



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, go to [regence.com/booklet/2017/OR/Platinum500](http://regence.com/booklet/2017/OR/Platinum500) or call 1 (888) 367-2116. 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1 (888) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>network</u> : \$500 individual / \$1,000 family per calendar year. Out-of- <u>network</u> : \$3,000 individual / \$6,000 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <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. Upfront benefits, <u>prescription drugs</u> and the following in- <u>network</u> services: <u>preventive care</u> , office and <u>urgent care</u> visits and outpatient mental health and substance use disorder therapy visits.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>network</u> : \$2,500 individual / \$5,000 family per calendar year. Out-of- <u>network</u> : \$10,000 individual / \$20,000 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> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://regence.com/PreferredOregon">regence.com/PreferredOregon</a> or call 1 (888) 367-2116 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</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
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 10% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Copayment</u> applies to each in-<u>network</u> office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u>.</p> <p>Coverage for complementary care (acupuncture and chiropractic spinal manipulations) is subject to \$25 <u>copayment</u> / visit, <u>deductible</u> waived. Limited to \$1,500 / year for all complementary care services combined.</p> <p>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.</p>
	<u>Specialist</u> visit	\$30 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for the first \$400 / year, then 10% <u>coinsurance</u>	No charge for the first \$400 / year, then 50% <u>coinsurance</u>	No charge for the first \$400 / year for upfront outpatient <u>diagnostic tests</u> . The \$400 / year limit is a combined in- <u>network</u> and out-of- <u>network</u> limit. Once the limit has been met and for all inpatient services, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://regence.com/formulary/2017/6tierEssential">regence.com/formulary/2017/6tierEssential</a> .	Generic drugs (preferred & non-preferred)	\$4 <u>copay</u> * / preferred retail prescription \$8 <u>copay</u> / preferred mail order prescription 25% <u>coinsurance</u> * / non-preferred retail prescription 20% <u>coinsurance</u> / non-preferred mail order prescription		<p>No coverage for <u>prescription drugs</u> not on the Essential Formulary.</p> <p>No coverage for <u>prescription drugs</u> from an out-of-<u>network</u> pharmacy.</p> <p>Limited to a 90-day supply retail (1 <u>copayment</u> per 30-day supply), 90-day supply mail order or 30-day supply injectable, self-administrable cancer chemotherapy and <u>specialty drugs</u>.</p> <p><u>Deductible</u> waived for all <u>prescription drugs</u>.</p> <p>The first fill for <u>specialty drugs</u> 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% <u>coinsurance</u>.</p> <p>*\$5 off <u>copayment</u> or 5% off <u>coinsurance</u> discount when filled at a preferred pharmacy</p>
	Preferred brand drugs	\$25 <u>copay</u> * / retail prescription \$50 <u>copay</u> / mail order prescription		
	Non-preferred brand drugs	50% <u>coinsurance</u> * / retail prescription 45% <u>coinsurance</u> / mail order prescription		
	<u>Specialty drugs</u> (preferred & non-preferred)	20% <u>coinsurance</u> / preferred retail prescription 50% <u>coinsurance</u> / non-preferred retail prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	5% <u>coinsurance</u> for ambulatory surgery center;	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	center)	10% <u>coinsurance</u> for all other facilities		
	Physician/surgeon fees	5% <u>coinsurance</u> for ambulatory surgery center physicians; 10% <u>coinsurance</u> for all other physicians	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> / visit	\$250 <u>copay</u> / visit	<u>Copayment</u> applies to the facility charge for each visit (waived if admitted), whether or not the <u>in-network deductible</u> has been met.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>In-network deductible</u> applies to <u>in-network</u> and <u>out-of-network</u> services.
	<u>Urgent care</u>	\$30 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Copayment</u> applies to each <u>in-network</u> office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to \$2,500 / day for inpatient non-emergency admission in non-participating facilities.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Copayment</u> applies to each <u>in-network</u> outpatient therapy visit only. All other outpatient testing and non-therapy services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to \$2,500 / day for inpatient non-emergency admission in non-participating facilities.
If you are pregnant	Office visits	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to \$2,500 / day for inpatient non-emergency admission in non-participating facilities.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 inpatient days (up to 60 days for head or spinal cord injury) and 30 outpatient visits each for rehabilitation and <u>habilitation services</u> / year. Includes
	<u>Habilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
				physical therapy, speech therapy, and occupational therapy. Limited to \$2,500 / day for inpatient non-emergency admission in non-participating facilities.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 inpatient days / year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problem other than refractive procedures.
	<u>Hospice services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of 5 consecutive respite days at a time).
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to 1 routine exam / year for individuals under age 19.
	Children's glasses	50% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Limited to 1 pair of lenses (2 lenses) and 1 standard frame / year for individuals under age 19.
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental services.

### 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.)

- Bariatric surgery
- Cosmetic surgery, except for certain situations
- Dental care (Adult)
- Fertility treatment
- Long-term care
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care, spinal manipulations only
- Hearing aids
- Non-emergency care when traveling outside the U.S.

