Platinum Access+ HMO® 0/25 OffEx

Benefit Summary (For groups 1 to 100)
(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* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This health plan uses the Access+ HMO® Provider Network

Calendar Year Medical Deductible	None
Calendar Year Out-of-Pocket Maximum[1]	$2,500 per individual / $5,000 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
PROFESSIONAL SERVICES	
Professional Benefits	
Primary care physician office visits (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)	$25 per visit
Other practitioner office visit	$25 per visit
Specialist physician office visit (also see the **Access+ *Specialist*SM Benefit** below)	$50 per visit
Teladoc consultation	$5 per consultation
Allergy Testing and Treatment Benefits	
Primary care physician office visits (includes visits for allergy serum injections)	$25 per visit
Specialist physician office visits (includes visits for allergy serum injections)	$50 per visit
Allergy serum purchased separately for treatment	50%
Access+ *Specialist*SM Benefits[2]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$50 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
Outpatient surgery performed at a free-standing ambulatory surgery center[3]	$100 per surgery
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center[3]	$150 per surgery
Outpatient visit	No Charge
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
OUTPATIENT X-RAY, IMAGING, PATHOLOGY AND LABORATORY BENEFITS	
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital or free-standing radiological center (prior authorization is required)	
Performed in a hospital (prior authorization is required)	$200 per visit
Performed in a free-standing radiological center (prior authorization is required)	$50 per visit

Outpatient diagnostic x-ray and imaging	
Performed in a hospital	$50 per visit
Performed in a free-standing or affiliated facility	$50 per visit
Outpatient diagnostic laboratory and pathology	
Performed in a hospital	$20 per visit
Performed in a free-standing or affiliated facility	$20 per visit
Laboratory services, California Prenatal Screening Program	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)	$250 per day up to 3 days per admission
INPATIENT SKILLED NURSING BENEFITS[5] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Services by a free-standing skilled nursing facility	$100 per day
Skilled nursing unit of a hospital	$100 per day
EMERGENCY HEALTH COVERAGE	
Emergency room services not resulting in admission – facility fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$250 per visit
Emergency room services resulting in admission – facility fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$250 per day up to 3 days per admission
Emergency room services not resulting in admission – physician fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	No Charge
Emergency room services resulting in admission – physician fee	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$100
PRESCRIPTION (PHARMACY) DRUG COVERAGE[4,6,7,9,10,11,12]	
Retail Pharmacies (up to a 30-day supply)	
Contraceptive drugs and devices[7]	No Charge
Tier 1 drugs	$5 per prescription
Tier 2 drugs	$15 per prescription
Tier 3 drugs	$25 per prescription
Tier 4 drugs (excluding Specialty Drugs)	20% up to $250 maximum per prescription
Mail Service Pharmacies (up to a 90-day supply)	
Contraceptive drugs and devices[7]	No Charge
Tier 1 drugs	$10 per prescription
Tier 2 drugs	$30 per prescription
Tier 3 drugs	$50 per prescription
Tier 4 drugs (excluding Specialty Drugs)	20% up to $500 maximum per prescription
Network Specialty Pharmacies[6] (up to a 30-day supply)	
Tier 4 drugs	20% up to $250 maximum per prescription
Oral anticancer medications	20% up to $200 maximum per prescription
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (member share is based upon allowed charges)	50%
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES[8]	
Inpatient hospital services (prior authorization is required)	$250 per day up to 3 days per admission

Residential care (prior authorization is required)	$250 per day up to 3 days per admission
Inpatient professional (physician) services	No Charge
Routine outpatient mental health and behavioral health services (includes professional/physician visits)	$25 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.)	No Charge
SUBSTANCE USE DISORDER SERVICES[8]	
Inpatient hospital services (prior authorization is required)	$250 per day up to 3 days per admission
Residential care (prior authorization is required)	$250 per day up to 3 days per admission
Inpatient professional (physician) services	No Charge
Routine outpatient substance use disorder services (includes professional/physician visits)	$25 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.)	No Charge
HOME HEALTH SERVICES	
Home health care agency services (up to 100 visits per calendar year)	$25 per visit
Medical supplies (see "prescription drug coverage" for specialty drugs)	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
CHIROPRACTIC BENEFITS	
Chiropractic services[1] (up to 15 visits per calendar year)	$15 per visit
ACUPUNCTURE BENEFITS	
Acupuncture services	$15 per visit
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and preconception physician office visits (for inpatient hospital services, see "Hospitalization Services")	No Charge
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	No Charge
Delivery and all inpatient physician services	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$100 per surgery
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services[1] (Excludes services such as in vitro fertilization. Member share of cost for self-administered drugs for infertility is described under “Prescription Drug Coverage“)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$75 per surgery
REHABILITATION/HABILITATIVE BENEFITS (Physical, Occupational, and Respiratory Therapy)	
Office location	$25 per visit

