2019 Premera Medicare Advantage Plan Information

Thank you for your interest in applying for the Premera Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Premera within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

Star Rating
Download Application: Current Member / New Member
Summary of Benefits: Advantage & Total (SSS) / Advantage, Classic & Classic Plus (KPSTW) / Alpine & Charter / Core / Peak & Sound
Provider Search
Pharmacy Search
Formulary

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC PO Box 26540 Eugene, Oregon 97402	Fax: 1.541.284.2994 or 888.632.5470 Secure File Upload: Click here Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-washington.com

Y0062_MULTIPLAN_CDA INSURANCE Washington 2019

2019 summary of benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HMO) H9302-011
PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HMO) H9302-007

This is a summary of drug and health services covered by Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO) January 1, 2019 to December 31, 2019.

Premera Blue Cross Medicare Advantage Peak + Rx (HMO) and Premera Blue Cross Medicare Advantage Sound + Rx (HMO) are Medicare Advantage HMO plans with a Medicare contract. Enrollment in either plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling customer service or accessing it on our website: **premera.com/ma**.

To join **Premera Blue Cross Medicare Advantage Peak + Rx (HMO) or Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Washington: King, Pierce, Snohomish, Thurston, and Whatcom.

If you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

This document is available in other formats, including audio CDs. For more information, please call us at 888-850-8526 (TTY/TDD: 711) or visit us at **premera.com/ma**. Representatives are available Monday – Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., from October 1 – March 31).

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PREMIUM AND BENEFITS	Available to residents of these counties: King, Pierce, Snohomish, Thurston, Whatcom	
	PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HMO)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HMO)
Monthly Plan Premium	You pay $0 per month. You must continue to pay your Medicare Part B premium.	You pay $40 per month. You must continue to pay your Medicare Part B premium.
Deductible	No deductible.	No deductible.
Part D Deductible	$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $6,700 annually. Includes copays and other costs for medical services for the year.	You pay no more than $6,500 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage	You pay a $595 copay per day for days 1–3. You pay a $0 copay per day for days 4 and beyond. **Prior Authorization rules may apply.**	You pay a $595 copay per day for days 1–3. You pay a $0 copay per day for days 4 and beyond. **Prior Authorization rules may apply.**
Outpatient Hospital Coverage	You pay a $395 copay for each Medicare-covered ambulatory surgical center visit. You pay 20% of the total cost for each Medicare-covered outpatient hospital surgery. **Prior Authorization rules may apply.**	You pay a $395 copay for each Medicare-covered ambulatory surgical center visit. You pay a $495 copay for each Medicare-covered outpatient hospital surgery. **Prior Authorization rules may apply.**
Doctor Visits • Primary Care Providers • Specialists	You pay a $15 copay per visit. You pay a $50 per visit (referral is required).	You pay a $10 copay per visit. You pay a $50 per visit (referral is required).
Preventive Care (such as flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.

Emergency Care	You pay an $80 copay per visit. Waived, if admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay an $80 copay per visit. Waived, if admitted to the hospital within 24 hours. Includes worldwide coverage.
Urgently Needed Services	You pay a $50 copay per visit. You pay an $80 copay per visit for worldwide coverage.	You pay a $50 copay per visit. You pay an $80 copay per visit for worldwide coverage.
Diagnostic Services/Labs/ Imaging		
• Diagnostic tests and procedures	You pay 20% of the total cost.	You pay 20% of the total cost.
• Lab services	You pay a $15 copay per day.	You pay a $15 copay per day.
• Outpatient x-rays	You pay a $20 copay per day.	You pay a $20 copay per day.
• Therapeutic radiology services (such as radiation treatment for cancer)	You pay 20% of the total cost. If your doctor provides additional services, a separate cost-sharing amount may apply. **Prior Authorization rules may apply.**	You pay 20% of the total cost. If your doctor provides additional services, a separate cost-sharing amount may apply. **Prior Authorization rules may apply.**
Hearing Services		
• Medicare-covered hearing exam	You pay $0 - $50 copay per visit. $0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.	You pay $0 - $50 copay per visit. $0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.
• Routine hearing exam	You pay $0 - $50 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.	You pay $0 - $50 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.
• Hearing aid	There is a $1,000 annual allowance per ear for hearing aids through Hearing Care Solutions provider.	There is a $1,000 annual allowance per ear for hearing aids through Hearing Care Solutions provider.

