

# Small Business Request for Contract Change



## Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Effective July 1, 2018

This form should be used to submit change requests for a small group with respect to its coverage with Blue Shield.

Please provide all requested information to avoid any delay in processing. Subsequent billing will reflect requested changes once processed by Blue Shield.

Return to: **Blue Shield of California**

Complete contract changes online at [blueshieldca.com](http://blueshieldca.com)

### Company information (required) – Please provide all requested information for your group.

Group name	Blue Shield group ID number	Group Tax ID
Renewal date	Group Administrator name	Group Administrator title

Total No. of employees \_\_\_\_\_ Total No. of eligible employees \_\_\_\_\_ Total No. of enrolled employees \_\_\_\_\_  
Total No. of employees declining Blue Shield coverage \_\_\_\_\_

**Note:** An enrollment application or refusal of coverage form is required for each eligible employee. If the group has any eligible employees who are not enrolling/enrolled and who have not provided a Refusal of Coverage form to Blue Shield, please provide completed forms for these individuals with this change form.

Do you offer another carrier's HMO alongside Blue Shield?  Yes  No

Carrier name:

Open enrollment dates:

### Contract change requests – Please complete this section to request administrative or eligibility changes to your group contract.

#### Employment-based affiliation and waiting periods

An employer may impose a bona fide employment-based orientation (affiliation) period for new employees, which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed 90 days.

Please note: If the employer imposes an orientation period, when completing an enrollment form for a new employee, the "date of hire" is the first day after completion of the orientation period.

**Employer orientation period** – Does the group impose an orientation period for new employees?  Yes  No

If yes, is your orientation period 30 days or less?  Yes  No

**Employer waiting period** – The group may select one of the following options. Coverage for an eligible employee will become effective following completion of the waiting period on the day specified.

- Effective first of month following date of hire (If hired on the first of the month, coverage will be effective the first of the following month)
- Effective first of month following 30 days from date of hire
- Effective first of the month following 60 days from date of hire
- Effective on the 91st day following date of hire

**Medical plan employer contribution changes** – Please indicate any change to the group's contribution amounts to employee coverage and/or dependent coverage below. The employer must contribute either (1) at least 50% of the total employee rates, or (2) a defined contribution of a minimum of \$100 per employee (or the cost of the total employee rates, whichever is less) for medical plan coverage.

If 100% of the employee's premium is paid by the employer, all eligible employees must enroll in coverage.

#### Current employer contribution amount

For employees \_\_\_\_\_% or \$ \_\_\_\_\_

For dependents \_\_\_\_\_% or \$ \_\_\_\_\_

#### New employer contribution amount

For employees \_\_\_\_\_% or \$ \_\_\_\_\_

For dependents \_\_\_\_\_% or \$ \_\_\_\_\_

**Domestic partner coverage\*** – Domestic partner eligibility is mandated per California law for any same-sex domestic partner, and opposite-sex couples where at least one partner is at least age 62 and eligible for Social Security (narrow coverage). You have the option to extend domestic partner coverage to opposite-sex couples under age 62 (broad coverage) at renewal by checking the box for "broad" coverage below.

#### Current domestic partner coverage option

Narrow  Broad

#### New domestic partner coverage option

Narrow  Broad

**Employee eligibility changes** – Please indicate any changes to employee eligibility requirements established by the group. For changes in eligibility based on number of hours worked, the most recent filed DE-9C must be provided with this form.

#### Current employee eligibility

- Full time (average of 30 hours per week)
- Both full time and part time (at least 20 but not more than 29 hours per week)

#### New employee eligibility

- Full time (average of 30 hours per week)
- Both full time and part time (at least 20 but not more than 29 hours per week)

\* Coverage applies to Medical, Dental and Vision only.

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**Change in group size and COBRA status** – Please complete this section if employee count has changed to impact whether the group is subject to COBRA or state Cal-COBRA requirements. Please note that Blue Shield must receive COBRA status change requests at the beginning of the calendar year.

- Group is currently subject to federal COBRA and will be subject to Cal-COBRA as of January 1.  
 Group is currently subject to Cal-COBRA and will be subject to federal COBRA as of January 1.

**Electronic Distribution of Evidence of Coverage (EOC) and Notices\*** – The group is responsible for the prompt distribution of the *Evidence of Coverage* booklets and other required coverage notices ("required materials") to covered employees. Electronic versions of required materials are emailed directly to the group administrator.

