Blue Shield Silver 70 HMO

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2017

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This plan is available only in certain California counties and cities "Service Area" as described in the *Evidence of Coverage*. You must reside in this select Service Area in order to enroll in this plan.
This health plan utilizes an Accountable Care Organization (ACO) for its provider network. Except for Emergency Services, Urgent Services when the Member is out of the Service Area, or when prior authorized, all services must be obtained through the Member's Personal Physician and within the Trio ACO HMO Provider Network to be covered.

This health plan uses the Trio ACO HMO Provider Network.

	Plan Providers [1]
Calendar Year Medical Deductible [1]	$2,500 per individual / $5,000 per family
Calendar Year Out-of-Pocket Maximum [2] (Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum.)	$6,800 per individual / $13,600 per family
Calendar Year Pharmacy Deductible [1] (Does not apply to contraceptive drugs and devices or oral anticancer medications. Otherwise applicable to covered drugs in Tiers 2, 3 and 4. Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum.)	$250 per individual / $500 per family
Lifetime Benefit Maximum	None

Covered Services	**Member Copayment**
	Plan Providers [1]
PROFESSIONAL SERVICES	
Professional Benefits	
Primary care physician office visit (Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services)	$35 per visit
Other practitioner office visit	$35 per visit
Specialist physician office visit (see also the **Access+ *Specialist*[SM] Benefit** below)	$70 per visit
Teladoc consultation	$5 per consultation
Allergy Testing and Treatment Benefits	
Primary care physician office visits (includes visits for allergy serum injections)	$35 per visit
Specialist physician office visits (includes visits for allergy serum injections)	$70 per visit
Allergy serum purchased separately for treatment	20%
Access+ *Specialist*[SM] Benefits [3]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$70 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	$0

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Covered Services	Member Copayment
	Plan Providers [1]
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
Outpatient surgery performed at a free-standing ambulatory surgery center [4]	20%
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center [4]	20%
Outpatient visit	20%
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	20%
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization required)	$300 per visit
Outpatient diagnostic x-ray and imaging performed in a hospital	$70 per visit
Outpatient diagnostic laboratory and pathology performed in a hospital	$35 per visit
Outpatient laboratory, California Prenatal Screening Program	$0
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician fee	20% (Subject to the calendar year medical deductible)
Inpatient non-emergency facility fee (semi-private room and board, and medically necessary services and supplies, including sub-acute care)	20% (Subject to the calendar year medical deductible)
INPATIENT SKILLED NURSING BENEFITS [5] (combined maximum of up to 100 days per benefit period; prior authorization required; semi-private accommodations)	
Services by a free-standing skilled nursing facility	20% (Subject to the calendar year medical deductible)
Skilled nursing unit of a hospital	20% (Subject to the calendar year medical deductible)
EMERGENCY HEALTH COVERAGE	
Emergency room visit not resulting in admission – facility fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	$350 per visit
Emergency room visit resulting in admission – facility fee (when the Member is admitted directly from the Emergency Room)	20% (Subject to the calendar year medical deductible)
Emergency room visit not resulting in admission – physician fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	$0
Emergency room visit resulting in admission – physician fee	$0
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$250 (Subject to the calendar year medical deductible)
	Plan Pharmacy [1]
PRESCRIPTION DRUG (PHARMACY) COVERAGE [6, 7, 8, 9, 10, 11, 12]	
Retail Pharmacies (up to a 30-day supply)	
Contraceptive drugs and devices [7]	$0
Tier 1 Drugs	$15 per prescription
Tier 2 Drugs	$55 per prescription (Subject to the calendar year pharmacy deductible)
Tier 3 Drugs	$80 per prescription (Subject to the calendar year pharmacy deductible)
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $250 maximum per prescription (Subject to the calendar year pharmacy deductible)

