PREMERA | BLUE CROSS

# Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2022

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** | **PLAN 5000** | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **MEDICAL COST SHARE OPTIONS** | | |
| **Individual Deductible PCY** (Family embedded deductible 2X Individual) | $5,000 | $10,000 |
| **Coinsurance (Member's percentage of costs after deductible based on allowable charges)** | 0% | 50% |
| **Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable** (Family embedded OOP max 2X Individual) | $5,000 | $10,000 |
| **Office Visit Cost Share** | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION** | | |
| **Preventive Office Visit** (Unlimited, subject to standard medical guidelines) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Immunizations** (Unlimited, subject to standard medical guidelines) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Health Education (HE)** (Unlimited) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Nicotine Dependency Programs (ND)** (Unlimited) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Diabetes Health Education (DE)** (Unlimited) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5000 | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **PROFESSIONAL CARE** | | |
| **Professional Office Visit** | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Telemedicine with Traditional Providers - General Medical** | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | $35 Copay, applies to the Out of Pocket Maximum | Not Covered |
| **Telemedicine - Mental Health (Virtual Care Only)** | Subject to Mental Health Outpatient Professional Care In-Network Cost Share | Not Covered |
| **Telemedicine - Chemical Dependency (Virtual Care Only)** | Subject to Chemical Dependency Outpatient Office Visit | Not Covered |
| **DIAGNOSTIC SERVICE OPTIONS** | | |
| **Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA** | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Other Professional Diagnostic Imaging** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Professional Diagnostic Major Imaging** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Other Professional Diagnostic Laboratory/Pathology** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Diagnostic Mammography** | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **FACILITY CARE OPTIONS** | | |
| **Inpatient Facility** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Inpatient Professional Services** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Outpatient Surgery Facility** | $75 Copay, then In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5000 | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled Nursing Facility** (90 days PCY; includes room and board, and facility billed professional and ancillary fees) | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **HOSPICE & HOME HEALTH CARE** | | |
| **Hospice Inpatient Facility** (14 Days; 6 month limit per lifetime) | $100 Copay, applies to the Out of Pocket Maximum, then Covered in Full | $100 Copay, applies to the Out of Pocket Maximum, then Covered in Full |
| **Hospice Care** (240 hours; 6 month limit per lifetime) | In Network Deductible, applies to the Out of Pocket Maximum, then Covered in Full | Out of Network Deductible, applies to the Out of Pocket Maximum, then Covered in Full |
| **Home Health Visits** (130 visits PCY) | In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **MATERNITY & REPRODUCTIVE CARE** | | |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Sterilization - Female** (Unlimited) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Sterilization - Male** (Unlimited) | Covered in Full | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **PREMERA DESIGNATED CENTERS OF EXCELLENCE (HERITAGE NETWORK ONLY – please call Customer Service to verify coverage)** | | |
| **Centers of Excellence Packaged Services** (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement) – Not available on Prime Network) | Covered in Full | Covered as any other service |
| **Centers of Excellence Travel and Care Coordination** (Limited to IRS Guidelines – Not available on Prime Network) | Covered in Full | Not Covered |
| **Centers of Excellence for Radiology** (Member Outreach Included) | Covered as any other service | Covered as any other service |
| **EMERGENCY CARE AND TRANSPORTATION OPTION** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $200 Copay, then In Network Deductible and 0% Coinsurance; applies to the Out of Pocket Maximum | $200 Copay, then In Network Deductible and 0% Coinsurance; applies to the Out of Pocket Maximum |
| **Emergency Room Physician** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum |
| **Urgent Care Center** | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Ambulance Transportation** (Unlimited) | $50 Copay, then In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | $50 Copay, then In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5000 | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (12 visits PCY) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Manipulations (Spinal and other)** (20 visits PCY) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **CHEMICAL DEPENDENCY & MENTAL HEALTH** | | |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Mental Health Inpatient Facility Care** (Unlimited) | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Mental Health Outpatient Professional Care** (Unlimited) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **REHABILITATION & NEURO** | | |
| **Rehab Inpatient Facility** (30 days PCY) | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain** (45 visits PCY; Massage Therapy - 12 additional visits PCY (separate from OP rehab limit)) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer** | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Medical Supplies, Equipment, Prosthetics** (Unlimited) | In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Foot Orthotics, Orthopedic Shoes and Accessories** ($300 PCY; Includes orthotics and orthopedic shoes) | In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5000 | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Transplants** (Unlimited; $7,500 travel and lodging limits) | Covered as any other service | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **SUPPLEMENTAL BENEFITS** | | |
| **Routine Vision Exam** (1 PCY) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Pediatric Vision Exam** (1 PCY under age 19) | $35 Copay, applies to the Out of Pocket Maximum | $35 Copay, applies to the Out of Pocket Maximum |
| **Routine Hearing Exam** (1 PCY) | $35 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum |
| **Hearing Hardware** ($3,000 every 3 calendar years) | Covered in Full (up to benefit maximum) | Covered in Full (up to benefit 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.*

# Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2022

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 in your Pharmacy Packet or at www.premera.com

| **PHARMACY PLAN** | **RX 5000** |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Drug List** | Preferred B3<br>Tier 1 = generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred brands |
| **Retail Cost Shares** | $5/$35/$70 |
| **Mail Cost Shares** | $15/$79/$210 |
| **Day Supply** | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days |
| **Individual Deductible PCY** | No Individual Deductible |
| **Family Deductible PCY** | No Family Deductible |
| **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.

*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.*

## Discrimination is Against the Law

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

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

## Getting Help in Other Languages

**This Notice has Important Information.** This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

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

**العربية (Arabic):**
**يحوي هذا الإشعار معلومات هامة.** قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (TTY: 800-842-5357)

**中文 (Chinese):**
**本通知有重要的訊息。**本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

**Oromoo (Cushite):**
**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

**Français (French):**
**Cet avis a d'importantes informations.** Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

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

**Deutsche (German):**
**Diese Benachrichtigung enthält wichtige Informationen.** Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

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

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

**Italiano (Italian):**
**Questo avviso contiene informazioni importanti.** Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

**日本語 (Japanese):**
**この通知には重要な情報が含まれています。**この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

**한국어 (Korean):**
**본 통지서에는 중요한 정보가 들어 있습니다.** 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

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

**ភាសាខ្មែរ (Khmer):**
**សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។** សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការព្រំប្រទល់របស់អ្នកគ្រប់គ្រង: Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ប្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានាវាំប់ងសុខភាពរបស់អ្នក ឬប្រាក់ជន្ទួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជន្ទួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស្លុយឡើយ។ 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 ਅਹਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

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

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

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

**Română (Romanian):**
**Prezenta notificare conține informații importante.** Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

**Русский (Russian):**
**Настоящее уведомление содержит важную информацию.** Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

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

**Español (Spanish):**
**Este Aviso contiene información importante.** Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

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

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

**Український (Ukrainian):**
**Це повідомлення містить важливу інформацію.** Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

**Tiếng Việt (Vietnamese):**
**Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).