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 1-800-508-4722 (TTY: 1-800-842-5357) or visit us at 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 [https://www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-508-4722 (TTY: 1-800-842-5357) to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$750 Individual / $2,250 Family. Copays and pharmacy are not subject to deductible.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Does not apply to copayments, prescription drugs and services listed below as &quot;No charge&quot;</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. 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>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for preventive dental services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-network: $4,250 Individual / $9,250 Family. Out-of-network: Unlimited. Pharmacy: $1,000 Individual / $1,700 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.premera.com">www.premera.com</a> or call 1-800-508-4722 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what you plan pays (balance billing).</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Specialist visit</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Preventive care/screening/immunization</td>
<td>Network Provider (You will pay the least): No charge  Out-of-Network Provider (You will pay the most): No charge</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Prior authorization is recommended for some outpatient imaging tests.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs</td>
<td>Network Provider (You will pay the least): $10 copayment (retail), $20 copayment (mail)  Out-of-Network Provider (You will pay the most): $10 copayment (retail), not covered (mail)</td>
<td>Covers up to a 30 day supply (retail), covers up to 90 day supply (mail). Certain preventive drugs are covered in full. Prior authorization is required for some drugs. Specialty drugs are Only covered at specific contracted specialty pharmacies or by mail from Accredo.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred brand drugs</td>
<td>Network Provider (You will pay the least): $30 copayment (retail), $60 copayment (mail)  Out-of-Network Provider (You will pay the most): $30 copayment (retail), not covered (mail)</td>
<td>Covers up to a 30 day supply (retail), covers up to 90 day supply (mail). Certain preventive drugs are covered in full. Prior authorization is required for some drugs. Specialty drugs are Only covered at specific contracted specialty pharmacies or by mail from Accredo.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred specialty drugs</td>
<td>Network Provider (You will pay the least): $100 copayment  Out-of-Network Provider (You will pay the most): Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Non-preferred generic drugs</td>
<td>Network Provider (You will pay the least): 30% coinsurance  Out-of-Network Provider (You will pay the most): 30% coinsurance</td>
<td>Except Non-pref. specialty: Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Non-preferred brand drugs</td>
<td>Network Provider (You will pay the least): 30% coinsurance  Out-of-Network Provider (You will pay the most): 30% coinsurance</td>
<td>Except Non-pref. specialty: Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Non-preferred specialty drugs</td>
<td>Network Provider (You will pay the least): 30% coinsurance  Out-of-Network Provider (You will pay the most): 30% coinsurance</td>
<td>Except Non-pref. specialty: Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Prior authorization is recommended for some services.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Physician/surgeon fees</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency medical transportation</td>
<td>Network Provider (You will pay the least): 20% coinsurance  Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Urgent care</td>
<td>Network Provider (You will pay the least): Hospital-based: 20% coinsurance  Out-of-Network Provider (You will pay the most): Hospital-based: 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>
If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Children's eye exam</th>
<th>Children's glasses</th>
<th>Children's dental check-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 copayment</td>
<td>Lenses: $25 Frames: up to $150, plus 20% discount for out-of-pocket costs</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single lenses: up to $50 Lined bifocal lenses: up to $75 Lined trifocal lenses: up to $100 Progressive lenses: up to $75 Frames up to $70</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Vision coverage provided by **VSP**. Limited to one eye exam per plan year. Note: vision coverage can be waived.

More information about **vision coverage** is available at [www.vsp.com](http://www.vsp.com) or call VSP at (800) - 877-7195

<table>
<thead>
<tr>
<th>Exclusive Services</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assisted fertilization treatment</td>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Long-term care</td>
<td>• Chiropractic care or other spinal manipulations</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td></td>
<td>• Foot care</td>
</tr>
<tr>
<td></td>
<td>• Hearing aids</td>
</tr>
</tbody>
</table>

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

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

**Excluded Services & Other Covered Services:**

- Deductible is waived for preventive dental check-up.
- Routine exams limited to 2 per plan year.
- Cleanings limited to 2 per plan year.
- Note: dental coverage can be waived.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 1-800-508-4722 or TTY 1-800-842-5357, or the state insurance department at 907-269-7900 or 1-800-467-8725, or Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
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 1-800-508-4722.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-508-4722.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne’ 1-800-508-4722.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan's overall deductible** $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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,400</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $60
- **The total Peg would pay is** $3,240

- **The plan’s overall deductible** $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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,130</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $20
- **The total Joe would pay is** $2,900

- **The plan’s overall deductible** $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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$230</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $0
- **The total Mia would pay is** $980

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Premera Blue Cross Blue Shield of Alaska is an Independent Licensee of the Blue Cross Blue Shield Association.
Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska 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, HHB Building Washington, D.C. 20201, 1-800-368-1019,

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 Blue Shield of Alaska. 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 1-800-508-4722 (TTY: 1-800-842-5357).

