PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Starting 1/1/17

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	PERSONALCARE BRONZE 4500	
	PARTNER SYSTEM IN-NETWORK	PARTNER SYSTEM OUT-OF-NETWORK
Deductible (In-network only - Family embedded deductible 2X Individual)	$4,500 PCY	Not Covered
Coinsurance	30%	Not Covered
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$7,150 PCY	Not Covered
Office Visit Cost Share	$35 Copay designated PCP, applies to the Out of Pocket Maximum; $75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visits	$35 Copay designated PCP, applies to the Out of Pocket Maximum; $75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	$35 Copay designated PCP, applies to the Out of Pocket Maximum; $75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Outpatient Professional Services	In Network Deductible, then 30%	Not Covered
Contraceptive Management Services (Unlimited)	Covered In Full	Not Covered
2 Emergency and Transportation Services		
Emergency Room - facility	$250 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 0%	$250 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 0%
Ambulance Service - ground (Unlimited)	$250 Copay, applies to the Out of Pocket Maximum	$250 Copay, applies to the Out of Pocket Maximum
Ambulance Service - air (Unlimited)	$250 Copay, applies to the Out of Pocket Maximum	$250 Copay, applies to the Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
Hospice Inpatient Facility (Unlimited)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
Inpatient Professional Services	Covered In Full	Not Covered
Organ Transplants (Unlimited; $5,000 travel and lodging limits)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	$35 Copay designated PCP, applies to the Out of Pocket Maximum	Not Covered
Inpatient Delivery Room and Board (Coverage for subscriber, spouse, dependent)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered

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	PARTNER SYSTEM IN-NETWORK	PARTNER SYSTEM OUT-OF-NETWORK
Chemical Dependency Outpatient Facility (Unlimited)	In Network Deductible, then 30%	Not Covered
Chemical Dependency Inpatient Facility (Unlimited)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
Mental Health Office Visit (Unlimited)	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Mental Health Outpatient Facility (Unlimited)	In Network Deductible, then 30%	Not Covered
Mental Health Inpatient Facility (Unlimited)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
6 Prescription Drug		
Drug List	M4	Not Covered
Pharmacy Deductible (Family Deductible 2x Individual)	$1,500 ded waived for generics	Not Covered
Retail (preferred generic/preferred brand/non-preferred) (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Pharmacy Deductible, then $25/Pharmacy Deductible, then $75/Pharmacy Deductible, then $175; All cost shares apply to the Out of Pocket Maximum	Not Covered
Mail Order (preferred generic/preferred brand/non-preferred) (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Pharmacy Deductible, then $75/Pharmacy Deductible, then $225/Pharmacy Deductible, then $525; All cost shares apply to the Out of Pocket Maximum	Not Covered
Specialty Rx (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	In Network Deductible, then $350; All cost shares apply to the Out of Pocket Maximum	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	$750 Copay per Day up to 5 Days, Plus In Network Deductible, applies to Out of Pocket Maximum	Not Covered
Rehab Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Habilitation Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Massage Therapy (Applies to rehab)	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered
Durable Medical Equipment (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 30%	Not Covered
8 Laboratory/Imaging Services		
Pathology	$100 Copay, applies to the out of pocket maximum; then In Network Deductible	Not Covered
Imaging - basic	$100 Copay, applies to the out of pocket maximum; then In Network Deductible	Not Covered

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MEDICAL PLAN	PERSONALCARE BRONZE 4500	
	PARTNER SYSTEM IN-NETWORK	PARTNER SYSTEM OUT-OF-NETWORK
Imaging - major (MRI, CT, PET)	$750 Copay, applies to the out of pocket maximum; then In Network Deductible	Not Covered
Diagnostic Mammography	$100 Copay, applies to the out of pocket maximum; then In Network Deductible	Not Covered
9 Preventive/Wellness Services & Chronic Disease Management		
Preventive Office Visit (Unlimited)	Covered In Full	Not Covered
Immunizations (Unlimited)	Covered In Full	Not Covered
Preventive Laboratory Screens	Covered In Full	Not Covered
Preventive Imaging	Covered In Full	Not Covered
Preventive Routine Mammography	Covered In Full	Not Covered
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY Under age 19)	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	$75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum
Pediatric Eyewear (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered In Full	Covered In Full
Pediatric Dental (preventive)	Waive Deductible, 0% (Covered in full)	Not Covered
Pediatric Dental (basic)	Waive Deductible, then 20%	Not Covered
Pediatric Dental (major)	Deductible, then 50%	Not Covered
Routine Hearing		
Routine Hearing Exam (1 every 2 calendar years)	Exam: $75 copay; Test: Covered in Full	Not Covered
Routine Hearing Aids and Hardware ($1000 every 3 calendar years)	Covered In Full	Covered In Full
Alternative Care		
Chiropractic (10 visits PCY)	$35 Copay, applies to the Out of Pocket Maximum	Not Covered
Acupuncture (12 visits PCY)	$35 Copay, applies to the Out of Pocket Maximum	Not Covered
Naturopath (Unlimited)	$35 Copay designated PCP, applies to the Out of Pocket Maximum; $75 Copay Specialist and non designated PCP, applies to the Out of Pocket Maximum	Not Covered