For printed versions of required materials, please contact us at **(800) 559-5905**.

**Health plan selection – For groups with one or more enrolling employees, the group may select plans from either the Off-Exchange or Mirror package options, but not both. Plan packages can not be combined.**

**Blue Shield of California Off-Exchange Package for Small Business** – The Blue Shield of California Off-Exchange Package is the only package that may be offered alongside another carrier's HMO plan. For groups with one or more enrolling employees offering Blue Shield of California, the group may choose from one up to 31 plans.

First choose plans from the 19 PPO options. You may select any combination of Full PPO, HSA-compatible HDHP, and Tandem PPO plans. Then choose from either the 12 Access+ HMO Network and Trio ACO HMO Network plans, or from the six Local Access+ HMO Network plans. PPO plan selection does not affect HMO plan options.

- Check here to submit a spreadsheet census for existing Off-Exchange plan membership in lieu of individual enrollment forms when making renewal changes to current medical elections. This census template is available on Broker Connection.  
 (Note: A spreadsheet census will only be accepted for currently enrolled employees and dependents.)

**PPO plans** – Full PPO and HSA-compatible HDHP plans share the full Blue Shield provider network. Tandem PPO plans have a select Blue Shield provider network. **You may select any combination of Full PPO Network and Tandem PPO Network plans.**

**Choose up to all 19 plans from the Full PPO Network (including HDHP plans) and the Tandem PPO Network.** Please remember to select all plans that the group would like to offer to all current and future employees.

- Choose all PPO plans **OR** select from individual plans below:

**PPO plans – Full PPO Network**

- Platinum Full PPO 0/10 OffEx
- Platinum Full PPO 250/15 OffEx
- Gold Full PPO 0/20 OffEx
- Gold Full PPO 450/30 OffEx
- Gold Full PPO 750/30 OffEx
- Gold Full PPO 1200/35 OffEx
- Silver Full PPO 1700/55 OffEx
- Silver Full PPO 2000/45 OffEx
- Bronze Full PPO 3750/65 OffEx
- Bronze Full PPO 5700/60 OffEx

**HSA-compatible HDHP plans – Full PPO Network**

- Silver Full PPO Savings 2000/20% OffEx
- Bronze Full PPO Savings 4300/40% OffEx
- Bronze Full PPO Savings 6550 OffEx

**Choosing HealthEquity means Blue Shield shares eligibility and claims data for a seamless experience.**

- Yes, we will offer HealthEquity as the HSA administrator.  
 If you do not select yes, work directly with your own HSA administrator.

**Tandem PPO plans – Tandem PPO Network**

- Platinum Tandem PPO 0/10 OffEx
- Platinum Tandem PPO 250/15 OffEx
- Gold Tandem PPO 750/30 OffEx
- Silver Tandem PPO 1700/55 OffEx
- Silver Tandem PPO 2000/45 OffEx
- Bronze Tandem PPO 3750/65 OffEx

**HMO plans** – Access+ HMO plans, Local Access+ HMO plans and Trio HMO plans have different provider networks. Access+ HMO plans, which have a full network, and Trio HMO plans, which have a select network, may be offered together. Local Access+ HMO plans, however, may **not** be offered with Access+ HMO plans or Trio HMO plans.

**Choose up to all 12 plans from the Access+ HMO Network and Trio ACO HMO Network**

**OR**

**Choose up to all six plans from the Local Access+ HMO Network**

- Choose all Access+ HMO and Trio HMO plans **OR** select from individual plans below:

**Access+ HMO plans – Access+ HMO Network**

- Platinum Access+ HMO® 0/20 OffEx
- Platinum Access+ HMO® 0/25 OffEx
- Platinum Access+ HMO® 0/30 OffEx
- Gold Access+ HMO® 500/35 OffEx
- Gold Access+ HMO® 1700/35 OffEx
- Silver Access+ HMO® 1750/55 OffEx

**Trio HMO plans – Trio ACO HMO Network**

- Platinum Trio HMO 0/20 OffEx
- Platinum Trio HMO 0/25 OffEx
- Platinum Trio HMO 0/30 OffEx
- Gold Trio HMO 500/35 OffEx
- Gold Trio HMO 1700/35 OffEx
- Silver Trio HMO 1750/55 OffEx

- Choose all Local Access+ HMO plans **OR** select from individual plans below:

