

Highlights of your Health Care Coverage

2020 PPO 70% Plan 4000

Effective Date: 10/01/2020

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 | | |
|---|--|--|
| 2020 PPO 70% PLAN 4000 | | |
| | HERITAGE (PLUS) IN-NETWORK | OUT-OF-NETWORK |
| MEDICAL COST SHARE OPTIONS | | |
| Individual Deductible PCY (Family embedded deductible 2X Individual) | \$4,000/\$8,000 | Shared with In-Network |
| Coinsurance (Member's percentage of costs after deductible based on allowable charges) | 30% | 50% |
| Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded Out of Pocket maximum 2X Individual) | \$6,000/\$12,000 | Shared with In-Network |
| Office Visit Cost Share | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION | | |
| Preventive Office Visit (Unlimited, subject to standard medical guidelines) | Covered In Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network & Out of Pocket Out of Pocket Maximum |
| Immunizations (Unlimited, subject to standard medical guidelines) | Covered In Full | Dependent Child to Age 18 Covered In Full; Members Over 18 Out of Network Deductible, then 50% |
| Health Education (HE) (Unlimited) | Covered In Full | Not Covered |
| Nicotine Dependency Programs (ND) (Unlimited) | Covered In Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network & Out of Network Out of Pocket Maximum |

| MEDICAL PLAN | | |
|---|--|---|
| 2020 PPO 70% PLAN 4000 | | |
| | HERITAGE (PLUS) IN-NETWORK | OUT-OF-NETWORK |
| Diabetes Health Education (DE) (Unlimited) | Covered In Full | Shared with In-Network Deductible then 50% Coinsurance, applies to Shared In-Network & Out of Network Out of Pocket Maximum |
| PROFESSIONAL CARE | | |
| Professional Office Visit (Includes TeleMedicine) | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Inpatient Professional Services | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Contraceptive Management Services (Unlimited) | Covered In Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| VIRTUAL CARE - ON DEMAND | | |
| Virtual Care - General Medical/ Dermatology (Voice/Video) | \$5 Copay, applies to the \$6,000 Out of Pocket Maximum | Not Applicable |
| DIAGNOSTIC SERVICE OPTIONS | | |
| Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA | Covered In Full | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| Other Professional Diagnostic Imaging | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| Professional Diagnostic Major Imaging | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| Other Professional Diagnostic Laboratory/Pathology | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| Diagnostic Mammography | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| FACILITY CARE OPTIONS | | |
| Inpatient Facility | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Outpatient Surgery Facility | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |

| MEDICAL PLAN | | |
|--|---|---|
| 2020 PPO 70% PLAN 4000 | | |
| | HERITAGE (PLUS) IN-NETWORK | OUT-OF-NETWORK |
| Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| PREMERA DESIGNATED CENTERS OF EXCELLENCE | | |
| Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement)) | Covered In Full | Covered as any other service |
| Travel and Care Coordination (Limited to IRS Guidelines) | Covered In Full | Not Covered |
| EMERGENCY CARE AND TRANSPORTATION OPTION | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$200 Copay then \$4,000 Deductible and 30% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum | \$200 Copay then \$4,000 Deductible and 30% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum |
| Emergency Room Physician | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum |
| Urgent Care Center | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Ambulance Transportation (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum |
| Air Ambulance (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum |
| OTHER SERVICES | | |
| Allergy/Therapeutic Injections | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Mental Health Inpatient Facility Care (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Mental Health Outpatient Professional Care (Unlimited) | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Telemedicine - Mental Health | Subject to Mental Health Outpatient Professional Care In-Network Cost Share | Not Applicable |
| Chemical Dependency Inpatient Facility Care (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |

| MEDICAL PLAN | | |
|--|--|--|
| 2020 PPO 70% PLAN 4000 | | |
| | HERITAGE (PLUS) IN-NETWORK | OUT-OF-NETWORK |
| Chemical Dependency Outpatient Professional Care (Unlimited) | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Rehab Inpatient Facility (30 Days PCY) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 Visits PCY) | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer | \$40 Copay, applies to the Out Of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Medical Supplies, Equipment, Prosthetics (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Home Health Visits (130 visits PCY) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network Out of Pocket Maximum |
| TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)) | Covered as any other service | Covered as any other service |
| Transplants (Unlimited; \$7,500 travel and lodging limits) | Covered as any other service | Not Covered |
| ALTERNATIVE CARE | | |
| Manipulations (Spinal and other) (12 visits PCY) | \$40 Copay, applies to Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared In-Network & Out of Network Out of Pocket Maximum |
| Acupuncture (12 visits PCY) | \$40 Copay, applies to Out of Pocket Maximum | Shared with IN-Network Deductible, then 50% Coinsurance, applies to Shared In-Network & Out of Network Out of Pocket Maximum |
| ANNUAL PLAN MAXIMUM | | |
| Annual Plan Maximum | Unlimited | Unlimited |

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.