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Definitions

Below is a list of commonly used healthcare terms. At Premera, our goal is to make using your health plan easy. This is just one of the ways we care for you.

allowed amount*	The maximum amount of the billed charge payable by the plan. When you receive services from in-network providers, you'll be responsible only for any applicable cost sharing, including deductibles, copays, coinsurance, and charges in excess of the stated benefit.
coinsurance	Your percentage of the cost for a service. If your plan's coinsurance is 20%, you pay 20% of the allowed amount and your plan pays the other 80%.
copay	This is a flat fee you pay for a specific service (like an office visit) at the time you receive the service.
covered in full	This means your plan pays the full cost for a service. You do not pay deductibles, coinsurance, or copays for services that are covered in full.
deductible	The amount of money you pay in medical costs before your health plan begins to pay.
drug list	A list of prescription drugs, both generic and brand name. Not all drugs are included in every drug list.
network	A group of doctors, dentists, pharmacies, hospitals, and other healthcare providers that contract with Premera to provide services and supplies at negotiated amounts called allowable amounts.
out-of-pocket maximum	The maximum amount of cost shares you will pay for covered services in a calendar year. After you've met your out-of-pocket maximum, the plan pays 100% for in-network services for the rest of the year.
primary care provider (PCP)	The doctor or other healthcare provider you designate to provide most of your healthcare needs. You can choose a different primary care provider for each family member. Your primary care doctor can be a family practice physician, general practice provider, geriatric practice provider, gynecologist, internist, nurse practitioner, obstetrician, pediatrician, physician's assistant, or naturopaths under some benefit plans.

* Note that if you see a non-contracted provider, you will be responsible for the difference between the allowable amount and the provider's billed charges, in addition to the coinsurance and any applicable copay. The allowable amount for a non-contracted provider is determined by Premera as described in your benefit booklet.

View the Summary of Benefits and Coverage, a glossary, and Supplemental Guide at **premera.com/SBC**. There is also information about privacy policies, provider organizations, key utilization management procedures, and pharmaceutical management procedures on the site.

General exclusions and limitations

Benefit plans typically have exclusions and limitations—what the plans limit or do not cover. The following are general exclusions and limitations for Premera benefit plans.*

What is limited or not covered

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Assisted Reproduction
- Caffeine dependence
- Complications of non-covered services
- Conditions arising from acts of war or service in the military
- Conditions arising from the member's commission of a felony or act of terrorism
- Convenience items (i.e., guest meals and services, television, telephone charges)
- Cosmetic services (except as specifically provided)
- Counseling or training in the absence of illness
- Food supplements (except medical foods)
- Experimental or investigative services
- Hair loss/hair prosthesis (wig)
- Institutional care, housing, incarceration, or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions.
- Over-the-counter or non-prescription drugs, except as required by law
- Private duty nursing
- Services in excess of specified benefit maximums and/or allowable charges
- Services payable by other types of insurance such as motor vehicle insurance or liability insurance
- Services received when you are not covered by this program
- Sexual problems
- Vision therapy, eye exercise, and vision surgeries to improve the refractive character of the cornea (LASIK)
- Voluntary support groups
- Work-related conditions for which you are eligible for benefits from other sources

Prior authorization

Certain medical services and prescriptions require approval from the health plan before the member gets them. Contact your Premera representative for more information.

More information

A supplemental guide that shares information about privacy policies, provider organization, key utilization management procedures, and pharmaceutical management procedures is available on **premera.com**.

* For a complete list of the exclusions and limitations, please see the plan contract or visit premera.com. Contact your Premera Blue Cross representative for more information.

PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

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

Premera:

- 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 the Civil Rights Coordinator.

If you believe that Premera 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 - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be 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 help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በእከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ(800-722-1471 (TTY: 800-842-5357

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。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 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. 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 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. 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 le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen 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 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong):
Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci 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 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese):
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、Premera Blue Cross 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る場合があります。この通知に記載されている可能性があ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。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 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. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានាវ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញផ្លែ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în 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 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. 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 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'amatalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en 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 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути 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 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng 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 giúp 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 800-722-1471 (TTY: 800-842-5357).