blue of california

Summary of Benefits

Individual and Family Plan
PPO Savings Benefit Plan

Bronze 60 HDHP PPO

This Summary of Benefits shows the amount you will pay for covered services under this Blue Shield of California benefit plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Provider Network:

Exclusive PPO Network

This benefit plan uses a specific network of health care providers, called the Exclusive PPO provider network. Providers in this network are called participating providers. You pay less for covered services when you use a participating provider than when you use a non-participating provider. You can find participating providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A calendar year deductible (CYD) is the amount a member pays each calendar year before Blue Shield pays for covered services under the benefit plan. Blue Shield pays for some covered services before the calendar year deductible is met, as noted in the Benefits chart below.

		When using a participating provider[3]	When using a non-participating provider[4]
Calendar year medical and pharmacy deductible	*Individual coverage*	$4,800	$9,600
This plan combines medical and pharmacy deductibles into one calendar year deductible.	*Family coverage*	$4,800: individual $9,600: family	$9,600: individual $19,300: family

Calendar Year Out-of-Pocket Maximum[5]

An out-of-pocket maximum is the most a member will pay for covered services each calendar year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a participating provider[3]	When using a non-participating provider[4]
Individual coverage	$6,550	$20,000
Family coverage	$6,550: individual $13,100: family	$20,000: individual $40,000: family

No Lifetime Benefit Maximum

Under this benefit plan there is no dollar limit on the total amount Blue Shield will pay for covered services in a member's lifetime.

Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Preventive Health Services[7]	$0		Not covered	
Physician services				
Primary care office visit	40%	✔	50%	✔
Specialist care office visit	40%	✔	50%	✔
Physician home visit	40%	✔	50%	✔
Physician or surgeon services in an outpatient facility	40%	✔	50%	✔
Physician or surgeon services in an inpatient facility	40%	✔	50%	✔
Other professional services				
Other practitioner office visit	40%	✔	50%	✔
Includes nurses, nurse practitioners, and therapists.				
Acupuncture services	40%	✔	50%	✔
Chiropractic services	Not covered		Not covered	
Teladoc consultation	40%	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	40%	✔	Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	40%	✔	50%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and initial postnatal	$0		50%	✔
Physician services for pregnancy termination	40%	✔	50%	✔
Emergency services and urgent care				
Emergency room services	40%	✔	40%	✔
If admitted to the hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room physician services	$0	✔	$0	✔
Urgent care physician services	40%	✔	50%	✔
Ambulance services	40%	✔	40%	✔

Benefits[6]	Your payment			
	When using a participating provider[3]		When using a participating provider[3]	
Outpatient facility services				
Ambulatory surgery center	40%	✔	50% up to $300/day plus 100% of additional charges	✔
Outpatient department of a hospital: surgery	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	40%	✔	Not covered	
• Physician inpatient services	40%	✔	Not covered	
Bariatric surgery services, designated California counties *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient facility services and Outpatient physician services payments apply.*				
Inpatient facility services	40%	✔	Not covered	
Outpatient facility services	40%	✔	Not covered	
Physician services	40%	✔	Not covered	

Benefits[6]	Your payment			
	When using a participating provider[3]		When using a participating provider[3]	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for covered services that are diagnostic, non-preventive health services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for covered services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	40%	✔	50%	✔
• Outpatient department of a hospital	40%	✔	50% up to $500/day plus 100% of additional charges	✔
• California Prenatal Screening Program	$0		$0	
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	40%	✔	50%	✔
• Outpatient department of a hospital	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	40%	✔	50%	✔
• Outpatient department of a hospital	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	40%	✔	50% up to $300/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a participating provider[3]		When using a participating provider[3]	
• Outpatient department of a hospital	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Rehabilitation and habilitative services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services. There is no visit limit for rehabilitation or habilitative services.*				
Office location	40%	✔	50%	✔
Outpatient department of a hospital	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	40%	✔	50%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	40%	✔	50%	✔
Prosthetic equipment and devices	40%	✔	50%	✔
Home health services *Up to 100 visits per member, per calendar year, by a home health care agency. All visits count towards the limit, including visits during any applicable deductible period, except hemophilia and home infusion nursing visits.*				
Home health agency services *Includes home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.*	40%	✔	Not covered	
Home visits by an infusion nurse	40%	✔	Not covered	
Home health medical supplies	40%	✔	Not covered	
Home infusion agency services	40%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	40%	✔	Not covered	

