SummaCare℠ **Silver 3500-Limited w/ 3 Free PCP Visits & Adult Vision** **Coverage for:** Individual, Spouse, Family | **Plan Type:** HMO

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 www.summacare.com or call 800.996.8701. 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 800.996.8701 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or $3,500 individual / $7,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, urgent care, diabetic eye exams, pediatric vision exam and frames and generic drugs 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $10,600 individual / $21,200 family	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, balance billing charges and health care 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. See www.summacare.com/providersearch or call 800.996.8701 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
		Indian Health Care Provider (ICHP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP 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	$0 copay for first three visits, then $15 copay per visit. Deductible does not apply.	Not covered	First three visits limit is combined for Primary Physician and Mental Health outpatient visits. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Specialist visit	No charge	$60 copay per visit. Deductible does not apply.	Not covered	Prior authorization is required to see a surgeon for back pain. Obtaining prior authorization is provider's responsibility for in-network services. Failure to obtain prior authorization will result in denial of claim. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider 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)	No charge	30% coinsurance	Not covered	Physician order required. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Not covered	Requires prior authorization. Obtaining prior authorization is provider's responsibility for in-network services. Failure to obtain prior authorization will result in denial of claim. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (ICHP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP 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 **http://www.summacare.com/formulary**	Generic drugs	No charge	$15/$25 copay per prescription (Deductible does not apply) for preferred/non-preferred generic drugs for up to a 30-day supply retail. $45/$75 copay per prescription (Deductible does not apply) for preferred/non-preferred generic drugs for up to a 90-day supply retail. $30/$50 copay per prescription (Deductible does not apply) for preferred/non-preferred generic drugs through our mail order pharmacy.	Not covered	Brand and generic drugs limited to a 90-day supply at retail. Brand and generic drugs up to a 90-day supply through mail order. $100 maximum for up to a 30-day supply of Brand Orally Administered Cancer Drugs. Some drugs require prior authorization. Refer to our formulary, http://www.summacare.com/formulary. Mail Order is covered through our Contracted Mail Order Pharmacy. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Preferred brand drugs	No charge	$50 copay per prescription for up to a 30-day supply retail. $150 copay per prescription for up to a 90-day supply retail. $125 copay per prescription through our mail order pharmacy.	Not covered	
	Non-preferred brand drugs	No charge	45% coinsurance per prescription for up to a 30-day or 90-day supply retail or through our mail order pharmacy.	Not covered	
	Specialty drugs	No charge	50% coinsurance per prescription for up to a 30-day supply retail.	Not covered	Limited up to a 30-day supply (retail prescription). Some drugs require prior authorization. Refer to our formulary, http://www.summacare.com/formulary. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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		Indian Health Care Provider (ICHP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$300 copay	Not covered	Certain outpatient services require prior authorization. Refer to prior authorization list at www.summacare.com. Obtaining prior authorization is provider's responsibility for in-network services. Failure to obtain prior authorization will result in denial of claim. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	30% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you need immediate medical attention	Emergency room care	No charge	$500 copay	$500 copay	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Emergency medical transportation	No charge	30% coinsurance	30% coinsurance	
	Urgent care	No charge	$75 copay. Deductible does not apply.	$75 copay. Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Not covered	Requires prior authorization. Obtaining prior authorization is provider's responsibility for in-network services. Failure to obtain prior authorization will result in denial of claim. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	30% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (ICHP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$0 copay for first three visits, then $15 copay per visit. Deductible does not apply.	Not covered	First three visits limit is combined for Primary Physician and Mental Health outpatient visits. Inpatient services require prior authorization. Obtaining prior authorization is provider's responsibility for in-network services. Failure to obtain prior authorization will result in denial of claim. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Inpatient services	No charge	30% coinsurance	Not covered	
If you are pregnant	Office visits	No charge	$15 copay for initial visit, then $0 copay. Deductible does not apply.	Not covered	Maternity care may include tests and services described elsewhere in the Summary of Benefits and Coverage (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Childbirth/delivery professional services	No charge	30% coinsurance	Not covered	
	Childbirth/delivery facility services	No charge	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Not covered	100 visits per calendar year. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Rehabilitation services	No charge	$15 copay per physical therapy or occupational therapy visit. Deductible does not apply. $60 copay per visit for all other rehabilitation services. Deductible does not apply.	Not covered	Physical Therapy, Occupational Therapy, Speech Therapy and Pulmonary Rehabilitation limited to 20 visits/calendar year each; Cardiac Rehabilitation limited to 36 visits/calendar year. 20 visits per habilitation service, includes Physical Therapy, Speech Therapy and Occupational Therapy; 30 visits per year for Mental/ Behavioral Health Outpatient Services; 20 hours per week for Clinical Therapeutic Intervention. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Habilitation services	No charge	$15 copay per physical therapy or occupational therapy visit. Deductible does not apply. $60 copay per visit for all other rehabilitation services. Deductible does not apply. $15 copay per mental health visit. Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (ICHP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	30% coinsurance	Not covered	90 days per calendar year. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Durable medical equipment	No charge	30% coinsurance	Not covered	Requires prior authorization. Obtaining prior authorization is provider's responsibility for in-network services. Failure to obtain prior authorization will result in denial of claim. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Hospice services	No charge	30% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	One routine exam every 12 months. One frame/set of lenses every 12 months. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Children's glasses	No charge	No charge	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	Routine fluoride dental exam for a child covered under preventive benefit at no charge in-network. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment. Initial testing covered only.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)		
• Chiropractic care • Hearing aids (ages 21 and younger)	• Infertility testing	• Routine eye care (Adult) • Teladoc visits