**Local Access+ HMO plans – Local Access+ HMO Network**

- Platinum Local Access+ HMO® 0/20 OffEx
- Platinum Local Access+ HMO® 0/25 OffEx
- Platinum Local Access+ HMO® 0/30 OffEx
- Gold Local Access+ HMO® 500/35 OffEx
- Gold Local Access+ HMO® 1700/35 OffEx
- Silver Local Access+ HMO® 1750/55 OffEx

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**Blue Shield of California Mirror Package for Small Business** – The plans in these packages “mirror” the standardized plans offered through Covered California. **Mirror package plans cannot be offered alongside our Off-Exchange plan package, or alongside any other carrier’s plans.** Groups with one or more enrolling employees who select this package may select any number of plans from the options below. A group has the option of choosing an HMO plan utilizing the Trio ACO HMO provider network along with a PPO plan utilizing the Full PPO provider network.

Check here to submit a spreadsheet census for existing Mirror plan membership in lieu of individual enrollment forms when making renewal changes to current medical elections. This census template is available on Broker Connection.  
(Note: a spreadsheet census will only be accepted for currently enrolled employees and dependents.)

<b>Platinum Mirror Plans</b> <input type="checkbox"/> Blue Shield Platinum 90 HMO 0/15 Trio + Child Dental <input type="checkbox"/> Blue Shield Platinum 90 PPO 0/15 + Child Dental	<b>Gold Mirror Plans</b> <input type="checkbox"/> Blue Shield Gold 80 HMO 0/25 Trio + Child Dental <input type="checkbox"/> Blue Shield Gold 80 PPO 0/25 + Child Dental
<b>Silver Mirror Plans</b> <input type="checkbox"/> Blue Shield Silver 70 HMO 2000/45 Trio + Child Dental <input type="checkbox"/> Blue Shield Silver 70 PPO 2000/45 + Child Dental	<b>Bronze Mirror Plans</b> <input type="checkbox"/> Blue Shield Bronze 60 PPO 6300/75 + Child Dental

**Optional benefits** – A rider for infertility benefits may be offered with either the Blue Shield of California Off-Exchange Package for Small Business or with the Blue Shield of California Mirror Package for Small Business. If selected, it must be offered with all medical plans – PPO and HMO.

Infertility benefits rider

\* Not applicable to life products.

**Specialty benefits plans – dental,\* vision\* and life insurance\* plan selection – Please complete this section to indicate changes to the group’s specialty benefit plans.**

**Section SB1 – Dental benefits**

**Dental Plan options** – The group may offer Blue Shield dental coverage with or without a medical plan.

When adding dental coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees and dependents elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing dental coverage.

The group may select from one of the plan options below.

**Single Dental Plan option**

**Dual Choice Dental Plan option** – Please select two plans from the options below.

**Triple Choice Dental Plan option** – Available with or without a Blue Shield medical plan. Please select three plans from the options below in one of the following combinations:

<input type="checkbox"/> 2 Dental HMO plans and 1 Dental PPO plan	<input type="checkbox"/> 2 Dental HMO plans and 1 Dental INO plan	<input type="checkbox"/> 3 Dental HMO plans
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The following Triple Choice Dental Plan options are only available when purchased with a Blue Shield medical plan:

<input type="checkbox"/> 2 Dental PPO plans and 1 Dental HMO plan	<input type="checkbox"/> 2 Dental INO plans and 1 Dental HMO plan	<input type="checkbox"/> 1 Dental PPO plan, 1 Dental INO plan, and 1 Dental HMO plan
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**Dental HMO plans**

<input type="checkbox"/> DHMO Basic	<input type="checkbox"/> DHMO Plus	<input type="checkbox"/> DHMO Deluxe	<input type="checkbox"/> DHMO Voluntary
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**Dental PPO plans**

<input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000 <input type="checkbox"/> Ultimate Dental Plus PPO for Small Business 50/2000 <input type="checkbox"/> Smile <sup>SM</sup> Deluxe 2000 50/2000/No Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Deluxe Plus 2000 50/2000/Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Deluxe 50/1500/Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Deluxe Gold 50/1500/Ortho/U85	<input type="checkbox"/> Smile <sup>SM</sup> 50/1500/No Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Plus 50/1500/Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Value 50/1500/No Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Plus Gold 50/1500/Ortho/U85 <input type="checkbox"/> Smile <sup>SM</sup> Basic 75/1000/No Ortho/MAC <input type="checkbox"/> Smile <sup>SM</sup> Basic Voluntary 75/1000/No Ortho/MAC
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**Dental In-Network Only (INO) plans\***