Benefits[6]	Your payment			
	When using a participating provider[3]		**When using a participating provider[3]**	
Skilled nursing facility (SNF) services *Up to 100 days per member, per benefit period, except when provided as part of a hospice program. All days count towards the limit, including days during any applicable deductible period and days in different SNFs during the calendar year.*				
Freestanding SNF	40%	✔	40%	✔
Hospital-based SNF	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Hospice program services *Includes pre-hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	40%	✔	50%	✔
• Self-management training	$0		50%	✔
Dialysis services	40%	✔	50% up to $300/day plus 100% of additional charges	✔
PKU product formulas and special food products	40%	✔	40%	✔
Allergy serum	40%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder benefits are provided through Blue Shield's mental health services administrator (MHSA).	**When using a MHSA participating provider[3]**	**CYD[2] applies**	**When using a MHSA non-participating provider[4]**	**CYD[2] applies**
Outpatient services				
Office visit, including physician office visit	40%	✔	50%	✔
Other outpatient services, including intensive outpatient care, behavioral health treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	40%	✔	50%	✔
Partial hospitalization program	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Psychological testing	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Inpatient services				
Physician inpatient services	40%	✔	50%	✔
Hospital services	40%	✔	50% up to $500/day plus 100% of additional charges	✔
Residential care	40%	✔	50% up to $500/day plus 100% of additional charges	✔

Prescription Drug Benefits[8,9]	Your payment			
	When using a participating pharmacy[3]	CYD[2] applies	When using a non-participating pharmacy[4]	CYD[2] applies
Retail pharmacy prescription drugs				
Per prescription, up to a 30-day supply.				
Tier 1 drugs	40% up to $500/ prescription	✔	Not covered	
Tier 2 drugs	40% up to $500/ prescription	✔	Not covered	
Tier 3 drugs	40% up to $500/ prescription	✔	Not covered	
Tier 4 drugs (excluding specialty drugs)	40% up to $500/ prescription	✔	Not covered	
Contraceptive drugs and devices	$0		Not covered	
Mail service pharmacy prescription drugs				
Per prescription, up to a 90-day supply.				
Tier 1 drugs	40% up to $1500/ prescription	✔	Not covered	
Tier 2 drugs	40% up to $1500/ prescription	✔	Not covered	
Tier 3 drugs	40% up to $1500/ prescription	✔	Not covered	
Tier 4 drugs (excluding specialty drugs)	40% up to $1500/ prescription	✔	Not covered	
Contraceptive drugs and devices	$0		Not covered	
Specialty drugs *Per prescription. Specialty drugs are covered at tier 4 and only when dispensed by a network specialty pharmacy. Specialty drugs from non-participating pharmacies are not covered except in emergency situations.*	40% up to $500/ prescription	✔	Not covered	
Oral anticancer drugs *Per prescription, up to a 30-day supply.*	40% up to $200/ prescription	✔	Not covered	

Pediatric Benefits	Your payment			
Pediatric benefits are available through the end of the month in which the member turns 19.	**When using a participating dentist[3]**	**CYD[2] applies**	**When using a non-participating dentist[4]**	**CYD[2] applies**
Pediatric dental[10]				
Diagnostic and preventive services				
• Oral exam	$0		10%	
• Preventive – cleaning	$0		10%	
• Preventive – x-ray	$0		10%	
• Sealants per tooth	$0		10%	
• Topical fluoride application	$0		10%	
• Space maintainers - fixed	$0		10%	
Basic services				
• Restorative procedures	20%		30%	
• Periodontal maintenance	20%		30%	
Major services				
• Oral surgery	50%		50%	
• Endodontics	50%		50%	
• Periodontics (other than maintenance)	50%		50%	
• Crowns and casts	50%		50%	
• Prosthodontics	50%		50%	
Orthodontics (medically necessary)	50%		50%	

Pediatric Benefits	Your payment			
Pediatric benefits are available through the end of the month in which the member turns 19.	**When using a participating provider[3]**	**CYD[2] applies**	**When using a non-participating provider[4]**	**CYD[2] applies**
Pediatric vision[11]				
Comprehensive eye examination				
One exam per calendar year.				
• Ophthalmologic visit	$0		$0 up to $30 plus 100% of additional charges	
• Optometric visit	$0		$0 up to $30 plus 100% of additional charges	
Eyewear/materials				
One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the benefit per calendar year. Any exceptions are noted below.				
• Contact lenses				
Non-elective (medically necessary) - hard or soft	$0		$0 up to $225 plus 100% of additional charges	
Up to two pairs per eye per calendar year.				
Elective (cosmetic/convenience)				
Standard and non-standard, hard	$0		$0 up to $75 plus 100% of additional charges	
Up to a 3 month supply for each eye per calendar year based on lenses selected.				
Standard and non-standard, soft	$0		$0 up to $75 plus 100% of additional charges	
Up to a 6 month supply for each eye per calendar year based on lenses selected.				
• Eyeglass frames				
Collection frames	$0		$0 up to $40 plus 100% of additional charges	

