

Changes to All Small Business PPO plans (Off-Exchange) Blue Shield of California

As of January 1, 2017

This notice describes changes and clarifications to your Blue Shield health coverage upon the group's renewal date. For detailed information about these changes, please read the *Evidence of Coverage* (EOC) and *Summary of Benefits* (SOB). If you have any questions about the changes listed below, please contact your Blue Shield representative or call Group Employer Services at **(800) 325-5166**.

The following changes are made to your health plan.

Description	Summary
Oral Anticancer Medications	<i>Pursuant to state regulatory requirements, oral anticancer medications are no longer subject to deductible. Previously, these drugs were subject to a pharmacy deductible.</i>
Calendar-Year Medical Deductible	<p><i>In accordance with 2017 IRS guidelines, the calendar-year medical deductible for covered services from participating providers has been altered for the following plans:</i></p> <p><i>The Silver Full PPO 1250/40 OffEx plan will increase from \$1,250 individual/\$2,500 family to \$1,300 individual/\$2,600 family</i></p> <p><i>The Bronze Full PPO 3500/60 OffEx plan will increase from \$3,500 individual/\$7,000 family to \$3,750 individual/\$7,500 family</i></p> <p><i>The Bronze Full PPO 4500/45 OffEx plan will increase from \$4,500 individual/\$9,000 family to \$5,100 individual/\$10,200 family</i></p> <p><i>The calendar-year medical deductible for covered services from non-participating providers has been altered for the following plans:</i></p> <p><i>The Silver Full PPO 1250/40 OffEx plan will increase from \$2,500 individual/\$5,000 family to \$2,600 individual/\$5,200 family</i></p> <p><i>The Bronze Full PPO 3500/60 OffEx plan will increase from \$7,000 individual/\$14,000 family to \$7,500 individual/\$15,000 family</i></p> <p><i>The Bronze Full PPO 4500/45 OffEx plan will increase from \$4,500 individual/\$9,000 family to \$5,100 individual/\$10,200 family</i></p>

A47514 (1/17)

	<p><i>The previous plans have changed from :</i> <i>Silver Full PPO 1250/40 OffEx</i> <i>Bronze Full PPO 3500/60 OffEx</i> <i>Bronze Full PPO 4500/45 OffEx</i></p> <p><i>to:</i> <i>Silver Full PPO 1300/45 OffEx</i> <i>Bronze Full PPO 3750/65 OffEx</i> <i>Bronze Full PPO 5100/60 OffEx</i></p>
<p>Calendar-Year Pharmacy Deductible</p>	<p><i>In accordance with 2017 IRS guidelines, the calendar-year pharmacy deductible for covered drugs from participating providers has been altered for the following plans:</i></p> <p><i>The Bronze Full PPO 5100/60 OffEx plan will decrease from \$225 individual/\$450 family to \$200 individual/\$400 family</i></p>
<p>Calendar-Year Out-of-Pocket Maximum</p>	<p><i>In accordance with 2017 IRS guidelines, the calendar-year out-of-pocket maximums for covered services from participating providers have been altered for the following plans:</i></p> <p><i>The Gold Full PPO 0/20 OffEx plan will increase from \$6,500 individual/\$13,000 family to \$6,800 individual/\$13,600 family;</i></p> <p><i>The Gold Full PPO 250/20 OffEx plan will increase from \$6,500 individual/\$13,000 family to \$6,800 individual/\$13,600 family;</i></p> <p><i>The Silver Full PPO 1300/45 OffEx plan will increase from \$6,500 individual/\$13,000 family to \$6,800 individual/\$13,600 family</i></p> <p><i>The Silver Full PPO 1700/40 OffEx plan will increase from \$6,500 individual/\$13,000 family to \$6,800 individual/\$13,600 family</i></p> <p><i>The Bronze Full PPO 3750/65 OffEx plan will increase from \$6,500 individual/\$13,000 family to \$6,800 individual/\$13,600 family;</i></p> <p><i>The Bronze Full PPO 5100/60 OffEx plan will increase from \$6,500 individual/\$13,000 family to \$6,800 individual/\$13,600 family</i></p>
<p>Primary Care Physician Office Visit</p>	<p><i>Pursuant to a standard plan design established by Covered California, the copayment for primary care physician office visits will be changing for the following plans:</i></p> <p><i>The Gold Full PPO 250/20 OffEx plan will increase from \$20 per visit to \$30 per visit</i></p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

