CIN (You will pay the least)	Out-of- Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	None
	Inpatient services	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Residential treatment is covered with no 24-hour nursing supervision requirement. Reduction for failure to pre-certify out-of-network services is \$500 per admission.
If you are pregnant	Office visits	\$30 <u>copay</u> per <u>provider</u> per date of service <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain <u>preventive services</u> . Any Enhanced network services that fall outside of preventive care/routine obstetric care, will pay at the most appropriate benefit in the plan document.
	Childbirth/delivery professional services	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which may be globally billed at time of delivery for pre-natal, post-natal and delivery services. Not all services are billed globally.
	Childbirth/delivery facility services	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider/CIN (You will pay the least)	Out-of- Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Provider/Facility aka Enhanced Network is not subject to 30-visit maximum.
	<u>Habilitation services</u>	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Provider/Facility aka Enhanced Network is not subject to 30-visit maximum.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Reduction for failure to pre-certify out-of-network services is \$500 per admission.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	One wig per calendar year is covered when related to medical condition. 2 pair of foot orthotics covered per calendar year.
	<u>Hospice services</u>	15% <u>coinsurance</u> <u>Deductible</u> does not apply	60% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic Surgery• Custodial care – in home or facility• Dental• Eye exam	<ul style="list-style-type: none">• Glasses• Hearing aids• Long-term care• Massage therapy	<ul style="list-style-type: none">• Routing eye care – Adult• 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.)		
<ul style="list-style-type: none">• Acupuncture (10 visits per calendar year)• Bariatric surgery• Chiropractic care (20 visits per calendar year)	<ul style="list-style-type: none">• Infertility treatment (\$15,000 LTM, \$5,000 LTM for infertility medications, excludes some services)	<ul style="list-style-type: none">• Private-duty nursing – short-term intermittent home skilled nursing

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: the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 (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: CommonSpirit Health Benefits Contact Center at (855) 475-4747, option (844) 908-4534 or visit us at www.NebraskaBlue.com or Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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

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 \$0
- Specialist copayment \$30
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$1,872
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,232

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

- The **plan's** overall deductible \$0
- Primary care copayment \$0
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$1,080
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,340

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

- The **plan's** overall deductible \$0
- Emergency room copayment \$200
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$271
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$471

Federally Required Notices

Discrimination is Against the Law

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

BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at (800) 991-5840.

If you believe that BCBSNE has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Manager, Corporate Compliance, P.O. Box 3248, Omaha, NE 68180-0001, Toll Free (800) 991-5840, Fax 402-392-4130, civilrights@nebraskablue.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

*This notice is translated as federally required.

Arabic

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

Chinese Traditional

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

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، سوالی 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

ဟ်သုၣ်ဟ်သး- တၢ်ဘိးဘၣ်သ့ၣ်ညါအံၤ/ဘၣ်သ့ၣ်သ့ၣ်/ကဆိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ/အရ့ၣ်ခိၣ်ဘၣ်ဃး/နလံာ်ပတံာ်တၢ်မ့တမ့ၢ်/တၢ်ဆုၣ်ကိၤသးန့ၣ်လီၤ.
က့ၢ်ယု/မ့ၢ်န့ၢ်မ့ၢ်သီအရ့ၣ်ခိၣ်လၢ/လံာ်ဘိးဘၣ်သ့ၣ်ညါအံၤအပူၤတက့ၢ်.
ဘၣ်သ့ၣ်သ့ၣ်/နကဘၣ်/ဟံးဂ့ၢ်ဝိလၢ/မ့ၢ်န့ၢ်လၢခံကတၢ်လၢ/တၢ်ဟ်ပနီၣ်န့ၢ်န့ၢ်/လၢနကဟ့ၣ်နတၢ်ဆိၣ်ဆုၣ်ဆိၣ်ချ့/တၢ်ဘူးတၢ်လဲတဖၣ်/မ့တမ့ၢ်/မၤန့ၢ်တၢ်မၤစၢၤလၢ/
တၢ်ပူၤလီၤလဲတဖၣ်န့ၣ်လီၤ. /န့ၢ်/မ့တမ့ၢ်/ပှၤတဂၤဂၤလၢ/နမၤစၢၤမ့ၢ်ဆိၣ်ဒီးတၢ်သံက့ၢ်အယိၤ./နဆိၣ်ဒီး
တၢ်ခွဲးတၢ်ယၢ်လၢ/ကမၤန့ၢ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ/နကျိၣ်လၢ/တလၢာ်ဘၣ်လၢာ်စ့ၤဘၣ်န့ၣ်လီၤ. /လၢနကကတၢ်တၢ်ဒီး/ပှၤကျိးထံတၢ်အဂီၢ်./ကိး 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 취
하셔야 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