Covered Services	Member Copayment
	Plan Pharmacy [1]
Mail Service Pharmacies (up to a 90-day supply)	
Contraceptive drugs and devices [7]	$0
Tier 1 Drugs	$45 per prescription
Tier 2 Drugs	$165 per prescription (Subject to the calendar year pharmacy deductible)
Tier 3 Drugs	$240 per prescription (Subject to the calendar year pharmacy deductible)
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $750 maximum per prescription (Subject to the calendar year pharmacy deductible)
Network Specialty Pharmacies [9, 10, 11] (up to a 30-day supply)	
Tier 4 Drugs	20% up to $250 maximum per prescription (Subject to the calendar year pharmacy deductible)
Oral anticancer medications	20% up to $200 maximum per prescription
	Plan Providers [1]
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	20%
Orthotic equipment and devices (separate office visit copayment may apply)	20%
DURABLE MEDICAL EQUIPMENT	
Breast pump	$0
Other durable medical equipment (Member share is based upon allowed charges)	20%
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES [13]	
Inpatient hospital services (prior authorization required)	20% (Subject to the calendar year medical deductible)
Residential care (prior authorization required)	20% (Subject to the calendar year medical deductible)
Inpatient professional (physician) services (prior authorization required)	20% (Subject to the calendar year medical deductible)
Routine outpatient mental health and behavioral health services (includes professional/physician visits; some services may require prior authorization and facility charges)	$35 per visit
Non-routine outpatient mental health and behavioral health services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, psychological testing, partial hospitalization programs, and transcranial magnetic stimulation. Some services may require prior authorization and facility charges. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.)	$0
SUBSTANCE USE DISORDER SERVICES [13]	
Inpatient hospital services (prior authorization required)	20% (Subject to the calendar year medical deductible)
Residential care (prior authorization required)	20% (Subject to the calendar year medical deductible)
Inpatient professional (physician) services (prior authorization required)	20% (Subject to the calendar year medical deductible)
Routine outpatient substance use disorder services (includes professional/physician visits; some services may require prior authorization and facility charges)	$35 per visit
Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, and office-based opioid detoxification and/or maintenance therapy. Some services may require prior authorization and facility charges. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.)	$0

Covered Services	Member Copayment
	Plan Providers [1]
HOME HEALTH SERVICES	
Home health care agency visits (up to 100 prior authorized visits per calendar year)	$45 per visit
Home infusion/home intravenous injectable therapy	$0
Home infusion nursing visits provided by a home infusion agency	$45 per visit
HOSPICE PROGRAM BENEFITS	
Routine home care	$0
Inpatient respite care	$0
24-hour continuous home care	$0
Short-term inpatient care for pain and symptom management	$0
CHIROPRACTIC BENEFITS	
Chiropractic services	Not Covered
ACUPUNCTURE BENEFITS	
Acupuncture services (benefits provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only)zx	$35 per visit
REHABILITATION AND HABILITATIVE BENEFITS (Physical, Occupational, and Respiratory Therapy)	
Office location	$35 per visit
SPEECH THERAPY BENEFITS	
Office location	$35 per visit
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and preconception physician office visit (for inpatient hospital services, see "Hospitalization Services")	$0
Delivery and all inpatient physician services	20% (Subject to the calendar year medical deductible)
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%
FAMILY PLANNING BENEFITS	
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	$0
Tubal ligation	$0
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%
Infertility services	Not Covered
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (Member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage")	20%
Diabetes self-management training in an office setting	$0
URGENT CARE BENEFITS (BlueCard® Program)	
Urgent services outside your personal physician service area	$35 per visit

Covered Services	Member Copayment

PEDIATRIC VISION BENEFITS [14] – Pediatric vision benefits are available for Members through the end of the month in which the Member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator.

	Plan Providers [1]
Comprehensive Eye Exam [15] **one per calendar year** (includes dilation, if professionally indicated)	
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0
Eyeglasses	
Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (lined) bifocal (V2200-2299) - Conventional (lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	$0
Optional Lenses and Treatments	
UV coating (standard only)	$0
Polycarbonate lenses	$0
Anti-reflective coating (standard only)	$35
High-index lenses	$30
Photochromic lenses – plastic	$0
Photochromic lenses – glass	$25
Polarized lenses	$45
Standard progressives	$0
Premium progressives	$95
Frame [16] (one frame per calendar year)	
Collection frame Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0
Non-collection frame (V2020)	Covered up to $150 maximum Allowance
Contact Lenses [17]	
Elective (Cosmetic/Convenience) – standard hard (V2500, V2510)	$0
Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	$0
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	$0
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	$0
Non-Elective (Medically Necessary) - hard or soft [18]	$0
Other Pediatric Vision Benefits	
Comprehensive low vision exam [18] (Once every 5 Calendar Years)	$0
Low vision devices [18] (One aid per Calendar Year)	$0
Diabetes management referral	$0

Covered Services	Member Copayment

PEDIATRIC DENTAL BENEFITS [19] – Pediatric dental benefits are available for Members through the end of the month in which the Member turns 19. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.