 álaba (Amharic):

ክፍያ Premera Blue Cross Blue Shield of Alaska ለመረጃ እርዳታ ከኔ ያደርጉት ከግለፋ ገለፋ ከጋጋ ከተደምጡ ከባንክ ለመረጃ Premera Blue Cross Blue Shield of Alaska ከጋጋ ለመረጃ ከጋጋ ከተደምጡ ከባንክ ያልተደምጡ።

عربية (Arabic):

يشمل هذا الإشعار معلومات هامة. قد يحتوي هذا الإشعار معلومات مهمة بخصوص طالب أو التغطية التي تريد الحصول عليها من خلال تقديم تظلم. قد تكون هناك تأخيرات مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراءات في تأكيد هذه التأخيرات على تغطية طالب أو المساعدة في فعالية التظلم. يمكن أن يكون الحصول على هذه المعلومات والمساعدة باتجاهات دون تكبد أي تكلفة. اتصل بـ 1-800-508-4722 (TTY: 1-800-842-5357)

中文 (Chinese):

本通知有重要的訊息。本通知可能有關請您透過Premera Blue Cross Blue Shield of Alaska 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1-800-508-4722 (TTY: 1-800-842-5357)。

Oromoo (Cushite):

Beeksinsi kun odeeffannoo barbaachisaa qaba.

Beekstii kun sagantaa yooaan karaa Premera Blue Cross Blue Shield of Alaska tiin tajajila keessan ilaachise odeeffannoo barbaachisaa qabaachuu danda’a.

Premera Blue Cross Blue Shield of Alaska

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan Iadann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvètè asirans lan atravè Premera Blue Cross Blue Shield of Alaska. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sètèn dat limit pou ka kenbe kouvètè 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 1-800-508-4722 (TTY: 1-800-842-5357).

Italiano (Italian):

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggemp iiti aplikasyonyo wennon coverage babanen iti Premera Blue Cross Blue Shield of Alaska. 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 alday tapno mapagtalinaedyo ty coverage ti salun-ayto wennon 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 1-800-508-4722 (TTY: 1-800-842-5357).

한국어 (Korean):
통지서에는 중요한 정보가 담겨 있습니다. 이 통지서에는 귀하의 신청에 관하여 그리고 Premera Blue Cross Blue Shield of Alaska를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 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 이와 같은 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-508-4722 (TTY: 1-800-842-5357)로 전화하십시오.
Premera Blue Cross Blue Shield of Alaska

In this notice, you may have key dates which may be contained in this notification. It is possible that you will need to take certain measures within specific timeframes to maintain your insurance coverage.

For customers with vision or hearing impairments, you may call TTY: 1-800-842-5357.

For more information or help in your language, call 1-800-508-4722 (TTY: 1-800-842-5357).
Fa’asamoan (Samoa):
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 Blue Shield of Alaska, ua e tau fia maua atu i ai. Fa’amolemale, ia e iiloilo 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’amatala e legaganaga e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefo 1-800-508-4722 (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 Blue Shield of Alaska. 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 1-800-508-4722 (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 Blue Shield of Alaska. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon unang mahanap ang iyong pagsakop sa kalusugan o tulung na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulung sa iyong wika ng walang gastos. Tumawag sa 1-800-508-4722 (TTY: 1-800-842-5357).

ไทย (Thai): ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอเข้าประกันสุขภาพของคุณผ่าน Premera Blue Cross Blue Shield of Alaska และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิ์จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-800-508-4722 (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 Blue Shield of Alaska. Зверніться увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні повідомлення. Існує імовірність того, що Вам може потрібно здійснити певні кроки у конкретні повідомлення. Існує імовірність того, що Вам може потрібно здійснити певні кроки у конкретні повідомлення. Існує імовірність того, що Вам може потрібно здійснити певні кроки у конкретні повідомлення.

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thể cung cấp thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross Blue Shield of Alaska. 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 theo pháp luật của quý vị. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-508-4722 (TTY: 1-800-842-5357).