

## Premera Blue Cross : QHDHP Plan

Coverage for: Individual or Family | Plan Type: High-Deductible

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, call 1-855-756-0798 (TTY: 1-800-842-5357) or visit us at [www.premera.com](http://www.premera.com). 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-855-756-0798 (TTY: 1-800-842-5357) to request a copy.

| Important Questions                                                 | Answers                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | Calendar year aggregate deductible. In-network: \$1,750 Individual / \$3,500 Family. Out-of-network: \$3,000 Individual / \$6,000 Family. | 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                                                                              |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. Does not apply to services listed below as "No charge"                                                                               | 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 preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.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-network: \$5,000 Individual / \$10,000 Family<br>Out-of-network: Unlimited                                                             | 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>Premium</u> , balance-billed 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://www.premera.com">www.premera.com</a> or call 1-855-756-0798 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</u> charge 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                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                       |                                                  | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                           |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>                                                                                                                                                                                                                                  | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                       | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                       | <u>Preventive care/screening/immunization</u>    | No charge                                           | Not covered                                               | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                             | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.                                                                |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://client.formularynavigator.com/Search.aspx?siteCode=1214076976">http://client.formularynavigator.com/Search.aspx?siteCode=1214076976</a> . | Generic drugs                                    | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization recommended for some drugs.      |
|                                                                                                                                                                                                                                                                                                       | Preferred brand drugs                            | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    |                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                       | Non-preferred brand drugs                        | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    |                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                       | <u>Specialty drugs</u>                           | 20% <u>coinsurance</u>                              | Not covered                                               | Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs.                                   |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Prior authorization recommended for some services. Penalty for out-of-network: no penalty.                                                                                |
|                                                                                                                                                                                                                                                                                                       | Physician/surgeon fees                           | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | None                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                        | <u>Emergency room care</u>                       | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                       | <u>Emergency medical transportation</u>          | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                      |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                   |                                                                                             | Limitations, Exceptions, & Other Important Information                                                   |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most)                                   |                                                                                                          |
|                                                                           | <u>Urgent care</u>                        | 20% <u>coinsurance</u>                              | Hospital-based:<br>20% <u>coinsurance</u><br>Freestanding center:<br>50% <u>coinsurance</u> | None                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                                                      | Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty. |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                                                      | None                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                                                      | None                                                                                                     |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                                                      | Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty. |
| If you are pregnant                                                       | Office visits                             | No charge                                           | 50% <u>coinsurance</u>                                                                      | None                                                                                                     |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                                                      | None                                                                                                     |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                                                      | None                                                                                                     |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                         |
|-----------------------------------------------------------------------|----------------------------------|-----------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                  | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Limited to 130 visits per calendar year                                                                                                                                                                        |
|                                                                       | <u>Rehabilitation services</u>   | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Limited to 15 outpatient visits per calendar year, limited to 30 inpatient days per calendar year.<br>Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty. |
|                                                                       | <u>Habilitation services</u>     | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Limited to 15 outpatient visits per calendar year, limited to 30 inpatient days per calendar year.<br>Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty. |
|                                                                       | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Limited to 60 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.                                                                 |
|                                                                       | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Prior authorization recommended to buy some medical equipment over \$500. Penalty for out-of-network: no penalty.                                                                                              |
|                                                                       | <u>Hospice services</u>          | 20% <u>coinsurance</u>                              | 50% <u>coinsurance</u>                                    | Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.                                                                           |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | Not covered                                         | Not covered                                               | None                                                                                                                                                                                                           |
|                                                                       | Children's glasses               | Not covered                                         | Not covered                                               | None                                                                                                                                                                                                           |
|                                                                       | Children's dental check-up       | Not covered                                         | Not covered                                               | None                                                                                                                                                                                                           |

## 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.)

- |                                    |                       |                            |
|------------------------------------|-----------------------|----------------------------|
| • Assisted fertilization treatment | • Dental care (Adult) | • Private-duty nursing     |
| • Bariatric surgery                | • Hearing aids        | • Routine eye care (Adult) |
| • Cosmetic surgery                 | • Long-term care      | • Weight loss programs     |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                   |             |                                                      |
|---------------------------------------------------|-------------|------------------------------------------------------|
| • Acupuncture                                     | • Foot care | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care or other spinal manipulations |             |                                                      |

**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: 1-800-562-6900 for the state insurance department, or the insurer at 1-855-756-0798. 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](http://www.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: your plan at 1-855-756-0798.

