# PACCAR Inc: U.S. Salaried Option B

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

<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>$700 Individual / $2,100 Family. Doesn’t apply to preventive care or prescription drugs. Copays and pharmacy are not subject to deductible.</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For preferred providers $4,500 Individual / $9,000 Family; For non-preferred providers $8,300 Individual / $15,900 Family.</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, 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>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of in-network providers, see <a href="http://www.premera.com">www.premera.com</a> or call 1-888-722-2275.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don't need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

Questions: Call 1-888-722-2275 or TDD/TTY 1-800-842-5357 or visit us at www.premera.com.
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.premera.com or call 1-888-722-2275 or TDD/TTY 1-800-842-5357 to request a copy.
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your cost if you use a</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>Out-Of-Network Provider</td>
</tr>
</tbody>
</table>

#### If you visit a health care provider’s office or clinic

- **Primary care visit to treat an injury or illness**
  - 20% coinsurance
  - 40% coinsurance
- **Specialist visit**
  - 20% coinsurance
  - 40% coinsurance
- **Other practitioner office visit**
  - 20% coinsurance for chiropractor and acupuncture; $10 copay/visit for Teladoc
  - 40% coinsurance for chiropractor and acupuncture

  Chiropractor limited to 30 visits per calendar year. Acupuncture subject to medical necessity.
- **Preventive care / screening / immunization**
  - No charge
  - No charge

#### If you have a test

- **Diagnostic test (x-ray, blood work)**
  - 20% coinsurance
  - 40% coinsurance
- **Imaging (CT/PET scans, MRIs)**
  - 20% coinsurance
  - 40% coinsurance

  Prior authorization is required for some outpatient imaging test. No penalty.

#### If you need drugs to treat your illness or condition

- **Generic drugs**
  - $10 copay (retail), $20 copay (mail)
  - $10 copay (retail), $20 copay (mail)
- **Preferred brand drugs**
  - 30% coinsurance, $30 min - $75 max (retail)
    - 30% coinsurance, $30 min - $75 max (retail)
  - 75 min - $180 max (mail)
    - 75 min - $180 max (mail)

  Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization is required for certain drugs. No charge for specific preventive drugs. Certain drugs are not covered. Refer to the **exclusion list**.

More information about **prescription drug coverage** is available at [Client Formulary](http://www.premera.com).

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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-Of-Network Provider</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>50% coinsurance, $50 min - $125 max (retail) $125 min - $300 max (mail)</td>
<td>50% coinsurance, $50 min - $125 max (retail) $125 min - $300 max (mail)</td>
<td>Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization is required for certain drugs. Certain drugs are not covered. Refer to the exclusion list.</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Generic: $10 copay (retail); Preferred: 30% coinsurance, $30 min - $75 max (retail); Non-preferred: 50% coinsurance, $50 min - $125 max (retail)</td>
<td>Generic: $10 copay (retail); Preferred: 30% coinsurance, $30 min - $75 max (retail); Non-preferred: 50% coinsurance, $50 min - $125 max (retail)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>Anesthesia: 20% coinsurance; All other: 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$150 copay/visit + 20% coinsurance</td>
<td>$150 copay/visit + 20% coinsurance</td>
<td>Emergency room copay waived if admitted to hospital</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Freestanding Center: 20% coinsurance; Hospital-Based: $150 copay/visit + 20% coinsurance</td>
<td>Freestanding Center: 40% coinsurance; Hospital-Based: $150 copay/visit + 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Prior authorization is required for all planned inpatient stays. No penalty.</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>Anesthesia: 20% coinsurance; All other: 40% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>Out-Of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% coinsurance; $10 copay/session for Teladoc</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td></td>
<td>Prior authorization is required for all planned</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td>inpatient stays. No penalty.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance; $10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>inpatient services</td>
<td>copay/session for Teladoc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for all planned</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>inpatient stays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No penalty.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for all planned</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>inpatient stays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No penalty.</td>
<td></td>
<td></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>Limited to 150 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 60 visits per calendar year. Prior</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for all planned</td>
<td></td>
<td>authorization is required for all planned</td>
</tr>
<tr>
<td></td>
<td>inpatient stays.</td>
<td></td>
<td>inpatient stays. No penalty.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>Limited to 60 visits per calendar year. Prior</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>authorization is required for all planned</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for all planned</td>
<td></td>
<td>inpatient stays. No penalty.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Limited to 60 days per calendar year. Prior</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>authorization is required for all planned</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for buy some</td>
<td></td>
<td>inpatient stays. No penalty.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Prior authorization is required for buy some</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>medical equipment over $500. No penalty.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>Limited to 10 inpatient days.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>Not covered</td>
<td>Elective plan option</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Excluded Services</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>Acupuncture if prescribed for rehabilitation</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Chiropractic care or other spinal manipulations</td>
</tr>
<tr>
<td>Dental care (Adult) – elective plan option</td>
<td>Foot Care</td>
</tr>
<tr>
<td>Long-term care</td>
<td>Hearing aids</td>
</tr>
<tr>
<td>Private-duty nursing</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Routine eye care (Adult) – elective plan option</td>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Weight loss programs</td>
<td></td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-888-722-2275. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. You can contact your plan at 1-888-722-2275. You can contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For questions about your rights, this notice, or assistance, you can contact your state insurance department at 1-800-562-6900. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-562-6900.

