

BridgeSpan Health Company: BridgeSpan Silver HDHP 3000 RealValue

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Eligible Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at bridgespanhealth.com/policy/2017/OR/SilverHDHP3000RealValueOregon or by calling 1 (855) 857-9943.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$3,000 single / \$6,000 family per calendar year. Out-of-network: \$10,000 single / \$20,000 family per calendar year. Doesn't apply to in-network preventive care. Amounts in excess of the <u>allowed amount</u> do not count toward the <u>deductible</u> . <u>Deductible</u> and <u>coinsurance</u> waived for Native Americans receiving services from Indian Health Providers.	Single: You must pay all the costs up to the single <u>deductible</u> amount before this plan begins to pay for covered services you use. Family: Insureds collectively must pay all the costs up to the family <u>deductible</u> amount before this plan begins to pay for any member's covered services. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$6,550 single / \$13,100 family* per calendar year. Out-of-network: Unlimited *An insured on family coverage will not have his or her <u>out-of-pocket limit</u> exceed \$7,150.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. See bridgespanhealth.com/RealValueOregon or call 1 (855) 857-9943 for lists of in-network or out-of-network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

Questions: Call 1 (855) 857-9943 or visit us at bridgespanhealth.com/policy/2017/OR/SilverHDHP3000RealValueOregon.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at www.cciio.cms.gov or call 1 (855) 857-9943 to request a copy.

Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	50% coinsurance	_____none_____
	Specialist visit	10% coinsurance	50% coinsurance	
	Other practitioner office visit	Not covered	Not covered	Acupuncture and spinal manipulations are excluded.
	Preventive care/ screening/immunization	No charge	50% coinsurance	Some in-network preventive health services require cost-sharing while others do not. For a complete list of preventive services covered with no cost-sharing, visit www.bridgespanhealth.com .
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	_____none_____

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at bridgespanhealth.com/formulary/2017/6tierEssential</p>	Generic drugs	10% coinsurance* / preferred generic retail prescription 5% coinsurance / preferred generic mail order prescription 25% coinsurance* / non-preferred generic retail prescription 20% coinsurance / non-preferred generic mail order prescription		<p>No coverage for prescription drugs not on the Essential Formulary.</p> <p>No coverage for prescription drugs from an out-of-network pharmacy.</p> <p>Coverage is limited to a 90-day supply retail, 90-day supply mail order or 30-day supply injectable, self-administrable cancer chemotherapy and specialty drugs.</p> <p>Deductible does not apply to certain preventive drugs, women's contraceptives or immunizations at a participating pharmacy.</p> <p>Deductible also waived for generic or brand-name drugs on the Essential Formulary specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List.</p> <p>The first fill for specialty drugs may be provided at a retail pharmacy, additional refills and any fills for specialty self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy.</p> <p>Coverage for self-administrable cancer chemotherapy drugs is 10% coinsurance.</p> <p>*5% discount when filled at a preferred pharmacy.</p>
	Preferred brand drugs	25% coinsurance* / retail prescription 20% coinsurance / mail order prescription		
	Non-preferred brand drugs	50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		
	Specialty drugs	40% coinsurance / preferred specialty drugs 50% coinsurance / non-preferred specialty drugs		
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	10% coinsurance	50% coinsurance	_____none_____
<p>If you need immediate medical attention</p>	Emergency room services	10% coinsurance	10% coinsurance	In-network deductible applies to out-of-network.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	50% coinsurance	
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Coverage is limited to \$3,000 / day for inpatient non-emergency admission in out-of-network facilities.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fee	10% coinsurance	50% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	50% coinsurance	Coverage is limited to \$3,000 / day for inpatient non-emergency admission in out-of-network facilities.
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	10% coinsurance	50% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	10% coinsurance	50% coinsurance	Coverage includes termination of pregnancy. Laws prohibit public funding of certain covered terminations of pregnancy. Premium payments are segregated to ensure compliance. Coverage is limited to \$3,000 / day for inpatient non-emergency admission in out-of-network facilities.
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	—————none—————
	Rehabilitation services	10% coinsurance	50% coinsurance	Coverage is limited to 30 inpatient days and 30 outpatient visits each for rehabilitation and habilitation services / year.
	Habilitation services	10% coinsurance	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	Coverage is limited to \$3,000 / day for inpatient non-emergency admission in out-of-network facilities.
	Durable medical equipment	10% coinsurance	50% coinsurance	Coverage is limited to 60 inpatient days / year.
	Hospice service	10% coinsurance	50% coinsurance	Coverage is limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problems other than refractive procedures.
If your child needs dental or eye care				Coverage is limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of five consecutive respite days at a time).
	Eye exam	No charge	No charge	Coverage is limited to 1 routine exam / year for insureds up to age 19.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
	Glasses	50% coinsurance	50% coinsurance	Coverage is limited to 1 pair of lenses (2 lenses) and 1 standard frame / year for insureds up to age 19, deductible waived.
	Dental check-up	No charge	No charge	Coverage is limited to 2 cleanings and 2 preventive oral examinations / year for insureds under age 19. Additional coverage is provided for basic and major pediatric dental services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care, including spinal manipulations • Cosmetic surgery, except for certain situations 	<ul style="list-style-type: none"> • Dental care (Adult) • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. or BridgeSpan service area 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care, including vision hardware (Adult) • Routine foot care, except for diabetic patients • Weight loss programs, unless required by law
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Hearing aids 		

