

Summary of Benefits

Bronze Tandem PPO 4500/70 OffEx

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

Provider Network:

Tandem PPO Network

This benefit Plan uses a specific network of Health Care Providers, called the Tandem PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating Provider ³	When using any combination of Participating ³ and Non-Participating ⁴ Providers
Calendar Year medical and pharmacy Deductible	<i>Individual coverage</i>	\$4,500	\$9,000
<i>This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible</i>	<i>Family coverage</i>	\$4,500: individual \$9,000: Family	\$9,000: individual \$18,000: Family

Calendar Year Out-of-Pocket Maximum⁵

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider ³	When using any combination of Participating ³ or Non-Participating ⁴ Providers
<i>Individual coverage</i>	\$7,350	\$12,550
<i>Family coverage</i>	\$7,350: individual \$14,700: Family	\$12,550: individual \$25,100: Family

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Preventive Health Services⁷	\$0		Not covered	
California Prenatal Screening Program	\$0		\$0	
Physician services				
Primary care office visit	\$70/visit	✓	50%	✓
Specialist care office visit	\$90/visit	✓	50%	✓
Physician home visit	\$70/visit	✓	50%	✓
Physician or surgeon services in an Outpatient Facility	30%	✓	50%	✓
Physician or surgeon services in an inpatient facility	30%	✓	50%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$70/visit	✓	50%	✓
Acupuncture services	\$25/visit	✓	50%	✓
Chiropractic services <i>Up to 12 visits per Member, per Calendar Year.</i>	50%		50%	
Teladoc consultation	\$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	30%	✓	Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	\$90/visit	✓	50%	✓
Pregnancy and maternity care⁷				
Physician office visits: prenatal and initial postnatal	\$0		50%	✓
Physician services for pregnancy termination	30%	✓	50%	✓
Emergency services				
Emergency room services <i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>	50%	✓	50%	✓
Emergency room Physician services	30%	✓	30%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Urgent care center services	\$70/visit	✓	50%	✓
Ambulance services <i>This payment is for emergency or authorized transport.</i>	30%	✓	30%	✓
Outpatient Facility services				
Ambulatory Surgery Center	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
Outpatient department of a Hospital: surgery	\$200/surgery plus 30%	✓	50% up to \$350/day plus 100% of additional charges	✓
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
Inpatient facility services				
Hospital services and stay	30%	✓	50% up to \$2000/day plus 100% of additional charges	✓
Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>				
• Special transplant facility inpatient services	30%	✓	Not covered	
• Physician inpatient services	30%	✓	Not covered	
Bariatric surgery services, designated California counties <i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and Outpatient Physician services payments apply.</i>				
Inpatient facility services	30%	✓	Not covered	