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2020 PPO 70% Plan 4000

Effective Date: 10/01/2020

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List at www.premera.com

| PHARMACY PLAN | |
|---|--|
| 2020 PPO 70% PLAN 4000 - RX | |
| PRESCRIPTION DRUGS | |
| Drug List | Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands |
| Retail Cost Shares | \$10/\$50/\$80 |
| Mail Cost Shares | \$30/\$150/\$240 |
| Day Supply | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days |
| Out of Network (Non-participating retail pharmacies) | Retail Pharmacy & Preventive Generic Drug List Same as In-Network; Out of Network Mail Order Not Covered |
| Out of Pocket Maximum | Applies to the medical out of pocket maximum |
| Annual Benefit Maximum | Unlimited |

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.

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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).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይይዛል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊያረው ይችላል። (በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤና ሽፋንዎን ለመጠበቅና በአስፈላጊ አርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች አርምዎ መውሰድ ይቻላል። ይህን መረጃ እንዲያገኙ እና ያለምንም ከፍተኛ በደንቅዎ አርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي 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 اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلمتك دون تكبد اية 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) ti 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 kouvéti asirans lan atravé 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 kouvéti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resewva 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):

Tsaw ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsaw 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 dhuav cov caij nyooq uas tee 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 lawm 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 mabaln nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabaln dagiti importante a petsa iti daytoy a pakdaar. Mabaln nga adda rumbeng nga aramidenyong 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 pagpasao 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. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈ່ງການນໍາມໍລິມະສິດ. ແຈ່ງການນໍາມໍລິມະສິດຂອງທ່ານກ່ຽວກັບຄ່າຄ່ອງຂະໜາດ ຫຼື ຄວາມຄົມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ຄວາມຄົມຄອງປະກັນໄພຂອງທ່ານ. ທ່ານອາດຈະຈ່າຍເງິນດ້ວຍການຕາມກຳນົດ ເວລາສະເພາະເພື່ອຮັກສາຄວາມຄົມຄອງປະກັນສະໄໝ ຫຼື ຄວາມຄຸ່ມຄຸນເພື່ອເລືອກຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໃດຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຄຸ່ມຄຸນເພື່ອເລືອກຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້ອບເສອນຄ່າ. ໃຫ້ໃບໂທ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការកំណត់របស់អ្នកកាមយ: Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជូនសមត្ថភាព ដល់កំណត់ថ្លៃជាក់លាក់សំខាន់ ដើម្បីនឹងរក្សាឱ្យមានការគោរពកំណត់របស់អ្នក ឬប្រាក់ចំនូលចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ នឹងជួយនាំក្នុងការស្រាវជ្រាវអំពីសេវាសុខភាពរបស់លុយឡើយ។ 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 ਅਨੁਮਾਤੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸ਼ਰਤ ਕਵਰੇਜ ਵਿੱਖੋਈ ਹੈ ਤੇ ਜਾਂ ਉਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਵਿਚੋਂ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁਝ ਖਾਸ ਕਰਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨੂੰ ਮੁੜ ਵਿੱਚ ਤੋਂ ਅਪਣੀ 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 ای تا یک سال بعد از 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 یا شماره 800-722-1471 (کارتیران TTY 800-842-5357) تماس با شماره 800-842-5357 تماس بفرمایید.

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 zwrócić 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 de 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 dumneavoastră 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 sau acoperirea asigurării 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 faia maua atu i ai. Fa'amolemole, ia e iloilu 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 mau fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe lea ia tatau e mau atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana o te malamalama i ai aunoa ma se togia 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. Maaaring 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):

ประกาศนี้คือข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับบริการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย 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 страховального 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).