<input type="checkbox"/> Smile <sup>SM</sup> INO Dental Plan 50/1500/Endo-Perio 80%/Ortho <input type="checkbox"/> Smile <sup>SM</sup> INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho <input type="checkbox"/> Smile <sup>SM</sup> INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho <sup>1</sup> <input type="checkbox"/> Smile <sup>SM</sup> INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho <sup>1</sup>	<input type="checkbox"/> Smile <sup>SM</sup> INO Dental Plan 50/2500/Endo-Perio 80%/Ortho <input type="checkbox"/> Smile <sup>SM</sup> INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho <input type="checkbox"/> Smile <sup>SM</sup> INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho <sup>1</sup> <input type="checkbox"/> Smile <sup>SM</sup> INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho <sup>1</sup>
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**Indicate dental plan employer contribution amount here:**

For dental coverage, the employer must contribute at least 50% of the employee's premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

For employees \_\_\_\_\_% or \$ \_\_\_\_\_ For dependents \_\_\_\_\_% or \$ \_\_\_\_\_

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

1 Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

**Section SB2 – Vision coverage**

**Vision coverage\*** – The group may offer Blue Shield vision coverage with or without a medical plan.

When adding vision coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees and dependents elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing vision coverage.

The group may select from one of the plan options below.

<b>Ultimate Vision for Small Business (12-12-12)</b>	<b>Preferred Vision for Small Business (12-12-24)</b>	<b>Enhanced Vision for Small Business (12-24-24)</b>
<input type="checkbox"/> Ultimate Vision Plus 0/0/150/120	<input type="checkbox"/> Preferred Vision Plus 0/0/150/120	<input type="checkbox"/> Enhanced Vision Plus 0/0/150/120
<input type="checkbox"/> Ultimate Vision 0/0/150	<input type="checkbox"/> Preferred Vision 0/0/150	<input type="checkbox"/> Enhanced Vision 0/0/150
<input type="checkbox"/> Ultimate Vision Plus 15/25/150/120	<input type="checkbox"/> Preferred Vision Plus 15/25/150/120	<input type="checkbox"/> Enhanced Vision Plus 15/25/150/120
<input type="checkbox"/> Ultimate Vision 15/25/150	<input type="checkbox"/> Preferred Vision 15/25/150	<input type="checkbox"/> Enhanced Vision 15/25/150
<input type="checkbox"/> Ultimate Vision 0/0/120	<input type="checkbox"/> Preferred Vision 0/0/120	<input type="checkbox"/> Enhanced Vision 0/0/120
<input type="checkbox"/> Ultimate Vision 15/25/120	<input type="checkbox"/> Preferred Vision 15/25/120	<input type="checkbox"/> Enhanced Vision 15/25/120
<input type="checkbox"/> Ultimate Vision Voluntary 15/25/150 <sup>1</sup>	<input type="checkbox"/> Preferred Vision Voluntary 15/25/120 <sup>1</sup>	<input type="checkbox"/> Enhanced Vision Voluntary 15/25/120 <sup>1</sup>

**Indicate vision plan employer contribution amount here:**

For vision coverage, the employer must contribute a minimum of 25% of the total employee premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

For employees \_\_\_\_\_% or \$ \_\_\_\_\_ For dependents \_\_\_\_\_% or \$ \_\_\_\_\_

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

1 Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

**Section SB3 – Life/AD&D insurance**

**Group term life insurance\*** – Requires a minimum of two eligible employees.

The group may offer Blue Shield group term life and AD&D insurance coverage with or without a medical plan.

When adding life insurance coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please complete an enrollment, refusal of coverage, or subscriber change request form for all eligible employees. (Refusal of coverage is only allowed for contributory plans.)