رهنگه ئەم ئاگاداریه زانیاری گرنگی تیدا بێت دهرباره داواکاری یان روومالکردنهکمهت بهدوای بهرواره سهههکهکانی ناو ئەم ئاگاداریه
بگهڕێ. لهوانهیه پێویست بکات له هههنگه دوا واده کرداریک بکهیت بۆ نهوهی روومالی تههندروستیت بهردهوام بێت یان یارمهتی بۆ
تیچوو و هکانت دهست بخهیت. ئەگه تۆ یان کهسێک که تۆ یارمهتی دهدهیت پرساری ههیه، تۆ مافی دهسکهوتنی یارمهتی و زانیاریت به
زمانی خوێت بێ بهرامبهر ههیه. بۆ فسهکردن لهگهڵ وهرگیریک، پهیههندی به 18009915840 بکه.

Lao

ສົ່ງ ທີ່ ຄວນ ເອົາ ຈື່ ໃສ່ : ແຈ້ງ ການ ສະ ບັ ບ ນ ັ ັ
ອາດຈະມີ ຂໍ້ ມຸ ນ ທ ັ ສໍາ ຄ ັ ນ ກ ັ ບົວ ກ ັ ບ ກ ັ ນ ສະ ຫຼ ັ ກ ຫຼ ັ
ການ ອ ັ ມ ອ ອ ງ ສ ັ ຂ ັ ພ ັ ບ ຂ ອ ງ ທ ັ ັ ນ . ຈ ັ ງ ອ ກ ຫ ັ ວ ນ ທ ັ ທ ັ ສໍາ ຄ ັ ນ ໃ ນ ແ ຈ ັ ງ ກ ັ ນ ສ ັ ບ ັ ບ ນ ັ ັ .
ທ ັ ັ ນ ອ ັ ດ ັ ຈ ັ ຕ ັ ອ ັ ດ ັ ັ ນ ກ ັ ນ ໃ ນ ຂ ອ ບ ຂ ອ ດ ັ ໂ ດ ຫ ັ ນ ັ ງ
ເ ພ ັ ັ ອ ັ ຮ ັ ກ ສ ັ ກ ັ ນ ອ ັ ມ ັ ອ ອ ງ ດ ັ ັ ນ ສ ັ ຂ ັ ພ ັ ບ ຂ ອ ງ ທ ັ ັ ນ ຫຼ ັ
ໄດ້ ຮ ັ ບ ກ ັ ນ ຊ ັ ວ ຍ ັ ຫຼ ັ ອ ັ ທ ັ ັ ງ ັ ນ ງ ັ ບ ັ ພ ັ ມ ັ ນ . ຖ ັ ັ ຫຼ ັ ກ ັ ທ ັ ັ ນ
ຫຼ ັ ັ ບ ັ ກ ັ ນ ທ ັ ທ ັ ທ ັ ັ ນ ກ ັ ັ ງ ັ ຊ ັ ວ ຍ ັ ຫຼ ັ ອ ັ ຢ ັ ນ ັ ນ
ມ ັ ັ ກ ັ ກ ັ ມ ັ ທ ັ ັ ນ ມ ັ ັ ດ ັ ໂ ດ ັ ຮ ັ ບ ກ ັ ນ ຊ ັ ວ ຍ ັ ຫຼ ັ ອ ັ ແ ລ ັ
ໄດ້ ຮ ັ ບ ັ ຂ ັ ມ ັ ນ ທ ັ ັ ປ ັ ນ ພ ັ ສ ັ ຂ ອ ງ ທ ັ ັ ນ ໂ ດ ັ ຍ ັ ບ ັ ສ ັ ອ ັ ນ ັ ັ ຈ ັ ັ ັ ັ ັ .
ຕ ັ ອ ງ ກ ັ ນ ັ ມ ັ ກ ັ ບ ນ ັ ອ ັ ປ ັ ພ ັ ສ ັ , ຈ ັ ັ ງ ັ ທ ັ ຫ ັ ປ ັ 1-800-991-5840.

Nepali

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

Oromo

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

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.