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877.267.2323 x61565 or www.cms.gov/cciio/index.html. 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 on how 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: the plan at 800.996.8701 or the Ohio Department of Insurance's Consumer Hotline at 800.686.1526 or www.insurance.ohio.gov.

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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 800.996.8701.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.996.8701.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800.996.8701.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800.996.8701.]

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	$3,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other (coinsurance)	30%

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	$3,500
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,270**

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

The plan's overall deductible	$3,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other (coinsurance)	30%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$3,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other (coinsurance)	30%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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

Important Information

SummaCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, gender identity or sex.

SummaCare does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, gender identity or sex.

SummaCare:

- 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 Member Services.

If you believe that SummaCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, gender identity or sex, you can file a grievance through Member Services:

Civil Rights Coordinator
PO Box 1107
Akron, OH 44309-1107
Toll-free: 800.996.8701
TTY: 800.750.0750
Fax: 330.996.8545
Email: appeals@summacare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Customer Service Representative 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, DC 20201, 800.368.1019, 800.537.7697 (TDD).

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

Important Information
Language Access Services:

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de SummaCare, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-996-8701.

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de SummaCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-996-8701.

如果您，或是您正在協助的對象，有關於 插入 SBM 項目的名稱 SummaCare 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字1-800-996-8701。

本通知有重要的訊息。本通知有關於您透過 插入SBM 項目的名稱 SummaCare 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 在此插入數字1-800-996-8701。

Falls Sie oder jemand, dem Sie helfen, Fragen zum SummaCare haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-996-8701 an.

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch SummaCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-996-8701.

صوصخب قلئسأ هدعاست صخش بدل وأ كيدل ناك نإ 1-800-996-8701. ب لصتا SummaCare ، تاملعملاو تدعاسملا بلع لوصحلا يف قحلا كيدلف
مجرتم عم ثدحتلل .ةفلكت ةيا نود نم كتغلب ةيرورضلا

لالخ نم ةيطغتلا بلع لوصحلل كبلط صوصخب ةمهم تاملعم راعشالا اذه يوحي .ةماه تاملعم راعشالا اذه يوحي عفد يف تدعاسملل وا ةيحصلا كتيطغت بلع SummaCare. اذه يف ةماهلا خيراوتلا نع ثحبا
ظافحلل ةنيعم خيراوت يف ءارجا ذاختال جاتحت دق .راعشالا
1-800-996-8701. فيلاكتلا .كل قحلا يف روصحلا بلع تاملعملاو تدعاسملاو كتغلب نم نود يأ ةفلكت .ب لصتا

Important Information

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut SummaCare, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-996-8701 uffrufe.

Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit SummaCare. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу SummaCare, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-996-8701.

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через SummaCare. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-996-8701.

Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de SummaCare, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-996-8701.

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de SummaCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l’aide dans votre langue à aucun coût. Appelez 1-800-996-8701.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về SummaCare, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-996-8701.

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình SummaCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800- Isin yookan namni biraa isin deeggartan SummaCare irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta’een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-996-8701 tiin bilbilaa.

Important Information

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa SummaCare tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-800-996-8701 tii bilbilaa.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이SummaCare 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-996-8701로 전화하십시오.

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고SummaCare을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1- 800-996-8701 로 전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su SummaCare, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-996-8701.

Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso SummaCare. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 1-800-996-8701.

ご本人様、またはお客様の身の回りの方でも、SummaCareについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手 したりすることができます。料金はかかりません。通訳とお話される場合、1-800-996-8701までお電話ください。

この通知には重要な情報が含まれています。この通知には、SummaCareの申請または補償範囲に関する重要な情報が含まれています。この通知
に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合が あります。ご希望の言語による情報とサポートが無料で提供されます。1-800-996-8701までお電話ください。

Important Information

Als u, of iemand die u helpt, vragen heeft over SummaCare, heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel 1-800-996-8701.

Deze mededeling heeft belangrijke informatie. Deze mededeling heeft belangrijke informatie over uw aanvraag of dekking via SummaCare. Kijk naar belangrijke datums in deze mededeling. Het kan nodig zijn om actie te ondernemen binnen bepaalde termijnen om uw zorgverzekering te behouden of hulp met kosten te krijgen. U heeft het recht op deze informatie en hulp in uw taal zonder kosten. Bel 1-800-996-8701.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про SummaCare, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-800-996-8701.

Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через SummaCare. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1-800-996-8701.

Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind SummaCare, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 1-800-996-8701.

Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin SummaCare. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 1-800-996-8701.