

Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2020

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
 Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	STERLING 750	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$750	\$1,500
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family Embedded OOP Max \$14,300)	\$6,000	Unlimited
Office Visit Cost Share	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered In Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Not Covered
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN		STERLING 750	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
VIRTUAL CARE - ON DEMAND			
Virtual Care - General Medical/ Dermatology (Voice/Video)	Covered In Full	Not Applicable	
DIAGNOSTIC SERVICE OPTIONS			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
FACILITY CARE OPTIONS			
Inpatient Facility	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence Packaged Services (Heritage Prime Network - No Eligible Services)	Covered as any other service	Covered as any other service	
EMERGENCY CARE AND TRANSPORTATION OPTION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$750 Deductible and 20% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum	\$200 Copay then \$750 Deductible and 20% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum	
Emergency Room Physician	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
Urgent Care Center	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
OTHER SERVICES			

MEDICAL PLAN		
	STERLING 750	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Allergy/Therapeutic Injections	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine - Mental Health	Covered In Full	Not Applicable
Chemical Dependency Inpatient Facility Care (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$750 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))	Covered as any other service	Covered as any other service
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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

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

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

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

PHARMACY PLAN	
STERLING 750 - RX	
PRESCRIPTION DRUGS	
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Retail Cost Shares	\$10/\$30/\$60/\$250
Mail Cost Shares	\$25/\$75/\$150/\$250
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

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Discrimination is Against the Law

Pravera Blue Cross complies with applicable Federal and state laws and does not discriminate on the basis of race, national origin, age, disability, or sex. Pravera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

- Provides health and services to people with disabilities in community activities with us, such as:
 - Qualified sign language interpreters
 - Written information in alternate large print, audio, accessible electronic formats, other formats
- Provides language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Communication in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Pravera 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 complaint with the Civil Rights Coordinator, Complaints and Appeals, 700 Blue Sky Drive, Suite 400, St. Louis, MO 63103. TTY: 800-642-6367. You file 800-332-7622, Fax: 424-9316, TTY: 800-642-6367. Email: Appeal.Discrimination@Pravera.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 www.hhs.gov/ocr/ocomplaintportal/, or by first mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 508F, Main Building, Washington, D.C. 20201. 1-800-368-1019, 800-637-7887 (TDD). Complaint forms are available at www.hhs.gov/officefor-civil-rights.

Getting Help in Other Languages

This notice has important information. This notice may have important information about your enrollment or coverage through Pravera Blue Cross. Please read this notice carefully. If you need help understanding this notice, please call the number below. We can help you understand this notice in your language or help with costs. You have the right to get this information in your language at no cost. Call 800-722-1471 (TTY: 800-642-6367).

العربية (Arabic)
Pravera Blue Cross هي شركة تأمين صحية تقدم خدماتها في اللغة العربية. نحن نقدم خدماتنا في اللغة العربية لجميع عملائنا. إذا كنت بحاجة إلى مساعدة في فهم هذا الإعلان، يرجى الاتصال بنا. يمكننا مساعدتك في فهم هذا الإعلان في لغتك الأم. نحن نقدم هذه الخدمة مجانًا. اتصل بنا على الرقم 800-722-1471 (TTY: 800-642-6367).

فارسی (Farsi)
Pravera Blue Cross یک شرکت بیمه است که خدمات خود را به زبان فارسی ارائه می‌دهد. ما خدمات خود را به زبان فارسی برای تمام مشتریان خود ارائه می‌دهیم. اگر شما نیاز به کمک در درک این اطلاعیه دارید، لطفاً با ما تماس بگیرید. ما می‌توانیم به شما در درک این اطلاعیه به زبان مادری شما کمک کنیم. این خدمات به شما هیچ هزینه‌ای ندارد. با ما تماس بگیرید: 800-722-1471 (TTY: 800-642-6367).

中文 (Chinese)
Pravera Blue Cross 提供中文服務。我們提供中文服務給所有客戶。如果您需要協助理解這份通知，請與我們聯繫。我們可以在您的母語中為您提供這份通知的解釋。這項服務是免費的。請撥打電話 800-722-1471 (TTY: 800-642-6367)。

日本語 (Japanese)
Pravera Blue Cross は日本語サービスを提供しています。私たちはすべてのお客様に日本語サービスを提供しています。この通知を理解するのに助けが必要な場合は、お気軽に私たちとご連絡ください。母国語でこの通知の内容を説明することができます。このサービスは無料です。お問い合わせ番号は 800-722-1471 (TTY: 800-642-6367) です。

한국어 (Korean)
Pravera Blue Cross는 한국어 서비스를 제공합니다. 우리는 모든 고객에게 한국어 서비스를 제공합니다. 이 공지사항을 이해하는 데 도움이 필요하다면, 저희와 연락하십시오. 저희는 귀하의 모국어로 이 공지사항의 내용을 설명할 수 있습니다. 이 서비스는 무료입니다. 문의 번호는 800-722-1471 (TTY: 800-642-6367)입니다.