Pediatric Benefits	Your payment			
Pediatric benefits are available through the end of the month in which the member turns 19.	**When using a participating provider[3]**	**CYD[2] applies**	**When using a non-participating provider[4]**	**CYD[2] applies**
Non-collection frames	$0 up to $150 plus 100% of additional charges		$0 up to $40 plus 100% of additional charges	
• Eyeglass lenses *Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.*				
Single vision	$0		$0 up to $25 plus 100% of additional charges	
Lined bifocal	$0		$0 up to $35 plus 100% of additional charges	
Lined trifocal	$0		$0 up to $45 plus 100% of additional charges	
Lenticular	$0		$0 up to $45 plus 100% of additional charges	
Optional eyeglass lenses and treatments				
• Ultraviolet protective coating (standard only)	$0		Not covered	
• Polycarbonate lenses	$0		Not covered	
• Standard progressive lenses	$0		Not covered	
• Premium progressive lenses	$95		Not covered	
• Anti-reflective lens coating (standard only)	$35		Not covered	
• Photochromic - glass lenses	$25		Not covered	
• Photochromic - plastic lenses	$0		Not covered	
• High index lenses	$30		Not covered	
• Polarized lenses	$45		Not covered	
Low vision testing and equipment				
• Comprehensive low vision exam *Once every 5 calendar years.*	$0		Not covered	
• Low vision devices *One aid per calendar year.*	$0		Not covered	
Diabetes management referral	$0		Not covered	

Prior Authorization

The following are some frequently-utilized benefits that require prior authorization:

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from non-participating providers
- Pediatric vision non-elective contact lenses and low vision testing and equipment
- Mental health services, except outpatient office visits
- Hospice program services
- Some prescription drugs (see blueshieldca.com/pharmacy)

Please review the Evidence of Coverage for more about benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the benefits, limitations, and exclusions that apply to coverage under this benefit plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A deductible is the amount you pay each calendar year before Blue Shield pays for Covered Services under the benefit plan.

If this benefit plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year combined medical and pharmacy Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year combined medical and pharmacy Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Essential health benefits count towards the Calendar Year Deductible.

This benefit plan has separate Deductibles for:

- Participating Provider Deductible and Non-Participating Provider Deductible

Family coverage has an individual Deductible within the family Deductible. This means that the Deductible will be met for an individual who meets the individual Deductible prior to the family meeting the family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

Notes

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the calendar year OOPM. You will continue to be responsible for Copayments or Coinsurance for the following Covered Services after the Calendar Year Out-of-Pocket Maximum is met:

- bariatric surgery: additional covered travel expenses for bariatric surgery
- dialysis center benefits: dialysis services from a Non-Participating Provider
- benefit maximum: charges for services after any benefit limit is reached

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This benefit plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

Family coverage has an individual OOPM within the family OOPM. This means that the OOPM will be met for an individual who meets the individual OOPM prior to the family meeting the family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the physician office visit, you may have a Copayment or Coinsurance for the visit.

Notes

8 Outpatient Prescription Drug Coverage:
Medicare Part D-non-creditable coverage-

This benefit plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Part D plan from October 15th through December 7th of each year. If you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Services telephone number on your Member identification card, Monday through Thursday, 8 a.m. to 5 p.m., or Friday 9 a.m. to 5 p.m.

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus any applicable Drug tier Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

Request for Medical Necessity Review. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Member payment.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply. When this occurs, the Copayment or Coinsurance will be pro-rated.

10 Pediatric Dental Coverage:

Pediatric dental benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

11 Pediatric Vision Coverage:

Pediatric vision benefits are provided through Blue Shield's Vision Plan Administrator (VPA).

Covered Services from Non-Participating Providers. There is no Copayment or Coinsurance up to the listed Allowable Amount. You pay all charges above the Allowable Amount.

Coverage for frames. If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $99.06.
- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

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Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our 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, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)