**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 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 1-855-756-0798.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-756-0798.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-756-0798.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-756-0798.

*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   | \$1,750 |
| ■ Specialist coinsurance          | 20%     |
| ■ Hospital (facility) coinsurance | 20%     |
| ■ Other coinsurance               | 20%     |

#### 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,750        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,010</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                   |         |
|-----------------------------------|---------|
| ■ The plan's overall deductible   | \$1,750 |
| ■ Specialist coinsurance          | 20%     |
| ■ Hospital (facility) coinsurance | 20%     |
| ■ Other coinsurance               | 20%     |

#### 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 | \$7,400 |
|--------------------|---------|

#### In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$1,750        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,970</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                   |         |
|-----------------------------------|---------|
| ■ The plan's overall deductible   | \$1,750 |
| ■ Specialist coinsurance          | 20%     |
| ■ Hospital (facility) coinsurance | 20%     |
| ■ Other coinsurance               | 20%     |

#### 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 | \$1,900 |
|--------------------|---------|

#### In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$1,750        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$40           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,790</b> |

## 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](mailto: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 Ave 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 1-855-756-0798 (TTY: 1-800-842-5357).

### አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናት ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ከፍተኛ በቋንቋ እርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 1-855-756-0798 (TTY: 1-800-842-5357) ይደውሉ።

### العربية (Arabic):

يحتوي هذا الإشعار معلومات هامة. قد يحتوي 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

1-855-756-0798 (TTY: 1-800-842-5357)

### 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

1-855-756-0798 (TTY: 1-800-842-5357)。

### 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 1-855-756-0798 (TTY: 1-800-842-5357) 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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 hnuv 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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 aplikasyonyo 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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**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。1-855-756-0798 (TTY: 1-800-842-5357)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. 1-855-756-0798 (TTY: 1-800-842-5357) 로 전화하십시오.

**ລາວ (Lao):**

**ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ.**

ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross.

ອາດຈະມີວັນທີສໍາຄັນໃນແຈ້ງການນີ້.

ທ່ານອາດຈະຈຳເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້.

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ

ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໃດໜຶ່ງໄດ້ຢູ່ເບື້ອງຕົ້ນ.  
ໃຫ້ໂທຫາ 1-855-756-0798 (TTY: 1-800-842-5357).

**ភាសាខ្មែរ (Khmer):**

**សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។**

សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ

ប្រកាសរបស់អ្នកកាតាមរយៈ Premera Blue Cross ។  
ប្រហែលជាមាន

កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។

អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព

ដល់កំណត់ថ្លៃជាក់លាក់នានា

ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក  
ប្រាកដជានូវចេញថ្លៃ។

អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ

និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយ  
ឡើយ។ សូមទូរស័ព្ទ 1-855-756-0798

(TTY: 1-800-842-5357)។

**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 ਨੋਟਿਸ ਨਵੇਂ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ

ਜਸ਼ਨਵਰੀ ਕਵਰੇਜ ਰਿਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ

ਦੇ ਇਕੱਠ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁਝ ਖਾਸ

ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ, ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੇ ਆਪਣੀ

ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ,  
ਕਾਲ 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798

کاربران TTY تماس با شماره (1-800-842-5357) 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 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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**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'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).

**ไทย (Thai):**

**ประกาศนี้มีข้อมูลสำคัญ**  
ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้  
คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย  
คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-855-756-0798 (TTY: 1-800-842-5357)

**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 800-1-855-756-0798 (TTY: 1-800-842-5357).

**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 1-855-756-0798 (TTY: 1-800-842-5357).