हिन्दी (Hindi)
Pravera Blue Cross हिंदी सेवा प्रदान करता है। हम सभी ग्राहकों को हिंदी सेवा प्रदान करते हैं। यदि आपको इस सूचना को समझने में मदद चाहिए, तो कृपया हमसे संपर्क करें। हम आपको अपनी मातृभाषा में इस सूचना की व्याख्या कर सकते हैं। यह सेवा मुफ्त है। हमारे संपर्क नंबर 800-722-1471 (TTY: 800-642-6367) हैं।

ไทย (Thai)
Pravera Blue Cross มีบริการภาษาไทย. เราให้บริการภาษาไทยกับลูกค้าทุกคน. หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อนี้, กรุณาติดต่อเรา. เราสามารถช่วยคุณทำความเข้าใจข้อนี้ในภาษาแม่ของคุณได้. บริการนี้เป็นฟรี. ติดต่อเราที่ 800-722-1471 (TTY: 800-642-6367).

မြန်မာစာ (Burmese)
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Pravera Blue Cross မြန်မာစာဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။ ကျားအားလုံးအတွက် မြန်မာစာဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။ အကယ်၍ ဤအကြောင်းအရာကို နားလည်ရန် အကူအညီလိုအပ်ပါက၊ ဤအကြောင်းအရာကို မိမိတို့၏ မိခင်ဘာသာစကားဖြင့် ရှင်းပြနိုင်ပါသည်။ ဤဝန်ဆောင်မှုသည် အခမဲ့ဖြစ်သည်။ ဖုန်းနံပါတ်မှာ 800-722-1471 (TTY: 800-642-6367) ဖြစ်သည်။

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Overview (Czech)

Pravera Blue Cross poskytuje zdravotní služby. Poskytujeme zdravotní služby všem našim klientům. Pokud potřebujete pomoc při pochopení této informace, obraťte se na nás. Můžeme vám pomoci porozumět této informaci v vaší mateřštině. Tato služba je zdarma. Kontaktujte nás na telefonním čísle 800-722-1471 (TTY: 800-642-6367).

France (French)

Pravera Blue Cross fournit des services de santé. Nous fournissons des services de santé à tous nos clients. Si vous avez besoin d'aide pour comprendre cette information, contactez-nous. Nous pouvons vous aider à comprendre cette information dans votre langue maternelle. Ce service est gratuit. Appelez-nous au 800-722-1471 (TTY: 800-642-6367).

Germany (German)

Pravera Blue Cross bietet Gesundheitsleistungen an. Wir bieten Gesundheitsleistungen allen unseren Kunden an. Wenn Sie Hilfe benötigen, um diese Informationen zu verstehen, kontaktieren Sie uns. Wir können Ihnen helfen, diese Informationen in Ihrer Muttersprache zu verstehen. Diese Dienstleistung ist kostenlos. Rufen Sie uns unter 800-722-1471 (TTY: 800-642-6367).

Spanish (Spanish)

Pravera Blue Cross ofrece servicios de salud. Ofrecemos servicios de salud a todos nuestros clientes. Si necesita ayuda para entender esta información, comuníquese con nosotros. Podemos ayudarle a entender esta información en su idioma materno. Este servicio es gratuito. Llámennos al 800-722-1471 (TTY: 800-642-6367).

Hebrew (Hebrew)

Pravera Blue Cross מספקת שירותי בריאות. אנו מספקים שירותי בריאות לכל לקוחותינו. אם אתם צריכים עזרה להבין את המידע הזה, אנא פנו אלינו. נוכל לעזור לכם להבין את המידע הזה בשפת אם שלכם. שירות זה חינם. קחו אתנו לידי 800-722-1471 (TTY: 800-642-6367).

Italian (Italian)

Pravera Blue Cross fornisce servizi sanitari. Forniamo servizi sanitari a tutti i nostri clienti. Se avete bisogno di aiuto per comprendere queste informazioni, contattateci. Possiamo aiutarvi a comprendere queste informazioni nella vostra lingua madre. Questo servizio è gratuito. Chiamateci al 800-722-1471 (TTY: 800-642-6367).