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside of the coverage area

For more information on your rights to continue coverage, contact the insurer at 1 (855) 857-9943. You may also contact your state insurance department at (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Division of Financial Regulation, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883; through the Internet at: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by E-mail at: cp.ins@state.or.us.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Division of Financial Regulation at (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by E-mail at: cp.ins@state.or.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (855) 857-9943.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$3,960
- Patient pays: \$3,580

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$430
Limits or exclusions	\$150
Total	\$3,580

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$2,130
- Patient pays: \$3,270

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$230
Limits or exclusions	\$40
Total	\$3,270

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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DISCRIMINATION IS AGAINST THE LAW

This Notice has Important Information. BridgeSpan Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This notice has 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 help with costs. You have the right to get this information, and other information about your application or coverage, in your own language at no cost. Call 855-857-9943. (TTY: 711)

HELP IN OTHER LANGUAGES

The following translations help people who do not read English understand their rights and responsibilities and who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Spanish: Este aviso tiene información importante. BridgeSpan Health cumple con las leyes de derechos civiles federales aplicables y no discrimina sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Este aviso tiene información importante sobre su solicitud o cobertura. Busque las fechas importantes en este aviso. Es posible que tenga que tomar alguna acción en un determinado plazo para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y otra información sobre su solicitud o cobertura, en su propio idioma y sin costo. Llame al 855-857-9943. (TTY: 711)

Chinese Traditional: 本通知含有重要資訊。 BridgeSpan Health 遵守適用之聯邦政府民權法，不會因種族、膚色、原始出生國籍、年齡、身心障礙或性別的不同而予以差別待遇。本通知含有有關您申請或進行承保的重要資訊。請留意本通知內的重要日期。請在期限之前採取行動，以確保您的醫療保障或協助支付費用。您有權索取使用您語言撰寫的這類資訊，以及有關您申請或承保的相關資訊。請撥打 855-857-9943 索取。（聽障專線：711）

Vietnamese: Thông báo này có Thông tin Quan trọng. BridgeSpan Health tuân thủ luật pháp Liên bang về quyền công dân hiện hành và không phân biệt đối xử theo chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật hoặc giới tính. Thông báo này có 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. Quý vị có quyền lấy thông tin này và thông tin khác về đơn đăng ký hoặc bảo hiểm, bằng ngôn ngữ của mình miễn phí. Gọi số 855-857-9943. (TTY: 711)

Korean: 이 공지 사항에는 중요 정보가 들어 있습니다. BridgeSpan Health 은 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 따라 차별하지 않습니다. 이 공지 사항에는 해당 신청서 또는 적용 범위에 관한 중요한 정보가 있습니다. 이 공지 사항의 주요 날짜를 찾아 보십시오. 해당 건강 보험을 그대로 유지하거나 비용을 지원 받으려면 특정 기한까지 조치를 취하셔야 합니다. 귀하는 모국어로 작성된 본 정보나 해당 신청서 또는 보장 범위에 대한 기타 정보를 무료로 받을 수 있는 권리가 있습니다. 855-857-9943로 연락하십시오. (TTY: 711)



Russian: В данном Уведомлении содержится важная информация. BridgeSpan Health несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 855-857-9943. (TTY: 711)

Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon. Ang BridgeSpan Health ay sumusunod sa mga naaangkop na Pederal na batas sa mga karapatang sibil at hindi nagdidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. Ang abiso na ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o coverage. Hanapin ang mga importanteng petsa sa abiso na ito. Maaaring kailangan mong gumawa ng hakbang hanggang sa mga partikular na takdang araw upang mapanatili mo ang iyong coverage sa kalusugan o tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito, at iba pang impormasyon tungkol sa iyong aplikasyon o coverage, sa iyong sariling wika nang walang bayad. Tumawag sa 855-857-9943. (TTY: 711)

Ukrainian: Це повідомлення містить важливу інформацію. BridgeSpan Health дотримується застосовного федерального законодавства про громадянські права та не проводить політику дискримінації за расовою приналежністю, кольором шкіри, походженням, віком, інвалідністю та статевою ознакою. Це повідомлення містить важливу інформацію про пов'язану з вами програму або страхове покриття. Зверніть увагу на ключові дати в цьому повідомленні. Щоб зберегти за собою план медичного страхування або право отримувати грошову допомогу, можливо, вам потрібно буде вжити відповідні заходи, для яких установлено певні часові обмеження. Ви маєте право на безкоштовне отримання рідною мовою як цієї інформації, так і будь-якої іншої, пов'язаної з програмою чи страховим покриттям. Телефонуйте за таким номером: 855-857-9943 (телетайп: 711).

Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ ។ BridgeSpan Health អនុលោមទៅតាមច្បាប់របស់សហព័ន្ធលើសិទ្ធិពលរដ្ឋ ហើយមិនមានការរើសអើងចំពោះពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទឡើយ ។ សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗអំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ។ សូមរកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងសេចក្តី ជូនដំណឹងនេះ ។ អ្នកអាចត្រូវបានវិធានការឱ្យបានត្រឹមកាលបរិច្ឆេទកំណត់ ដើម្បីរក្សាបាននូវការធានារ៉ាប់រងសុខភាព ឬបានទទួលការជួយចេញការចំណាយថ្លៃថែទាំសុខភាពរបស់អ្នក ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ និងព័ត៌មានដទៃ អំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ជាភាសាដែលអ្នកប្រើ ដោយមិនបាច់បង់ប្រាក់ឡើយ ។ ហៅមកលេខ 855-857-9943 ។ (អ្នកពិបាកស្តាប់ ឬពិបាកនិយាយដែលប្រើ TTY សូមហៅមកលេខ ៖ 711)



Japanese: このお知らせには大変重要な情報が含まれています。BridgeSpan Health は、適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、身体障害、性別による差別をしません。このお知らせには保険の申請と適用に関する重要な情報が含まれています。このお知らせに記載されている重要な日付にご注意ください。健康保険適用や医療費支援を引き続き受けるためには締切日までに手続きを行う必要があります。あなたにはこのお知らせおよび申請と保険適用に関するその他の情報について、無料かつ母国語で知る権利があります。こちらまでお電話ください：855-857-9943。(TTY: 711)

Amharic: ይህ ማሳሰቢያ ጠቃሚ መረጃ ይዟል። BridgeSpan Health በሚተገበረው የፌዴራል ሲቪል መብቶች ህግጋት በዘር፣ በቀለም፣ በመጠብቅ ብሄር፣ እድሜ፣ የአካል ጉዳት ወይም የታ መድሎ አይደረግም። ማሳሰቢያው ስለ ማመልከቻዎችና ሽፋን ጠቃሚ መረጃ አለው። በዚህ ማሳሰቢያ ላይ ቁልፍ ቀናትን ይፈልጉ። በተወሰኑ የመጨረሻ ቀናት የጤና ሽፋኑ ላይ ወይም የወጪን ድጋፍ እንዲቀጥል እረምጃ መውሰድ ያስፈልጋል። ይህንን መረጃ እንዲሁም በማመልከቻዎት ወይም ሽፋኑ ላይ ሌሎችንም መረጃዎች በራስዎን ቋንቋ ያለምንም ክፍያ የማግኘት መብት አለዎት። 855-857-9943 ይደውሉ። (ቲቲዋይ:- 711)

