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 deductible?	**Enhanced Network Provider (CIN) deductible:** $0 individual /$0 family per calendar year **Out-of-Network deductible:** $6,000 individual /$12,000 family per calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Well-child care, preventive drug list medications, first colonoscopy and mammogram of the benefit period, ambulance services, in-network mental health/substance abuse, in-network office services, preventive care, and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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 deductible specific services.
What is the out-of-pocket limit for this plan?	**Enhanced Network Provider (CIN) out-of-pocket limit:** $4,000 individual /$8,000 family per calendar year **Out-of-Network out-of-pocket limit** $12,000 individual /$24,000 family per calendar year	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?	Premiums, penalties, balance billing, and healthcare that 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. **Enhanced Network Level: Blueprint Health Network** See www.NebraskaBlue.com/FindADoctor or call (844) 908-4534 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 the 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 (balance billing). 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 **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	$15 copay per provider per date of service Deductible does not apply.	60% coinsurance	Primary Care Physicians (PCP) are defined as General and Family Practice, Internal Medicine, OB/ GYN, Pediatricians, Nurse Practitioners and PAs.
	Specialist visit	$30 copay per provider per date of service Deductible does not apply.	60% coinsurance	Applies to Non-PCP provider types
	Preventive care/screening/ immunization	No charge Deductible does not apply.	No charge Deductible does not apply.	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 providers if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance Deductible does not apply.	60% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Deductible and coinsurance do not apply to the first mammogram and colonoscopy of the benefit period.
	Imaging (CT/PET scans, MRIs)	15% coinsurance Deductible does not apply.	60% coinsurance	None

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **enrollment.cap-rx.com/chi** For specialty prescriptions, go to www.dignityhealth.org/arizona/ locations/stjosephs/ services/pharmacy	Generic drugs	CommonSpirit Health Pharmacy: $5 copay Other Retail: $10 copay Home Delivery: $12.50 copay Deductible does not apply.	Retail: 60% coinsurance. Home Delivery: N/A	Covers up to a 30-day supply from an in- network retail pharmacy or a 90-day supply from a home delivery pharmacy. If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name coinsurance plus the difference between the generic and brand-name. Maintenance medications must be filled for a 90-day supply using a CommonSpirit Health-owned pharmacy or the CommonSpirit Health Home delivery pharmacy. Any combination of diabetic supplies and insulin purchased at a network pharmacy is subject to one copayment or the applicable coinsurance amount for the insulin. Additional copayment / coinsurance amounts will apply to any combination of supplies purchased separately from the above mentioned insulin purchase criteria. 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.
	Preferred brand drugs	CommonSpirit Health Pharmacy: 15% coinsurance $20 min/$55 max Other Retail: 30% coinsurance $40 min/$110 max Home delivery: 15% coinsurance $50 min/$87.50 max. Deductible does not apply.	Retail: 60% coinsurance Home Delivery: N/A	
	Non-preferred brand drugs	CommonSpirit Health Pharmacy: 25% coinsurance $32.50 min/$80 max Other Retail: 50% coinsurance $65 min/$160 max Home delivery: 25% coinsurance $80 min/$162.50 max. Deductible does not apply.	Retail: 60% coinsurance Home Delivery: N/A	
	Specialty drugs	Refer to above costs	Refer to above costs	

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% coinsurance Deductible does not apply.	60% coinsurance	Deductible and coinsurance do not apply to the first mammogram and colonoscopy of the benefit period.
	Physician/surgeon fees	15% coinsurance Deductible does not apply.	60% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay per facility per date of service for facility and physician(s) services combined Deductible does not apply.	$200 copay per facility per date of service for facility and physician(s) services combined	50% coinsurance 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.
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	Ambulance services received from an out-of-network provider may balance-bill the difference in the billed amount and the allowed amount.
	Urgent care	$50 copay per provider per date of service Deductible does not apply.	$75 copay per provider per date of service Deductible does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance Deductible does not apply.	60% coinsurance	Reduction for failure to pre-certify out-of-network services is $500 per admission.
	Physician/surgeon fees	15% coinsurance Deductible does not apply.	60% coinsurance	None

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% coinsurance Deductible does not apply.	60% coinsurance	None
	Inpatient services	15% coinsurance Deductible does not apply.	60% coinsurance	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	$15 copay per provider per date of service Deductible does not apply.	60% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. 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% coinsurance Deductible does not apply.	60% coinsurance	Benefits shown reflect OB/GYN practitioner services which may be globally billed at time of delivery for prenatal, post-natal and delivery services. Not all services are billed globally.
	Childbirth/delivery facility services	15% coinsurance Deductible does not apply.	60% coinsurance	None

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	Home health care	15% coinsurance Deductible does not apply.	60% coinsurance	None
	Rehabilitation services	15% coinsurance Deductible does not apply.	60% coinsurance	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Facilities aka Enhanced Network is not subject to 30-visit maximum.
	Habilitation services	15% coinsurance Deductible does not apply.	60% coinsurance	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Facilities aka Enhanced Network is not subject to 30-visit maximum.
	Skilled nursing care	15% coinsurance Deductible does not apply.	60% coinsurance	Reduction for failure to pre-certify out-of-network services is $500 per admission.
	Durable medical equipment	15% coinsurance Deductible does not apply.	60% coinsurance	One wig per calendar year is covered when related to medical conditions. 2 pairs of foot orthotics covered per calendar year.
	Hospice services	15% coinsurance Deductible does not apply.	60% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Custodial care – in home or facility
- Dental Care
- Eye Exam
- Routine eye care (Adult)
- Glasses
- Long Term Care
- Massage Therapy
- Hearing aids
- Routine Foot Care
- Weight loss programs