Dental Services		
• Medicare-covered dental services	You pay a $50 copay per visit.	You pay a $50 copay per visit.
• Routine dental services	Not covered.	You pay a $20 copay for routine preventive dental services. No out-of-network coverage.
Vision Services		
• Medicare-covered vision exam	You pay a $50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
	You pay a $0 copay for a Medicare-covered glaucoma screening.	You pay a $0 copay for a Medicare-covered glaucoma screening.
• Medicare-covered vision hardware	You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.
• Routine vision exam	You pay a $20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a $20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.
• Routine vision hardware	You pay a $30 copay. There is a $120 benefit limit for routine eyeglasses (lenses and frames) or contact lenses every 24 months.	You pay a $30 copay. There is a $120 benefit limit for routine eyeglasses (lenses and frames) or contact lenses every 24 months.
Mental Health Services		
• Inpatient mental health care	You pay a $595 copay per day for days 1–2. You pay a $0 copay per day for days 3–90.	You pay a $595 copay per day for days 1–2. You pay a $0 copay per day for days 3–90.
• Outpatient mental health care	You pay a $40 copay for each Medicare-covered individual or group therapy visit. **Prior Authorization rules may apply.**	You pay a $40 copay for each Medicare-covered individual or group therapy visit. **Prior Authorization rules may apply.**

Skilled Nursing Facility	You pay a $0 copay per day for days 1–20. You pay a $167.50 copay per day for days 21–60. You pay a $0 copay per day for days 61–100. **Prior Authorization rules may apply.**	You pay a $0 copay per day for days 1–20. You pay a $167.50 copay per day for days 21–59. You pay a $0 copay per day for days 60–100. **Prior Authorization rules may apply.**
Physical Therapy	You pay a $40 copay per visit.	You pay a $40 copay per visit.
Ambulance	You pay a $280 copay each way for Medicare-covered Ambulance transport. **Prior Authorization rules may apply.**	You pay a $255 copay each way for Medicare-covered Ambulance transport. **Prior Authorization rules may apply.**
Transportation	Not covered.	Not covered.
Medicare Part B Drugs	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs. **Prior Authorization rules may apply.**	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs. **Prior Authorization rules may apply.**

PRESCRIPTION DRUG BENEFITS (PART D)			
Deductible Phase	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $160 for your Tier 3, 4, and 5 drugs.		
Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,820.			
	Standard Retail Cost-sharing (in-network) (up to 31-day supply)	Mail Order Cost-sharing (93-day supply)	Long-Term Care Cost-sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $3 copay.	You pay a $7.50 copay.	You pay a $3 copay.
Tier 2: Generic	You pay a $14 copay.	You pay a $35 copay.	You pay a $14 copay.
Tier 3: Preferred Brand	You pay a $47 copay.	You pay a $117.50 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 50% of the total cost.	You pay 50% of the total cost.	You pay 50% of the total cost.
Tier 5: Specialty	You pay 30% of the total cost.	Not offered.	You pay 30% of the total cost.
Cost-sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.			
Coverage Gap			
After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 37% of the costs of generic drugs until your out-of-pocket costs reach $5,100, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.			

PRESCRIPTION DRUG BENEFITS (PART D)			
Deductible Phase	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $160 for your Tier 3, 4, and 5 drugs.		
Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,820.			
	Standard Retail Cost-sharing (in-network) (up to 31-day supply)	Mail Order Cost-sharing (93-day supply)	Long-Term Care Cost-sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $2 copay.	You pay a $5 copay.	You pay a $2 copay.
Tier 2: Generic	You pay a $12 copay.	You pay a $30 copay.	You pay a $12 copay.
Tier 3: Preferred Brand	You pay a $47 copay.	You pay a $117.50 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 50% of the total cost.	You pay 50% of the cost.	You pay 50% of the total cost.
Tier 5: Specialty	You pay 30% of the total cost.	Not offered.	You pay 30% of the total cost.
Cost-sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.			
Coverage Gap			
After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 37% of the costs of generic drugs until your out-of-pocket costs reach $5,100, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.			

Catastrophic Coverage	Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the cost of the drug, or • $3.40 copay for a generic drug, or a drug that is treated like a generic, and $8.50 copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the cost of the drug, or • $3.40 copay for a generic drug, or a drug that is treated like a generic, and $8.50 copay for all other drugs.

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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
Premera Blue Cross Medicare Advantage Plans - Complaints & Appeals
PO Box 262527, Plano, TX 75026
Phone: 888-850-8526, fax: 800-889-1076, TTY: 711
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 888-850-8526 (TTY: 711).

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 እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 888-850-8526 (TTY: 711) 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 بـ(TTY: 711) 888-850-8526

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 888-850-8526 (TTY: 711)。

Premera Blue Cross is an HMO plan with a with a Medicare contract. Enrollment in Premera Blue Cross depends on renewal.

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 888-850-8526 (TTY: 711) tii bilbilaa.

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 888-850-8526 (TTY: 711).

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。888-850-8526 (TTY: 711)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. 888-850-8526 (TTY: 711) 로 전화하십시오.

ភាសាខ្មែរ (Khmer)**:**
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។
សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ
ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន
កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព
ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា
ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។
អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ
និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 888-850-8526 (TTY: 711)។

ລາວ (Lao)**:**
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 888-850-8526 (TTY: 711).

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 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 ਤਾਰੀਖ਼ 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 888-850-8526 (TTY: 711).

Р**усский** (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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).