	Plan Dentists
Diagnostic and Preventive	
Oral exam	$0
Preventive - cleaning	$0
Preventive - x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Space maintainers - fixed	$0
Basic Services [20]	
Restorative procedures	20%
Periodontal maintenance services	20%
Major Services [20]	
Crowns and casts	50%
Endodontics	50%
Periodontics (other than maintenance)	50%
Prosthodontics	50%
Oral surgery	50%
Orthodontics [20, 21]	
Medically necessary orthodontics	50%

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

Endnotes

1. For family coverage, there is an individual medical deductible and a separate individual pharmacy deductible within the family medical and pharmacy deductibles. This means that the medical and pharmacy deductibles will be met for an individual who meets the individual medical and pharmacy deductibles prior to meeting the family medical and pharmacy deductibles.
   After the calendar year medical deductible is met, the Member is responsible for a copayment or coinsurance from plan providers.

2. For family coverage, there is also an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum.

   Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum, except copayments or coinsurance for:
   - Charges in excess of specified benefit maximums

   Copayments and charges for services not accruing to the Member's calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.

3. To use this option, Members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health or substance use disorder services must be provided by a MHSA network participating provider.

4. Participating ambulatory surgery centers may not be available in all areas. Outpatient surgery services may also be obtained from a hospital or an ambulatory surgery center that is affiliated with a hospital, and paid according to the hospital services benefits.

5. Skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

6. This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Medicare Part D premium.

7. Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and are not subject to the calendar year medical deductible. However, if a brand contraceptive drug is selected when a Tier 1 drug equivalent is available, the Member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its Tier 1 drug equivalent. The difference in cost that the Member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. In addition, select brand contraceptives may need prior authorization to be covered without a copayment. The Member may receive up to a 12-month supply of contraceptive Drugs.

8. If the Member or physician selects a brand drug when a Tier 1 drug equivalent is available, the Member is responsible for paying the difference in cost between the cost to Blue Shield for the brand drug and its Tier 1 drug equivalent, in addition to the Tier 1 copayment. The difference in cost that the Member must pay does not accrue to any calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. Refer to the *Evidence of Coverage* and Summary of Benefits for details.

9. Network Specialty Pharmacies dispense Specialty Drugs, which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty Drugs which may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

10. Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or upon Member request, at an associated retail store for pickup.

11. Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the *Evidence of Coverage*. In such circumstances, the applicable Specialty Drug copayment or coinsurance will be pro-rated.

12. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception.

13. Mental Health and Substance Use Disorder Services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating providers. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers.

14. All vision services must be provided through a participating vision care provider. For a list of participating vision providers, Members can search in the "Find a Provider" section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. Any vision services deductibles, copayments, and coinsurance for covered vision services from participating vision providers accrue to the calendar year out-of-pocket maximum. Costs for non-covered services, services from non-participating vision providers, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

15. The comprehensive examination benefit allowance includes fitting, evaluation and follow-up care fees for Non-Elective (Medically Necessary) Contact Lenses (hard or soft) or Elective Contact Lenses (standard hard or soft) in lieu of eyeglasses by Participating or Preferred Providers.

16. This benefit covers collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "collection," but are required to maintain a comparable selection of frames that are covered in full. For non-collection frames, the allowable amount is up to $150; however, if (a) the participating provider uses wholesale pricing, then the wholesale allowable amount will be up to $99.06, or if (b) the participating provider uses warehouse pricing, then the warehouse allowable amount will be up to $103.64. Participating providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this benefit, the Member is responsible for the difference between the allowable amount and the provider's charge.

17. Contact lenses are covered in lieu of eyeglasses. See the Definitions section in the *Evidence of Coverage* for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

18. A report from the provider and prior authorization from the contracted Vision Plan Administrator is required.

19. Pediatric dental benefits are available through a network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this network. For a list of participating dentists, Members can search in the "Find a Provider" section of blueshieldca.com. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.

    Copayments and coinsurance for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services. Costs for non-covered services charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

20. There are no waiting periods for pediatric dental services.

21. The Member's Copayment or Coinsurance for covered Medically Necessary Orthodontia 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.

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)