

Highlights of your Health Care Coverage

WA TECHNOLOGY INDUSTRY ASSOCIATION EMPLOYEE BENEFIT TRUST

Effective Date: 12/01/2019

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		
2019 TECH 80 \$250		
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$250	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	\$3,000	Shared with In-Network
Office Visit Cost Share	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered In Full	Covered In Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Covered In Full
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
PROFESSIONAL CARE		
Professional Office Visit	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

MEDICAL PLAN		
2019 TECH 80 \$250		
	IN-NETWORK	OUT-OF-NETWORK
Inpatient Professional Services	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Covered In Full
Other Professional Diagnostic Imaging	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Professional Diagnostic Major Imaging	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Other Professional Diagnostic Laboratory/Pathology	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Diagnostic Mammography	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
FACILITY CARE OPTIONS		
Inpatient Facility	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Outpatient Surgery Facility	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$250 Deductible and 20% Coinsurance; all cost shares apply to the \$3,000 Out of Pocket Maximum	\$200 Copay then \$250 Deductible and 20% Coinsurance; all cost shares apply to the \$3,000 Out of Pocket Maximum
Emergency Room Physician	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum

MEDICAL PLAN		
2019 TECH 80 \$250		
	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Center	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum
Air Ambulance (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Rehab Inpatient Facility (30 Days PCY)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 Visits PCY)	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

MEDICAL PLAN		
2019 TECH 80 \$250		
	IN-NETWORK	OUT-OF-NETWORK
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$250 Deductible, then 20% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))	Covered as any other service	Covered as any other service
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$25 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

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

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

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Effective Date: 12/01/2019

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

PHARMACY PLAN	
2018 TECH 80 \$250 - ESSENTIALS RX \$10/\$30/\$60/30% - \$25/\$75/\$60/30%	
PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Retail Cost Shares	\$10/\$30/\$60/30%
Mail Cost Shares	\$25/\$75/\$60/30%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Specialty Pharmacy 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.

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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).

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 ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአስፈላጊ አርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች አርምዎን መውሰድ ይጠበቃል። ይህን መረጃ አንዲያገኙ እና ያለምንም ከፍተኛ በጽንዖት አርዳታ አንዲያገኙ መብት አለዎት። በስልክ ቁጥር፡ 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

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

中文 (Chinese):

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

Oromoo (Cushite):

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltidhaan 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 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 caj nyooq 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、Premiera 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 **Premiera Blue Cross**를 통한 귀하의 신청에 관한 정보를
포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수
있습니다. 귀하의 귀하의 건강 커버리지에서 계속 유지하거나 비용을 절감하기
위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다.
귀하에 이러한 정보와 도움을 제공하는 언어로 비용 부담없이 전화할 수 있는
권리가 있습니다. 800-722-1471 (TTY: 800-842-5353)로 연락하십시오.

ລາວ (Lao):

ເຈດີການນິມົດຂຶ້ນສຳຄັນ. ເຈດີການນິມົດຂຶ້ນສຳຄັນກ່ຽວກັບຄຳຮ້ອງຂໍຂະໜັກ ຫຼື ຄວາມຮຸນຄອງປະກັນໄພຂອງທຸກຜູ້ນາມ Premier Blue Cross. ອາດຈະມີ ບັນຫາເກີດຂຶ້ນໃນເຈດີການນິມົດ. ທ່ານອາດຈະທຳຜິດຕ້ອງການຕາມການກຳນົດ ໄດ້ລາຍເລກເລື່ອກຳນົດຂອງທ່ານຮຸນຄອງປະກັນໄພຂອງທ່ານກ່ຽວກັບສະພາບ. ຫຼື ຄວາມຊຸ່ວຍເຫຼືອເລື່ອກຳນົດ ໃຊ້ຄຳຂໍຂອບການໄດ້. ທ່ານມີສິດເກັບຮັບຂໍ້ນຳນີ້ ແລະ ຄວາມຊຸ່ວຍເຫຼືອຂໍ້ນຳພາສາ ຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-482-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានចំពោះប្រជាជនខ្មែរ។ សេចក្តីជូនដំណឹងនេះប្រហែលមានចំពោះប្រជាជនយ៉ាងហោចបីពាន់ប្រាំបួន ឬក្នុងរយៈពេលបីសប្តាហ៍។
Premra Blue Cross ។ ប្រវត្តិរបស់នាយកដ្ឋានការងារសង្គមនៃគណៈកម្មាធិការជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្លៃដាក់ច្បាប់នានា នៅស្តីនឹងការទូទាត់ការងារសង្គមនៃការងារសង្គម ឬប្រាក់ចំនូលយញ្ញវន្ត។ អ្នកសាងសង់ប្រព័ន្ធចំពោះប្រជាជន នឹងជួយឱ្យគណៈកម្មាធិការសង្គមដោយមិនរកសេវាឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿਚ ਆਪਾ ਨਾਜ਼ਕੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premiera Blue Cross ਵੱਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜ਼ੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਨਾਜ਼ਕੀਆਂ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਜਵਦ ਆਪਾ ਤਾਤੀਆਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਹਾਡੀ ਸਮਰਥਨ ਕਵਰੇਜ ਵਿੱਚੋਂ ਹਟੇ ਜਾ ਓਸ ਤੀ ਲਾਗਜ ਜਵਿੱਚ ਮਦਦ ਹੋ ਵਿਛੁੱਟ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਆਪ ਕਾਰਮ ਚੁੱਣਣ ਤੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ .ਤੁਹਾਨੂੰ ਮੁੜਤ ਵਿਚ ਤੇ ਆਪਣੀ ਡਾਸ਼ਾ ਵਿਚ ਨਾਜ਼ਕੀਆਂ ਅਤੇ ਮਦਦ ਪ੍ਰਦਾਨ ਕਰਨ ਤੇ ਅਧਿਕਾਰ ਹੈ .ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

(Farsi) فارسی:

[illegible]

Polskie (Polish):

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

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premier 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):

Prezența notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Premiera 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 provizorie 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 Premier 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 ia i lenei fa'asilasila fa'i fa'amatalaga e sili ona taua e tatau ona e malamalama ia. O lenei fa'asilasila o se fesoaosani e fa'amatala atili i ia i le tulaga o le polokalamu, Premiera Blue Cross, ua e taua fia maua atu ia. Fa'amolemole, ia e iloilu fa'alelei a so fa'apitoa o'o ia i lenei fa'asilasila taua. Masalo o le'a ia ni feau e tatau ona e faia ao i le aulia le aso ua ta'ua i lenei fa'asilasila ina ia e ia iai pea ma maua fesoaosani mai ia i le polokalamu e le Malo o'o e ia i ia. O'o ia iai iate o le aia taua e maua atu i lenei fa'asilasila ma lenei fa'atalaga i legagana e te malamalama i ai aunoa ma se togia tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premier 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 Pautawa na ito ay naglalaman ng mahalagang impormasyon. Ang pautawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premier Blue Cross. Maaaring may mga mahalagang petsa dito sa pautawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga tinakdang 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):

ประกาศณีสื่อข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่เกี่ยวข้องกับการทางานของกระทรวงมหาดไทย
 สหภาพขององค์กร **Premera Blue Cross** และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้อง
 ดำเนินการบางอย่างในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่
 มีค่าใช้จ่าย คุณมีสิทธิ์ที่จะได้รับข้อมูลและข้อช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร
 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страховального покриття через Premiera Blue Cross. Зверніть увагу на ключові діти, 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. Давоніть 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 thể thông tin quan trọng về đơn xin tham gia hoặc học bổng bảo hiểm của quý vị qua chương trình Premiera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn 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).