SPEECH THERAPY BENEFITS	
Office location	$25 per visit
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage")	50%
Diabetes self-management training in an office setting	No Charge
URGENT CARE BENEFITS (BlueCard® Program)	
Urgent services outside your personal physician service area	$25 per visit

PEDIATRIC VISION BENEFITS[17] – 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.

Comprehensive Eye Exam[13]: 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)	No Charge
Optometric - New patient exams (92002/92004) - Established patient exams (92012/92014)	No Charge
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, plastic, or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	No Charge
Optional Lenses and Treatments	
UV coating	No Charge
Polycarbonate lenses	No Charge
Anti-reflective coating	$35
High-index lenses	$30
Photochromic lenses – plastic	$25
Photochromic lenses – glass	$25
Polarized lenses	$45
Standard progressives	$55
Premium progressives	$95
Frame [14] (one frame per calendar year)	
Collection frames 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.	No Charge
Non-Collection frames (V2020)	Covered Up to $150 maximum Allowance
Contact Lenses[15]	
Non-Elective (Medically Necessary) –hard or soft[22]	No Charge
Elective (Cosmetic/Convenience) –standard hard (V2500, V2510)	No Charge
Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	No Charge
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	No Charge
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	No Charge
Other Pediatric Vision Benefits	
Comprehensive low vision exam[22] (Once every 5 Calendar Years)	35%

Low vision devices[22] (One aid per Calendar Year)	35%
Diabetes management referral	No Charge

PEDIATRIC DENTAL BENEFITS[18] – 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 Blue Shield's Dental Plan Administrator..

Diagnostic and Preventive	
Oral exam	No Charge
Preventive – cleaning	No Charge
Preventive – x-ray	No Charge
Sealants per tooth	No Charge
Topical fluoride application	No Charge
Space maintainers – fixed	No Charge
Basic Services[19]	
Restorative procedures	20%
Periodontal maintenance services	20%
Major Services[19]	
Crowns and casts	50%
Endodontics	50%
Periodontics (other than maintenance)	50%
Prosthodontics	50%
Oral surgery	50%
Orthodontics[19,20]	
Medically necessary orthodontics	50%

1. For family coverage, there is 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
   - Family planning benefits: infertility services
   - Chiropractic benefits

   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 exact terms and conditions of coverage.

2. 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.

3. 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.

4. 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.

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. 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 requiring 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.

7. Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment. However, if a brand contraceptive 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 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. 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. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Summary of Benefits and *Evidence of Coverage*. Inpatient services for acute medical detoxification are covered under the medical benefit; see the Hospital Benefits (Facility

Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield participating providers.

9. 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.

10. 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 brand drug and its Tier 1 drug equivalent, in addition to the Tier 1 drug copayment. The difference in cost that the member must pay does not accrue to 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*. Refer to the *Evidence of Coverage* and Summary of Benefits for details.

11. This benefit 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 benefit plan's prescription drug coverage is creditable, you do not have to enroll in 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 any time 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 Part D premium.

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

13. The comprehensive examination benefit allowance does not include fitting and evaluation fees for contact lenses.

14. 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.

15. 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.

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

17. 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.

18. 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 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.

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

20. 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.

blue of california

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 bíiníghah? Doo bíiníghahgóó 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 է՞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 հետևի 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 یاسختان 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 យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាការសរសរបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទស្វាមីឲទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬក្រាមរយៈលេខ (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 โปรดขอความช่วยจากผู้อ่านได้ 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)