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Outpatient Facility services	\$200/surgery plus 30%	✓	Not covered	
Physician services	30%	✓	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>				
Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i>				
<ul style="list-style-type: none"> Laboratory center 	30%	✓	50%	✓
<ul style="list-style-type: none"> Outpatient department of a Hospital 	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
X-ray and imaging services <i>Includes diagnostic mammography.</i>				
<ul style="list-style-type: none"> Outpatient radiology center 	30%	✓	50%	✓
<ul style="list-style-type: none"> Outpatient department of a Hospital 	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
Other outpatient diagnostic testing <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>				
<ul style="list-style-type: none"> Office location 	30%	✓	50%	✓
<ul style="list-style-type: none"> Outpatient department of a Hospital 	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
Radiological and nuclear imaging services				
<ul style="list-style-type: none"> Outpatient radiology center 	30%	✓	50%	✓
<ul style="list-style-type: none"> Outpatient department of a Hospital 	\$100/visit plus 30%	✓	50% up to \$350/day plus 100% of additional charges	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Rehabilitative and Habilitative Services <i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.</i>				
Office location	\$70/visit	✓	50%	✓
Outpatient department of a Hospital	\$70/visit	✓	50% up to \$350/day plus 100% of additional charges	✓
Durable medical equipment (DME)				
DME	50%	✓	Not covered	
Breast pump	\$0		Not covered	
Orthotic equipment and devices	30%	✓	Not covered	
Prosthetic equipment and devices	30%	✓	Not covered	
Home health services <i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period, except hemophilia and home infusion nursing visits.</i>				
Home health agency services <i>Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i>	30%	✓	Not covered	
Home visits by an infusion nurse	30%	✓	Not covered	
Home health medical supplies	30%	✓	Not covered	
Home infusion agency services	30%	✓	Not covered	
Hemophilia home infusion services <i>Includes blood factor products.</i>	30%	✓	Not covered	
Skilled Nursing Facility (SNF) services <i>Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>				
Freestanding SNF	30%	✓	30%	✓
Hospital-based SNF	30%	✓	50% up to \$2000/day plus 100% of additional charges	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Hospice program services <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0	✓	Not covered	
Other services and supplies Diabetes care services <ul style="list-style-type: none"> • Devices, equipment, and supplies • Self-management training 	50%	✓	Not covered	
Dialysis services	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
PKU product formulas and Special Food Products	30%	✓	30%	✓
Allergy serum billed separately from an office visit	30%	✓	50%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).</i>	When using a MHSA Participating Provider ³	CYD ² applies	When using a MHSA Non-Participating Provider ⁴	CYD ² applies
Outpatient services Office visit, including Physician office visit	\$70/visit	✓	50%	✓
Other outpatient services, including intensive outpatient care, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	30%	✓	50%	✓
Partial Hospitalization Program	30%	✓	50% up to \$350/day plus 100% of additional charges	✓
Psychological Testing	30%	✓	50%	✓
Inpatient services Physician inpatient services	30%	✓	50%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).</i>	When using a MHA Participating Provider ³	CYD ² applies	When using a MHA Non-Participating Provider ⁴	CYD ² applies
Hospital services	30%	✓	50% up to \$2000/day plus 100% of additional charges	✓
Residential Care	30%	✓	50% up to \$2000/day plus 100% of additional charges	✓

Prescription Drug Benefits^{8,9}

Your payment

<i>Pharmacy Network: Rx Spectrum Drug Formulary: Standard Formulary</i>	When using a Participating Pharmacy ³		CYD ² applies	When using a Non-Participating Pharmacy ⁴	CYD ² applies
	Level A	Level B			
Retail pharmacy prescription Drugs					
<i>Per prescription, up to a 30-day supply.</i>					
Tier 1 Drugs	\$20/prescription	\$25/prescription	✓	Not covered	
Tier 2 Drugs	\$55/prescription	\$85/prescription	✓	Not covered	
Tier 3 Drugs	\$80/prescription	\$130 /prescription	✓	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30 % up to \$ 500 /prescription	30 % up to \$ 500 /prescription	✓	Not covered	
Contraceptive Drugs and devices	\$0	\$0		Not covered	
Mail service pharmacy prescription Drugs					
<i>Per prescription, up to a 90-day supply.</i>					
Tier 1 Drugs		\$40/ prescription	✓	Not covered	
Tier 2 Drugs		\$110/ prescription	✓	Not covered	
Tier 3 Drugs		\$160/ prescription	✓	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)		30% up to \$1000/ prescription	✓	Not covered	
Contraceptive Drugs and devices		\$0		Not covered	

Prescription Drug Benefits^{8,9}

Your payment

Pharmacy Network: Rx Spectrum Drug Formulary: Standard Formulary	When using a Participating Pharmacy ³		CYD ² applies	When using a Non-Participating Pharmacy ⁴	CYD ² applies
	Level A	Level B			
Specialty Drugs <i>Per prescription. Specialty Drugs are covered at tier 4 and only when dispensed by a Network Specialty Pharmacy.</i>		30% up to \$500/ prescription	✓	Not covered	
Oral Anticancer Drugs <i>Per prescription, up to a 30-day supply.</i>		30% up to \$200/ prescription		Not covered	

Pediatric Benefits

Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	When using a Participating Dentist ³	CYD ² applies	When using a Non-Participating Dentist ⁴	CYD ² applies
Pediatric dental¹⁰ Diagnostic and preventive services <ul style="list-style-type: none"> • Oral exam \$0 • Preventive – cleaning \$0 • Preventive – x-ray \$0 • Sealants per tooth \$0 • Topical fluoride application \$0 • Space maintainers - fixed \$0 Basic services <ul style="list-style-type: none"> • Restorative procedures 20% • Periodontal maintenance 20% Major services <ul style="list-style-type: none"> • Oral surgery 50% • Endodontics 50% • Periodontics (other than maintenance) 50% • Crowns and casts 50% • Prosthodontics 50% Orthodontics (Medically Necessary) 50%				