The group may select from one of the plan options and coverage amounts below (if applicable). Flat benefit amounts are available in \$5,000 increments between the designated guaranteed-issue benefit amounts listed. **For groups of 10 or more eligible employees qualifying for composite life insurance rates, a quote must be included with this application.**

**Benefit amount:**

2-9 eligible employees: \$15,000-\$30,000

10-24 eligible employees: \$15,000-\$100,000

25-50 eligible employees: \$15,000-\$150,000

51-100 eligible employees: \$15,000-\$150,000 or \$175,000 or \$200,000

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- Flat amount** – All employees are covered at the same flat amount (up to a maximum benefit amount). \$ \_\_\_\_\_
- Multiple of salary** – All employees are covered for the same multiple of salary at a 1 or 2 times annual salary (up to maximum benefit amount). Benefit amounts established by salary are rounded to the next highest \$1,000.  
\_\_\_\_\_ times salary, maximum \$ \_\_\_\_\_
- Graded** – Employees are covered by class (up to 4), defined with different levels of benefits. The benefit amount for each class must be no more than 2.5 times that of the next lower class.
1. Class description \_\_\_\_\_ flat amount \$ \_\_\_\_\_
2. Class description \_\_\_\_\_ flat amount \$ \_\_\_\_\_
3. Class description \_\_\_\_\_ flat amount \$ \_\_\_\_\_
4. Class description \_\_\_\_\_ flat amount \$ \_\_\_\_\_
- Dependent life insurance** – Coverage amounts listed are per dependent, and are only available for employees electing life insurance. The maximum dependent benefit may not be more than 50% of the employee benefit. Benefits for children age 14 days to 6 months are 10% of the total benefit, and there is no coverage for infants from birth to 14 days. AD&D insurance coverage is not available for dependents.  
(choose one):  \$1,000  \$2,000  \$3,000  \$4,000  \$5,000

**Indicate group term life insurance plan employer contribution amount here:**

For life insurance coverage, the employer must contribute a minimum of 25% of the total employee premium. If a plan is non-contributory (100% paid by the employer), all eligible employees must enroll, no exceptions allowed.

For employees \_\_\_\_\_% or \$ \_\_\_\_\_ For dependents \_\_\_\_\_% or \$ \_\_\_\_\_

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

A46897

**Group representative signature**

The group understands that no requested change(s) will be effective until Blue Shield has processed this request and assigned an effective date. The group or the group's broker will be notified by Blue Shield of the change, or Blue Shield can be contacted for confirmation.

\_\_\_\_\_  
**Authorized group representative signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Group representative name (please print)**

\_\_\_\_\_  
**Group representative title (please print)**

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, 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: (844) 696-6070**

**Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto: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](http://www.hhs.gov/ocr/office/file/index.html).

# Notice of the Availability of Language Assistance Services Blue Shield of California

**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。如需免費幫助，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' ákohwiindzindoogí:** Díí naaltsoosish yíiniłta'go bíniǰhah? Doo bíniǰhahgóó éí, naaltsoos nich'í' yiidóoltaǰíí ła' nihee hółó. Díí naaltsoos atdó' t'áá Diné k'ehjí ádoolnííł nínízingo bíǰhah. Doo baǰah ílinígó shíká' adoowoł nínízingó nihich'í' béesh bee hodíilnih dóó námboo éí díí Blue Shield bee ného'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodíilnih. (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)

**મહમ:** آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیاراتان 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 شناسایی Blue Shield تان درج شده است و یا از طریق شماره تلفن (866) 346-7198 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। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់៖** តើអ្នកអាចលិខិតនេះ បានដើរឬទេ? 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 (866) 346-7198. (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 โปรดขอความช่วยเหลือจากผู้อ่านได้ 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। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मँबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສໍາຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສໍາລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

# Notice of the Availability of Language Assistance Services

## Blue Shield of California Life & Health Insurance Company

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。** 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

**Անվճար Լեզվական Ծառայություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

**خدمات مجانی مربوط به زبان.** میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាភាគីតិចថ្លៃ។** អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយសូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

**خدمات ترجمه بدون تکلفة.** يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357 Arabic.

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากสาม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

**Doo bááh ílínígó saad bee yát'i' bee aná'áwo'.** Díí shá ata'halne'dooígí hólóqodoo nínízingo éí bííghah. Naaltsoos naanínáhájeehígí shich'í' yíidooltah éí doodagó ła' shich'í' ádoolnííł nínízingo bííghah. Shíká a'doowoł nínízingo nihich'í' béesh bee hodíílnih dóo námbóo éí díí ninaaltsoos dootł'ízhígí bee néího'díłzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jí' hodíílnih. Hózhq' shíká anáá'doowoł nínízingo éí díí béeso ách'áah naa'nil bíł haz'áají' 1-800-927-4357jí' hodíílnih. Navajo

**ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ.** ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີ ໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ 1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ 1-800-927-4357. Laotian