

# Premera Blue Cross: WCIF Your Choice \$3000 Deductible Plan

Coverage Period: Beginning on or after 01/01/2017

Coverage for: Individual or Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://www.premera.com/SBC> or by calling 1-877-500-9247.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: <b>\$3,000</b> Individual / <b>\$6,000</b> Family. Out-of-network: <b>\$6,000</b> Individual / <b>\$12,000</b> Family. Does not apply to <b>copays</b> , <b>prescription drugs</b> and services listed below as "No charge".	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: <b>\$6,350</b> Individual / <b>\$12,700</b> Family Out-of-network: <b>\$12,700</b> Individual / <b>\$25,400</b> Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<b>Premium</b> , balance-billed charges, penalties for failure to obtain <b>prior authorization</b> for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of <b>in-network providers</b> , see <a href="http://www.premera.com">www.premera.com</a> or call 1-877-500-9247.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <b>specialist</b> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

**Questions:** Call 1-877-500-9247 or TTY 1-800-842-5357 or visit us at [www.premera.com](http://www.premera.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-500-9247 or TTY 1-800-842-5357 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 copay	50% coinsurance	-----none-----
	Specialist visit	\$35 copay	50% coinsurance	-----none-----
	Other practitioner office visit	\$35 copay	50% coinsurance	Spinal manipulations limited to 20 visits per calendar year, Acupuncture limited to 12 visits per calendar year
	Preventive care / screening / immunization	No charge	50% coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://client.formularynavigator.com/Search.aspx?siteCode=3067637890">http://client.formularynavigator.com/Search.aspx?siteCode=3067637890</a> .	Generic drugs	\$5 copay (retail), \$15 copay (mail)	Not covered	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	\$35 copay (retail), \$79 copay (mail)	Not covered	
	Non-preferred brand drugs	\$70 copay (retail), \$210 copay (mail)	Not covered	
	Specialty drugs	Generic: \$5 copay Pref. Brand: \$35 copay Non-Pref. Brand: \$70 copay	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$75 copay + 20% coinsurance	50% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copay + 20% coinsurance	\$200 copay + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	\$50 copay + 20% coinsurance	\$50 copay + 20% coinsurance	-----none-----
	Urgent care	Hospital-based: \$200 copay + 20% coinsurance Freestanding center: \$35 copay	Hospital-based: \$200 copay + 20% coinsurance Freestanding center: 50% coinsurance	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Office Visit: \$35 copay Facility: 20% coinsurance	50% coinsurance	-----none-----
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	Substance use disorder outpatient services	Office Visit: \$35 copay Facility: 20% coinsurance	50% coinsurance	-----none-----
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	50% coinsurance	-----none-----
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	-----none-----
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: \$35 copay Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year and an additional 12 visits for Massage Therapy per calendar year. Limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	Habilitation services	Outpatient: \$35 copay Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 90 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required to buy some medical equipment over \$500. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	Hospice service	Outpatient: 0% coinsurance Inpatient: \$100 copay	Outpatient: 0% coinsurance Inpatient: \$100 copay + 0% coinsurance	Limited to 240 respite hours, limited to 14 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Eye exam	\$35 copay	\$35 copay (under age 19) 50% coinsurance (over age 19)	Limited to one exam per calendar year
	Glasses	Not covered	Not covered	-----none-----
	Dental check-up	Not covered	Not covered	-----none-----

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

#### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-500-9247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at 1-877-500-9247. You can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For questions about your rights, this notice, or assistance, you can contact your state insurance department at 1-800-562-6900. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-562-6900.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-500-9247.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-500-9247.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-500-9247.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-500-9247.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,430
- Patient pays \$4,110

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$10
Coinsurance	\$900
Limits or exclusions	\$200
<b>Total</b>	<b>\$4,110</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,020
- Patient pays \$3,380

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$200
Coinsurance	\$100
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,380</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-877-500-9247 or TTY 1-800-842-5357 or visit us at [www.premera.com](http://www.premera.com).

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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 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 1-877-500-9247 (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 ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 1-877-500-9247 (TTY: 1-800-842-5357) ይደውሉ።

### العربية (Arabic):

يحيوي هذا الإشعار معلومات هامة. قد يحيوي 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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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。1-877-500-9247 (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. 1-877-500-9247 (TTY: 1-800-842-5357) 로 전화하십시오.

ລາວ (Lao):

**ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ.**

ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross.

ອາດຈະມີວັນທີສໍາຄັນໃນແຈ້ງການນີ້.

ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກໍານົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້.

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ

ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໃດໜຶ່ງເຊັ່ນຄໍາ. ໃຫ້ໃບທາ 1-877-500-9247 (TTY: 1-800-842-5357).

ភាសາខ្មែរ (Khmer):

**សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។**

សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ

ប្រកាសរបស់អ្នកតាមរយៈ: Premera Blue Cross ។ ប្រហែលជាមាន

កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។

អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាព

ដល់កំណត់ថ្លៃជាក់ច្បាស់នានា

ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក

ឬប្រាក់ជំនួយចេញថ្លៃ។

អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ

និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអសលុយ

ឡើយ។ សូមទូរស័ព្ទ 1-877-500-9247

(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 ਨਵਚ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ

ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ

ਦੇ ਇੱਛੁਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ

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

ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ,

ਕਾਲ 1-877-500-9247 (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 بی‌مه‌تان

یا کمک در پرداخت هزینه های درمانی‌تان، 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 1-877-

500-9247 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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (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 1-877-500-9247 (TTY: 1-800-842-5357).

**ไทย (Thai):**

**ประกาศนี้มีข้อมูลสำคัญ**  
**ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการ**  
**สมัครหรือขอเบเขตประกันสุขภาพของคุณผ่าน**  
**Premera Blue Cross**  
**และอาจมีกำหนดการในประกาศนี้**  
**คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลา**  
**เวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของ**  
**คุณหรือการช่วยเหลือที่มีค่าใช้จ่าย**  
**คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้**  
**ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-877-**  
**500-9247**  
**(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 800-1-877-500-9247 (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 1-877-500-9247 (TTY: 1-800-842-5357).