	<p><i>The Silver Full PPO 1300/45 OffEx plan will increase from \$40 per visit to \$45 per visit</i></p> <p><i>The Bronze Full PPO 3750/65 OffEx plan will increase from \$60 per visit to \$65 per visit</i></p> <p><i>The Bronze Full PPO 5100/60 OffEx plan will increase from \$45 per visit to \$60 per visit for the first three visits per calendar year prior to the deductible</i></p> <p><i>The previous plan has changed from:</i> <i>Gold Full PPO 250/20 OffEx</i></p> <p><i>To:</i> <i>Gold Full PPO 250/30 OffEx</i></p>
<p>Specialist Physician Office Visit</p>	<p><i>Pursuant to a standard plan design established by Covered California, the copayment for specialist physician office visits when referred by a physician will be changing for the following plans:</i></p> <p><i>The Gold Full PPO 0/20 OffEx plan will increase from \$45 per visit to \$60 per visit</i></p> <p><i>The Gold Full PPO 250/30 OffEx plan will increase from \$40 per visit to \$50 per visit</i></p> <p><i>The Silver Full PPO 1300/45 OffEx plan will increase from \$50 per visit to \$60 per visit</i></p> <p><i>The Silver Full PPO 1700/40 OffEx plan will increase from \$50 per visit to \$70 per visit</i></p> <p><i>The Bronze Full PPO 3750/65 OffEx plan will increase from \$70 per visit to \$85 per visit</i></p> <p><i>The Bronze Full PPO 5100/60 OffEx plan will increase from \$45 per visit to \$70 per visit for the first three visits per calendar year prior to the deductible</i></p>
<p>Plan coinsurance</p>	<p><i>To maintain the actuarial value of the health plan, Blue Shield will change the plan coinsurances for participating providers as follows:</i></p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

	<p><i>For the Bronze Full PPO 3750/60 OffEx plan, the coinsurance will decrease from 15% to 10%</i></p> <p><i>For the Bronze Full PPO 5100/60 OffEx plan, the coinsurance will decrease from 30% to 15%</i></p> <p><i>Covered services include: allergy serum purchases, emergency or authorized transport by ambulance, ambulatory surgery center, bariatric surgery, dialysis center, emergency room physician services, emergency room facility services resulting in admission, vasectomy, home health care, inpatient and outpatient facility services, inpatient and non-routine outpatient mental health and substance use disorder services, orthotics and prosthetics, outpatient x-ray and imaging, abortion, and skilled nursing facility</i></p>
Diabetes Care	<p><i>Pursuant to a standard plan design established by Covered California, office visits for Health Education Services, such as diabetes self-management training, shall be offered with no cost imposed on the member for the visit.</i></p>
Professional benefits	<p><i>Blue Shield is offering a new service addition for 2017. Teladoc benefits will be included in all health plans effective January 1, 2017. This was previously a buy-up service which is now being implemented as a standard plan benefit at a rate of \$5 per consultation with participating providers. In addition, this benefit is not subject to the medical deductible, where applicable.</i></p>
Emergency Services	<p><i>To maintain the actuarial value of the health plan, emergency room facility services not resulting in admission have changed for the following plans:</i></p> <p><i>The Gold Full PPO 0/20 OffEx plan increased from \$100 per visit plus an additional 30% to \$250 per visit plus an additional 30%</i></p> <p><i>The Gold Full PPO 250/30 OffEx plan increased from \$100 per visit plus an additional 20% to \$200 per visit plus an additional 20%</i></p> <p><i>The Silver Full PPO 1300/45 OffEx plan increased from \$150 per visit plus an additional 40% to \$250 per visit plus an additional 40%</i></p> <p><i>The Silver Full PPO 1700/40 OffEx plan increased from \$200 per visit plus an additional 30% to \$250 per visit plus an additional 30%</i></p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

