



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 1-844-722-4661 (TTY: 711) or visit us at [www.premera.com](http://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/> or call 1-844-722-4661 (TTY: 711) to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | In-network: \$4,000 Individual / \$8,000 Family.                                                                                                                         | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                              |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Does not apply to <u>Preventive care</u> , <u>copayments</u> , <u>prescription drugs</u> and services listed below as "No charge"                                   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                           |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                      | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-network: \$8,000 Individual / \$16,000 Family                                                                                                                         | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior authorization</u> for services, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a network provider?</b>            | Yes. Sherwood HMO network. See <a href="http://www.premera.com">www.premera.com</a> or call 1-844-722-4661 for a list of <u>network providers</u> .                      | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | Yes.                                                                                                                                                                     | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .                                                                                                                                                                                                                                                                                                                                                                                    |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                                                                                                                                                             | Services You May Need                                                                            | What You Will Pay                                                                                                                                                                                                                                                                                                                |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                  |                                                                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                     | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                    |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>                                                                                                                             | Primary care visit to treat an injury or illness                                                 | \$10 <u>copay</u> /visit                                                                                                                                                                                                                                                                                                         | Not covered                                        | None                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                  | <u>Specialist</u> visit                                                                          | \$65 <u>copay</u> /visit                                                                                                                                                                                                                                                                                                         | Not covered                                        | None                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                  | <u>Preventive care/screening/immunization</u>                                                    | No charge                                                                                                                                                                                                                                                                                                                        | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.                                                                                          |
| <b>If you have a test</b>                                                                                                                                                                        | <u>Diagnostic test</u> (x-ray, blood work)                                                       | 20% <u>coinsurance</u>                                                                                                                                                                                                                                                                                                           | Not covered                                        | None                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                                                                     | 20% <u>coinsurance</u>                                                                                                                                                                                                                                                                                                           | Not covered                                        | <u>Prior authorization</u> required for some outpatient imaging tests. Penalty: 50% of allowable charge to \$1,500 per occurrence.                                                                                                                                 |
| <b>If you need drugs to treat your illness or condition</b>                                                                                                                                      | Preferred generic drugs                                                                          | \$10 <u>copay</u> /prescription (retail),<br>\$30 <u>copay</u> /prescription (mail)                                                                                                                                                                                                                                              | Not covered                                        | Covers up to a 90 day supply (retail and mail). Retail pharmacies: one <u>copay</u> for each 30 day supply. No charge for specific preventive drugs. <u>Prior authorization</u> required for some drugs.                                                           |
| More information about <u>prescription drug coverage</u> is available at<br><br><a href="http://www.Premera.com/hmo/documents/059902_2026.pdf">www.Premera.com/hmo/documents/059902_2026.pdf</a> | Preferred brand drugs                                                                            | \$40 <u>copay</u> /prescription (retail),<br>\$120 <u>copay</u> /prescription (mail)                                                                                                                                                                                                                                             | Not covered                                        | Covers up to a 90 day supply (retail and mail). Retail pharmacies: one <u>copay</u> for each 30 day supply. <u>Prior authorization</u> required for some drugs.                                                                                                    |
|                                                                                                                                                                                                  | Preferred <u>specialty drugs</u>                                                                 | \$70 <u>copay</u> /prescription                                                                                                                                                                                                                                                                                                  | Not covered                                        | Covers up to a 30 day supply. <u>Prior authorization</u> required for some drugs.                                                                                                                                                                                  |
|                                                                                                                                                                                                  | Non-preferred generic drugs<br>Non-preferred brand drugs<br>Non-preferred <u>specialty drugs</u> | Non-pref. generic: \$150 <u>copay</u> /prescription (retail),<br>\$450 <u>copay</u> /prescription (mail)<br>Non-pref. brand: \$150 <u>copay</u> /prescription (retail),<br>\$450 <u>copay</u> /prescription (mail)<br>Non-pref. specialty: \$150 <u>copay</u> /prescription (retail),<br>\$450 <u>copay</u> /prescription (mail) | Not covered                                        | Non-pref. generic and non-pref. brand: Covers up to a 90 day supply (retail and mail). Retail pharmacies: one <u>copay</u> for each 30 day supply.<br>Non-pref. specialty drugs: Covers up to a 30 day supply. <u>Prior authorization</u> required for some drugs. |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                                                                   |                                                                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                     |
|---------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Network Provider<br>(You will pay the least)                                                                        | Out-of-Network Provider<br>(You will pay the most)                                                                  |                                                                                                                                                                                                                                            |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         | <u>Prior authorization</u> required for some services. Penalty: 50% of allowable charge to \$1,500 per occurrence.                                                                                                                         |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         | None                                                                                                                                                                                                                                       |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$300 <u>copay</u> /visit + 20% <u>coinsurance</u>                                                                  | \$300 <u>copay</u> /visit + 20% <u>coinsurance</u>                                                                  | Emergency room <u>copay</u> waived if admitted to hospital.                                                                                                                                                                                |