**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 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or [cciio.cms.gov](http://cciio.cms.gov) or your state insurance department. You may

also contact the [plan](#) at 1 (888) 367-2116. 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 [HealthCare.gov](#) or call 1 (800) 318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [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 the [plan](#) at 1 (888) 367-2116 or visit [regence.com](#) or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](#). You may also contact the Division of Financial Regulation by calling (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: [oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx](#); or by E-mail at: [cp.ins@state.or.us](mailto:cp.ins@state.or.us).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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 1 (888) 367-2116.

-----*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 \$500
- Specialist copayment \$30
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$16
Coinsurance	\$1,131
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,707</b>

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

- The plan's overall deductible \$500
- Specialist copayment \$30
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,253
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$255
<b>The total Joe would pay is</b>	<b>\$1,508</b>

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

- The plan's overall deductible \$500
- Specialist copayment \$30
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$400
Coinsurance	\$82
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$982</b>

## DISCRIMINATION IS AGAINST THE LAW

This Notice has Important Information. Regence 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 888-344-6347. (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.** Regence 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 888-344-6347. (TTY: 711)

**Chinese Traditional: 本通知含有重要資訊。** Regence 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 888-344-6347 索取。（聽障專線：711）

**Vietnamese: Thông báo này có Thông tin Quan trọng.** Regence 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 888-344-6347. (TTY: 711)

**Korean: 이 공지 사항에는 중요 정보가 들어 있습니다.** Regence은 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. 888-344-6347로 연락하십시오. (TTY: 711)

**Russian: В данном Уведомлении содержится важная информация.** Regence 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 888-344-6347. (TTY: 711)

**Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon.** Ang Regence 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 888-344-6347. (TTY: 711)

**Ukrainian: Це повідомлення містить важливу інформацію.** Regence 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: 888-344-6347 (телетайп: 711).

**Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ ។** Regence អនុលោមទៅតាមច្បាប់របស់សហព័ន្ធស្តីពីសិទ្ធិពលរដ្ឋ ហើយមិនមានការរើសអើងចំពោះពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទឡើយ ។ សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗអំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ។ សូមរកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងសេចក្តីជូនដំណឹងនេះ ។ អ្នកអាចត្រូវបានវិធានការឱ្យបានត្រឹមកាលបរិច្ឆេទកំណត់ ដើម្បីរក្សាបាននូវការធានារ៉ាប់រងសុខភាព ឬបានទទួលការជួយចេញការចំណាយថ្លៃថែទាំសុខភាពរបស់អ្នក ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ និងព័ត៌មានដទៃ អំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ជាភាសាដែលអ្នកប្រើ ដោយមិនបាច់បង់ប្រាក់ឡើយ ។ ហៅមកលេខ 888-344-6347 ។ (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。Regence 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： 888-344-6347。(TTY: 711)

**Amharic:** ይህ ማሳሰቢያ ጠቃሚ መረጃ ይዟል። Regence በሚተገበረው የፌዴራል ሲቪል መብቶች ህግጋት በዘር፣ በቀለም፣ በመጠብቅ ብሄር፣ እድሜ፣ የአካል ጉዳት ወይም ምሥራቅ ስድስ 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። 888-344-6347 ይደውሉ። (ቴሌፎን፡- 711)

**Cushite/Oromo:** Beeksisni kun odeeffannoo barbaachisaa qabatee jira. Regence Ulaagaa seera mirga Siivilii 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 beeksisaa 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 888-344-6347. (TTY: 711)

**Arabic:** يحتوي هذا الإخطار على معلومات مهمة. تمتثل Regence 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 888-344-6347. (الكتابة عن بُعد للسم: 711)

**Punjabi:** ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। Regence 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। 888-344-6347 ‘ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

**German: Diese Mitteilung enthält wichtige Informationen.** Regence 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 888-344-6347. (Fernschreiber: 711)

**Laotian: ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສໍາຄັນ.** Regence ສອດຄ່ອງກັບກົດໝາຍ ວ່າດ້ວຍ ສິດທິພົນລະເມືອງຂອງຮັຖບານກາງ ທີ່ກ່ຽວຂ້ອງ ແລະ ບໍ່ມີການຈໍາແນກ ເຊື້ອຊາດ, ສີເຜິ້ວ, ຊາດກໍາເນີດ, ອາຍຸ, ຄວາມເປັນຄົນພິການ ຫຼື ເພດ. ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການນໍາໃຊ້ຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງ. ຊອກຫາວັນທີທີ່ສໍາຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງການດໍາເນີນການໃນຂອບເຂດເວລາໃດຫຼື ເພື່ອ ໃຫ້ສືບຕໍ່ໄດ້ຮັບການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ທ່ານມີສິດເອົາຂໍ້ມູນນີ້ ແລະ ຂໍ້ມູນອື່ນ ກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕິດຕໍ່ 888-344-6347. (TTY: 711)