Cushite/Oromo: **Beeksisni kun odeeffannoo barbaachisaa qabatee jira.** BridgeSpan Health Ulaagaa seera mirga Siivillii Federaalaa kan guutuu fi sanyii, bifa, lammummaa, umrii, miidhama qaamaa ykn saala irratti hundaa’ee addaan hinqoodne dha. Beeksisni kun iyyannoo ykn haguuggii kara keessan irratti odeeffannoo barbaachisaa qabatee jira. Guyyoota furtuu beeksis kana keessa jiran ilaalaa. Haguuggii fayyaa ykn gargaarsa keessan eeggachuuf hanga dhuma yeroo ta’eetti tarkanfii ta’e gatii bastanii fudhachuu qabdu. Odeeffannoo kana fi waa’ee iyyannoo ykn haguuggii keessanii kaffaltii tokko malee afaan keessaniin argachuuf mirga qabdu. Bilbilaa 855-857-9943. (TTY: 711)

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. تمتثل BridgeSpan Health إلى قوانين الحقوق المدنية الفيدرالية المعمول بها ولا تمارس التمييز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس. يحتوي هذا الإخطار على معلومات مهمة عن الطلب أو التغطية الخاصة بك. ابحث عن التواريخ الرئيسية في هذا الإخطار. فقد تحتاج إلى اتخاذ إجراء ما قبل بعض المواعيد النهائية للحفاظ على التغطية الصحية الخاصة بك أو تلقي مساعدة بخصوص التكاليف. لديك الحق في الحصول على هذه المعلومات والمعلومات الأخرى المتعلقة بالطلب أو التغطية الخاصة بك بلغتك مجانًا. اتصل بالرقم 855-857-9943. (الكتابة عن بُعد للصم: 711)

Punjabi: ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। BridgeSpan Health ਲਾਗੂ ਫੈਡਰਲ ਨਾਗਰਿਕ ਅਧਿਕਾਰਾਂ ਦੇ ਕਨੂੰਨ ਦੇ ਅਨੁਰੂਪ ਹੈ ਅਤੇ ਜਾਤਿ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਿਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਅਧਾਰ ‘ਤੇ ਭੇਦਭਾਵ ਨਹੀਂ ਕਰਦਾ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੇ ਬੇਨਤੀ-ਪੱਤਰ ਅਤੇ ਸੁਰੱਖਿਆ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮੁੱਖ ਮਿਤੀਆਂ ਵੇਖੋ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਸੁਰੱਖਿਆ ਰੱਖਣ ਜਾਂ ਲਾਗਤਾਂ ਨਾਲ ਮਦਦ ਕਰਨ ਲਈ ਨਿਯਤ ਮਿਆਦ ਸੀਮਾਵਾਂ ਦੁਆਰਾ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ, ਅਤੇ ਆਪਣੇ ਬੇਨਤੀ ਪੱਤਰ ਜਾਂ ਸੁਰੱਖਿਆ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। 855-857-9943 ‘ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)



German: Diese Mitteilung enthält wichtige Informationen. BridgeSpan Health hält die Grundrechte der USA ein und es finden keine Diskriminierungen aufgrund von Rasse, Hautfarbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht statt. Diese Mitteilung enthält wichtige Informationen über Ihren Antrag oder die entsprechende Versicherungsdeckung. 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. Sie haben das Recht, diese Informationen und andere Informationen über Ihren Antrag oder Ihren Versicherungsschutz kostenlos in Ihrer Sprache zu erhalten. Rufen Sie folgende Nummer an 855-857-9943. (Fernschreiber: 711)

Laotian: ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສໍາຄັນ. BridgeSpan Health ສອດຄ່ອງກັບກົດໝາຍ ວ່າດ້ວຍ ສິດທິພົນລະເມືອງຂອງຮັຖບານກາງ ທີ່ກ່ຽວຂ້ອງ ແລະ ບໍ່ມີການຈໍາແນກ ເຊື້ອຊາດ, ສີ່ຜິວ, ຊາດກໍາເນີດ, ອາຍຸ, ຄວາມເປັນຄົນພິການ ຫຼື ເພດ. ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການນໍາໃຊ້ຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງ. ຊອກຫາວັນທີ່ສໍາຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງການດໍາເນີນການໃນຂອບເຂດເວລາໃດຫຼື ເພື່ອ ໃຫ້ສືບຕໍ່ໄດ້ຮັບການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ທ່ານມີສິດເອົາຂໍ້ມູນນີ້ ແລະ ຂໍ້ມູນອື່ນ ກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕິດຕໍ່ 855-857-9943. (TTY: 711)