Does this Coverage Provide Minimum Essential Coverage?

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

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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-722-1471.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-722-1471.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

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

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(normal delivery)</td>
<td>(routine maintenance of a well-controlled condition)</td>
</tr>
</tbody>
</table>

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,320
- **Patient pays:** $2,220

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

| Deductibles                   | $700         |
| Copays                        | $20          |
| Coinsurance                   | $1,300       |
| Limits or exclusions          | $200         |
| **Total**                     | **$2,220**   |

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,820
- **Patient pays:** $1,580

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

| Deductibles                   | $700         |
| Copays                        | $400         |
| Coinsurance                   | $400         |
| Limits or exclusions          | $80          |
| **Total**                     | **$1,580**   |

This is not a cost estimator.

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

See the next page for important information about these examples.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

☑️ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
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 any 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, 1-800-336-1010, 800-537-7687 (TDD)

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).

Chinese (Traditional):

本通知有重要訊息，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。您可能會在截止日期之前採取行動，以保持您的健康保險或費用補貼。您有權利免費以此通知的母語得到本通知及幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Chinese (Simplified):

本通知有重要訊息，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。您可能會在截止日期之前採取行動，以保持您的健康保險或費用補貼。您有權利免費以此通知的母語得到本通知及幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Italian (Italian):

Giudizio è contro la Legge

Premera Blue Cross risponde alle leggi federali sulle discriminazioni e non discriminà sulla base del colore, della razza, della nazionalità, dell'età, del disabilità, o del sesso. Premera Blue Cross non esclude persone o le tratta diversamente a motivo di razza, colore, nazionalità, età, disabilità o sesso.

Premera:
- Fornisce aiuti gratuiti e servizi a persone con disabilità per comunicare efficacemente con noi, ad esempio:
  - Interpessi di lingua iscritta
  - Informazioni scritte in altre lingue (formati grandi, audizioni, formati elettronici accessibili, altri formati)
- Fornisce servizi di lingua gratuita a persone la lingua madre non è l'inglese, ad esempio:
  - Interpreti qualificati
  - Informazioni scritte in altre lingue

Se ne serve, contattare il Responsabile dei diritti civili.

Se pensi che Premera Blue Cross non abbia fornito questi servizi o si sia discriminato in qualsiasi modo sulla base del colore, del colore, della nazionalità, dell'età, del disabilità, o del sesso, è possibile presentare una protesta:
Responsabile dei diritti civili - Comunicazioni e proteste
P.O. Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email ComunicazioniDepartmentInquiries@Premera.com

È possibile presentare una protesta in persona o per posta, fax o email. Se si necessita di aiuto per presentare una protesta, il Responsabile dei diritti civili è disponibile per aiutare.

È possibile anche presentare una protesta di diritti civili con il U.S. Department of Health and Human Services, Office for Civil Rights, tramite la pagina Web per le proteste, disponibile presso https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o per posta o telefono all'U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-336-1010, 800-537-7687 (TDD)

Getting Help in Other Languages

Questo avviso contiene informazioni importanti. Questo avviso potrebbe contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potresti essere interessato a 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).
日本の（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の申告または情報提供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情報がまたは重要である旨をご確認ください。健康保険や利用することができます。特に、終了の期限までに行動を取らないリスクがある場合があります。ご希望の言語による情報をサポートで提供されます。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 Cross를 통해 헬스케어에 관한 정보를 포함하고 있을 것입니다. 본 통지서에는 핵심적인 정보 및 구성을 포함할 수 있습니다. 귀하의 신청에 관하여 해당을 지휘하려는 의무가 없음을 알립니다. 귀하의 역할과 보험료의 인도에 대한 비용을 알 수 있는 권리가 있습니다。800-722-1471（TTY: 800-842-5357）로 정확하게 이해하세요。

ポルトガル語（Portuguese）
Esse 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 ajudar custos. Você tem o direito de obter esta informação e ajudar em idioma e sem custos. Ligue para para 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 и определенные предельные сроки для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по номеру телефона 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 de 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）.

Polskie（Polish）
To ogłoszenie zawiera ważne informacje. To ogłoszenie może zawierać ważne informacje odnoszące się do Polski wiadomości lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zweryfikować w naszych lokalnych되지 않거나 후속 처리가 안된 사항을 포함한 정보를 포함할 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서에는 혼란을 유발할 수 있는 정보가 포함될 수 있습니다. 본 통지서には重要な情報が含まれています。この通知には、Premera Blue Crossの申告または情報提供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情報がまたは重要である旨をご確認ください。