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

- Acupuncture (10 visits per calendar year)
- Bariatric Surgery
- Chiropractic care (20 visits per calendar year)
- Infertility treatment ($15,000 LTM, $5,000 LTM for infertility medications, excludes some services)
- 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: (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: contact: CommonSpirit Health Benefits Contact Center at (855) 475-4747, option 1; Blue Cross and Blue Shield Nebraska at (844) 908-4534 or visit 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 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,896
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,956**

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

The plan's overall deductible	**$0**
Specialist copayment	**$30**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$1,101
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,161**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$200
Coinsurance	$262.5
What isn't covered	
Limits or exclusions	$60
The total Mia would pay is	**$522.5**

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

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

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

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica 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: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

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, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်ၤအဲၣ်ဒိး တၢ်ကျိးထံစၢၤကလီနၤတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီနှၣ်, ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနန့ၣ်ခဲလၢာ်အဒုၣ်သးခးကူအလိၢ်ခံတကပၤအဖီခိၣ်နှၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቂያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíijį' béésh bee hodíílnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

COMIFB-0119-I

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 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.

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– တၢ်ဘိးဘဉ်သ့ဉ်ညါဏံၤ/ဘဉ်သ့ဉ်သ့ဉ်/ကဆိဉ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ/ဏရှဒိဉ်ဘဉ်ဃး/နလံာ်ပတံထိဉ်တၢ်/မ့တမ့ၢ်/တၢ်ဏုဉ်ကိၤသးန့ဉ်လီၤ. ကွၢ်ဃု/မ့ၢ်နံၤမ့ၢ်သီဏရှဒိဉ်လၢ/လံာ်ဘိးဘဉ်သ့ဉ်ညါဏံၤဏပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ်/နကဘဉ်/ဟံးဂ့ၢ်ဖိလၢ/မ့ၢ်နံၤလၢခံကတၢ်လၢ/တၢ်ဟ်ပနီဉ်နှ်နၤ/လၢနကဟ့ဉ်နတၢ်ဆိဉ်ဆူဉ်ဆိဉ်ချ/တၢ်ဘူးတၢ်လဲတဖဉ်/မ့တမ့ၢ်/မၤန့ၢ်တၢ်မၤစၢၤလၢ/တၢ်ပ့ၤလီၤလဲတဖဉ်နူဉ်လီၤ. /နၤ/မ့တမ့ၢ်/ပ့ၤတဂၤဂၤလၢ/နမၤစၢၤမ့ၢ်ဆိဉ်ဒီးတၢ်သံကွၢ်ဏယိ,/နဆိဉ်ဒီး
တၢ်ခွဲးတၢ်ယာ်လၢ/ကမၤန့ၢ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ/နကျိာ်လၢ/တလၫာ်ဘူဉ်လၫာ်စ့ၤဘဉ်နူဉ်လီၤ. /လၢနကကတိၤတၢ်ဒီး:/ပ့ၤကျိးထံတၢ်ဏဂီၢ်,/ကိ: 1-800-991-5840.တက့ၢ်.

Korean

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

Kurdish

ئاگاداری

ڕەنگە ئەم ئاگادارییە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕوومالّکردنەکەت.بەدوای بەرواره سەرەکیەکانی ناو ئەم ئاگاداریە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕوومالّی تەندروستیت بەردەوام بێت یان پارمەتی 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 لەگەلّ وەرگێرێک، پەیوەندی بە .18009915840 بکە.

Lao

ສ ິ່ ງທ ີ່ ຄວນເອ ົາໃຈໃສ ່: ແຈ ້ ງການສະບ ັ ບນ ີ້
ອາດຈະມ ີ ຂ ໍ້ ມ ູ ນທ ີ່ ສຳຄ ັ ນກ ່ ຽວກ ັ ບການສະໝ ັ ກ ຫ ຼື ໍ
ການຄ ຸ້ ມຄອງສ ຸ ຂະພາບຂອງທ ່ ານ. ລ ໍ ຖ້ າເບິ່ ງວ ັ ນທ ີ ສຳຄ ັ ນໃນແຈ ້ ງການສະບ ັ ບນ ີ້.
ທ ່ ານອາດຈະຕ ້ ອງດ ຳເນ ີ ນການພາຍໃນກຳນົດເວລາໃດໜ ຶ່ ງ ເ
ພື່ ອຮ ັ ກສາການຄ ຸ້ ມຄອງດ ້ ານສ ຸ ຂະພາບຂອງທ ່ ານ ຫ ຼື
ໃດ ້ ຮ ັ ບການຊ ່ ວຍເຫ ຼື ອທາງດ ້ ານຄ ່ າ ບໍ ລິ ການ. ຖ ້ າທ ່ ານຫ ຼື ໍ
ຫ ຼື ໍ ບ ຸ ກຄ ົ ນທ ີ່ ທ ່ ານກຳລ ັ ງຊ ່ ວຍເຫ ຼື ອ ມ ີ ຄຳຖາມ,ທ ່ ານມ ີ ສ ິ ດໄດ ້ ຮ ັ ບການຊ ່ ວຍເຫ ຼື ອ ແລະ
ໄດ ້ ຮ ັ ບຂ ໍ້ ມ ູ ນທ ີ່ ເປ ັ ນພາສາຂອງທ ່ ານໂດຍບ ໍ່ ເສຍຄ ່ າໃຊ ້ ຈ ່ າຍ.
ຕ ິ ດຕໍ່ ພົ ວພັ ນ ເພື່ ອລົ ມກ ັ ບນາຍແປພາສາ, ລ ໍ ຖ ້ າໂທຫາເບີ 1-800-991-5840.

Nepali

ध्यानाकर्षण: 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 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.