Japanese (Japanese)

Pravera Blue Crossは健康サービスを提供しています。私たちはすべてのお客様に健康サービスを提供しています。この通知を理解するのに助けが必要な場合は、お気軽に私たちとご連絡ください。母国語でこの通知の内容を説明することができます。このサービスは無料です。お問い合わせ番号は 800-722-1471 (TTY: 800-642-6367) です。

Korean (Korean)

Pravera Blue Cross는 건강 서비스를 제공합니다. 우리는 모든 고객에게 건강 서비스를 제공합니다. 이 공지사항을 이해하는 데 도움이 필요하다면, 저희와 연락하십시오. 저희는 귀하의 모국어로 이 공지사항의 내용을 설명할 수 있습니다. 이 서비스는 무료입니다. 문의 번호는 800-722-1471 (TTY: 800-642-6367)입니다.

Portuguese (Portuguese)

Pravera Blue Cross oferece serviços de saúde. Oferecemos serviços de saúde a todos os nossos clientes. Se precisar de ajuda para entender esta informação, contate-nos. Podemos ajudá-lo a entender esta informação no seu idioma materno. Este serviço é gratuito. Ligue para 800-722-1471 (TTY: 800-642-6367).

Russian (Russian)

Pravera Blue Cross предоставляет медицинские услуги. Мы предоставляем медицинские услуги всем нашим клиентам. Если вам нужна помощь в понимании этой информации, свяжитесь с нами. Мы можем помочь вам понять эту информацию на вашем родном языке. Эта услуга бесплатна. Позвоните нам по номеру 800-722-1471 (TTY: 800-642-6367).

Tamil (Tamil)

Pravera Blue Cross ஆரோக்கிய சேவைகளை வழங்குகிறது. எங்கள் அனைத்து வாடிக்கையாளர்களுக்கும் ஆரோக்கிய சேவைகளை வழங்குகிறோம். இந்த அறிவிப்பை புரிந்துகொள்ள உதவுவதற்கான உதவியை நாடுங்கள். உங்கள் தாய்மொழியில் இந்த அறிவிப்பை விளக்க முடியும். இது ஒரு இலவச சேவை. 800-722-1471 (TTY: 800-642-6367) இல் தொடர்பு கொள்ளுங்கள்.

Thai (Thai)

Pravera Blue Cross มีบริการสุขภาพ. เราให้บริการสุขภาพกับลูกค้าทุกคน. หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อนี้, กรุณาติดต่อเรา. เราสามารถช่วยคุณทำความเข้าใจข้อนี้ในภาษาแม่ของคุณได้. บริการนี้เป็นฟรี. ติดต่อเราที่ 800-722-1471 (TTY: 800-642-6367).

Urdu (Urdu)

Pravera Blue Cross صحتی خدمات فراہم کرتی ہے۔ ہمیں اپنے تمام گاہکوں کو صحتی خدمات فراہم کرنے ہیں۔ اگر آپ کو اس اطلاعیت کو سمجھنے میں مدد کی ضرورت ہے، تو براہ کرم ہم سے رابطہ کریں۔ ہم آپ کو اپنی مادری زبان میں اس اطلاعیت کی وضاحت کر سکتے ہیں۔ یہ سروس مفت ہے۔ ہمارے رابطہ نمبر 800-722-1471 (TTY: 800-642-6367) ہے۔

Vietnamese (Vietnamese)

Pravera Blue Cross cung cấp các dịch vụ y tế. Chúng tôi cung cấp các dịch vụ y tế cho tất cả khách hàng của chúng tôi. Nếu bạn cần trợ giúp để hiểu thông tin này, vui lòng liên hệ với chúng tôi. Chúng tôi có thể giúp bạn hiểu thông tin này bằng tiếng mẹ đẻ của bạn. Dịch vụ này miễn phí. Gọi cho chúng tôi tại số 800-722-1471 (TTY: 800-642-6367).

Yiddish (Yiddish)

Pravera Blue Cross פארשטעלט געזונט דינסטן. מיר פארשטעלן געזונט דינסטן אלע אונזערע קליענטן. ווען איר נוצן אונזערע דינסטן, קען איר אונזערע דינסטן באניצן אין אונזערע דינסטן. מיר קענען אונז אונזערע דינסטן באניצן אין אונזערע דינסטן. דער דינסט איז פארשיידן. רופן אונז און אונזערע דינסטן באניצן אין אונזערע דינסטן. 800-722-1471 (TTY: 800-642-6367).

Zhinese (Chinese)

Pravera Blue Cross 提供中文服務。我們提供中文服務給所有客戶。如果您需要協助理解這份通知，請與我們聯繫。我們可以在您的母語中為您提供這份通知的解釋。這項服務是免費的。請撥打電話 800-722-1471 (TTY: 800-642-6367)。

Other (Other)

Pravera Blue Cross provides health services. We provide health services to all our customers. If you need help understanding this information, contact us. We can help you understand this information in your language. This service is free. Call us at 800-722-1471 (TTY: 800-642-6367).