|                                                                           | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                                                                              | 20% <u>coinsurance</u>                                                                                              | None                                                                                                                                                                                                                                       |
|                                                                           | <u>Urgent care</u>                             | Hospital-based: \$300 <u>copay</u> /visit + 20% <u>coinsurance</u><br>Freestanding center: \$25 <u>copay</u> /visit | Hospital-based: \$300 <u>copay</u> /visit + 20% <u>coinsurance</u><br>Freestanding center: \$25 <u>copay</u> /visit | None                                                                                                                                                                                                                                       |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         | <u>Prior authorization</u> required for all planned inpatient stays. Penalty: 50% of allowable charge to \$1,500 per stay.                                                                                                                 |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         | None                                                                                                                                                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office Visit: \$10 <u>copay</u> /visit<br>Facility: 20% <u>coinsurance</u>                                          | Not covered                                                                                                         | None                                                                                                                                                                                                                                       |
|                                                                           | Inpatient services                             | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         | <u>Prior authorization</u> required for all planned inpatient stays. Penalty: 50% of allowable charge to \$1,500 per stay.                                                                                                                 |
| If you are pregnant                                                       | Office visits                                  | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). |
|                                                                           | Childbirth/delivery professional services      | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         |                                                                                                                                                                                                                                            |
|                                                                           | Childbirth/delivery facility services          | 20% <u>coinsurance</u>                                                                                              | Not covered                                                                                                         |                                                                                                                                                                                                                                            |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                  | Network Provider<br>(You will pay the least)                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                    |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 20% <u>coinsurance</u>                                                    | Not covered                                        | Limited to 130 visits per calendar year                                                                                                                                                                                                                                                            |
|                                                                       | <u>Rehabilitation services</u>   | Outpatient: \$65 <u>copay</u> /visit<br>Inpatient: 20% <u>coinsurance</u> | Not covered                                        | Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty: 50% of allowable charge to \$1,500 per stay. |
|                                                                       | <u>Habilitation services</u>     | Outpatient: \$65 <u>copay</u> /visit<br>Inpatient: 20% <u>coinsurance</u> | Not covered                                        | Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty: 50% of allowable charge to \$1,500 per stay. |
|                                                                       | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                                                    | Not covered                                        | Limited to 90 days per calendar year. <u>Prior authorization</u> required for all planned inpatient stays. Penalty: 50% of allowable charge to \$1,500 per stay.                                                                                                                                   |
|                                                                       | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                                                    | Not covered                                        | <u>Prior authorization</u> required to buy some medical equipment. Penalty: 50% of allowable charge to \$1,500 per occurrence.                                                                                                                                                                     |
|                                                                       | <u>Hospice services</u>          | 20% <u>coinsurance</u>                                                    | Not covered                                        | Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.                                                                                                                                                               |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | Not covered                                                               | Not covered                                        | None                                                                                                                                                                                                                                                                                               |
|                                                                       | Children's glasses               | Not covered                                                               | Not covered                                        | None                                                                                                                                                                                                                                                                                               |
|                                                                       | Children's dental check-up       | Not covered                                                               | Not covered                                        | None                                                                                                                                                                                                                                                                                               |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture
- Chiropractic care or other spinal manipulations
- Foot care
- Hearing aids

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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). For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-844-722-4661 or TTY711. 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 1-844-722-4661 or TTY711, or the state insurance department at 1-800-562-6900, 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.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the 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 1-844-722-4661.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-722-4661.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-844-722-4661.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-722-4661.

—————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.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist</u> copay                     | \$65    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$4,000        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$1,700        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,770</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist</u> copay                     | \$65    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$200          |
| <u>Copayments</u>                 | \$1,500        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist</u> copay                     | \$65    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$600          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,600</b> |



## Notice of availability and nondiscrimination 844-722-4661 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាផ្សេងៗ និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

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Tajaaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

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ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمکها و خدمات امدادی مقتضی، تماس بگیرید.

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