Pediatric Benefits

Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Pediatric vision¹¹				
Comprehensive eye examination <i>One exam per Calendar Year.</i>				
• Ophthalmologic visit	\$0		All charges above \$30	
• Optometric visit	\$0		All charges above \$30	
Eyewear/materials				
<i>One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.</i>				
• Contact lenses				
Non-elective (Medically Necessary) - hard or soft	\$0		All charges above \$225	
<i>Up to two pairs per eye per Calendar Year.</i>				
Elective (cosmetic/convenience)				
Standard and non-standard, hard	\$0		All charges above \$75	
<i>Up to a 3 month supply for each eye per Calendar Year based on lenses selected.</i>				
Standard and non-standard, soft	\$0		All charges above \$75	
<i>Up to a 6 month supply for each eye per Calendar Year based on lenses selected.</i>				
• Eyeglass frames				
Collection frames	\$0		All charges above \$40	
Non-collection frames	All charges above \$150		All charges above \$40	
• Eyeglass lenses				
<i>Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.</i>				
Single vision	\$0		All charges above \$25	
Lined bifocal	\$0		All charges above \$35	
Lined trifocal	\$0		All charges above \$45	

Pediatric Benefits

Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Lenticular	\$0		All charges above \$45	
Optional eyeglass lenses and treatments				
• Ultraviolet protective coating (standard only)	\$0		Not covered	
• Polycarbonate lenses	\$0		Not covered	
• Standard progressive lenses	\$55		Not covered	
• Premium progressive lenses	\$95		Not covered	
• Anti-reflective lens coating (standard only)	\$35		Not covered	
• Photochromic - glass lenses	\$25		Not covered	
• Photochromic - plastic lenses	\$25		Not covered	
• High index lenses	\$30		Not covered	
• Polarized lenses	\$45		Not covered	
Low vision testing and equipment				
• Comprehensive low vision exam <i>Once every 5 Calendar Years.</i>	35%		Not covered	
• Low vision devices <i>One aid per Calendar Year.</i>	35%		Not covered	
Diabetes management referral	\$0		Not covered	

Prior Authorization

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

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from Non-Participating Providers
- Pediatric vision non-elective contact lenses and low vision testing and equipment
- Mental health services, except outpatient office visits, electroconvulsive therapy, and Psychological Testing
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

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

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

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

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

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

This benefit plan has separate Deductibles for:

- Participating Provider Deductible and Non-Participating Provider Deductible

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

3 Using Participating Providers:

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

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

Participating Pharmacies. Blue Shield has two participation levels for retail pharmacies: Level A and Level B. You can go to any Level A or Level B pharmacy to obtain covered Drugs.

4 Using Non-Participating Providers:

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

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

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

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

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

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

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

Essential health benefits count towards the OOPM.

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

This benefit Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

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

6 Separate Member Payments When Multiple Covered Services are Received:

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

7 Preventive Health Services:

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

8 Outpatient Prescription Drug Coverage:

Medicare Part D-non-creditable coverage-

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

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

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

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

Notes

10 Pediatric Dental Coverage:

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

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

11 Pediatric Vision Coverage:

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

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

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

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

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

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

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

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

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

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' ákohwiindzindooígí: Díí naaltsoosísh yíiniłta'go bíinígah? Doo bíinígahgóó éí, naaltsoos nich'í' yíidóolta'hígíí ła' nihee hółó. Díí naaltsoos áldó' t'áá Diné k'ehjí ádoonííł nínízingo bíighah. Doo ąąah ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodiilnih dóó námboo éí díí Blue Shield bee néiho'díłzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jí' hodiilnih. (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 اختیاران 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)

ਮਰੱਤਵਪੂਰਨ: 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 បានដែរឬទេ? បើមិនអាចទេ យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទក្លាមញ់ទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្ទងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما لمساعدك 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 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 मंबर/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)