<p>Outpatient Prescription Drugs</p>	<p>To maintain the actuarial value of the health plan, the cost of Tier 2 drugs obtained at a participating pharmacy has increased from \$50 per prescription to \$55 per prescription at retail pharmacies and from \$100 per prescription to \$110 per prescription at mail-service pharmacies for the Silver Full PPO 1300/45 OffEx plan.</p>
<p>Rehabilitation and Habilitative Services and Speech Therapy</p>	<p>To maintain the actuarial value of the health plan and align with current portfolio designs, these two benefits Rehabilitation and Habilitative Services (Physical, Occupational, and Respiratory Therapy) and Speech Therapy will be billed according to the Physician Office Visit amount. The coverage has changed from 30% coinsurance per visit to \$60 copayment per visit for the Bronze Full PPO 5100/60 OffEx plan.</p>
<p>Partial Hospitalization Services</p>	<p>To maintain the actuarial value of the health plan, Partial Hospitalization services for Mental Health, Behavioral Health, and/or Substance Use Disorder are not subject to a daily maximum. Previously, there was a \$350 daily maximum imposed on these benefits for the following plans:</p> <p>Silver Full PPO 1300/45 OffEx Silver Full PPO 1700/40 OffEx Bronze Full PPO 3750/65 OffEx Bronze Full PPO 5100/60 OffEx</p>

The following clarifications are made to the description of benefits of your health plan.

Description	Summary
<p>Mental Health and Substance Use Disorder</p>	<p>In order to clarify benefit intent, the following changes have been made to the Mental Health Section of the SOB:</p> <p>Clearly distinguish "Mental Health and Behavioral Health – Non Routine Outpatient Services" from "Routine Outpatient Services"</p> <p>Similarly, the following clarification has been made to the Substance Use Disorder section of the SOB in order to align with the Mental Health section:</p> <p>The Outpatient services have been split out into two subgroupings, Substance Use Disorder – Routine</p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

	<p><i>Outpatient Services and Non-Routine Outpatient Services</i></p> <p><i>Due to system limitations, for both the Mental Health and Substance Use Disorder Sections, the line item for "Post-discharge ancillary care" has been removed from the SOB, but continues to be covered and adjudicated with no change.</i></p> <p><i>In order to align with Covered California naming conventions, for the Routine Outpatient Services for Substance Use Disorder, Office-Based Opioid Treatment (OBOT) has been redefined as "Office Based Opioid Detoxification and/or Maintenance Therapy".</i></p>
<p>Pregnancy and Maternity Care</p>	<p><i>In order to clarify benefit intent, the following change has been made to the SOB:</i></p> <p><i>The Postnatal physician office visit now represents the cost of the initial visit, rather than that of the subsequent visit.</i></p>
<p>Professional Benefits</p>	<p><i>In order to align with standard Covered California plan designs, the Physician Home Visit is now considered a Specialist Office Visit and is paid at that benefit copayment for each plan. The following plans have had a change in coverage:</i></p> <p><i>Platinum Full PPO 0/10 OffEx plan had a change from 10% coinsurance to \$25 per visit</i></p> <p><i>Platinum Full PPO 150/15 OffEx plan had a change from 10% coinsurance to \$30 per visit</i></p> <p><i>Gold Full PPO 0/20 OffEx had a change from 30% coinsurance to \$60 per visit</i></p> <p><i>Gold Full PPO 250/30 OffEx had a change from 20% coinsurance to \$50 per visit.</i></p> <p><i>Gold Full PPO 750/20 OffEx had a change from 20% coinsurance to \$35 per visit</i></p> <p><i>Gold Full PPO 1000/35 OffEx had a change from 20% coinsurance to \$50 per visit</i></p> <p><i>Silver Full PPO 1300/45 OffEx plan had a change from 40% coinsurance to \$60 per visit</i></p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

	<p><i>Silver Full PPO 1700/40 OffEx plan had a change from 30% coinsurance to \$70 per visit</i></p> <p><i>Bronze Full PPO 3750/65 OffEx had a change from 15% coinsurance to \$85 per visit</i></p> <p><i>Bronze Full PPO 5100/60 OffEx had a change from 30% coinsurance to \$70 per visit</i></p>
<p>Pediatric Vision</p>	<p><i>Due to requirements provided by the Department of Managed Healthcare, the following clarifications have been made to the SOB:</i></p> <p><i>For Eyewear/Materials, it is made clear that within a given calendar year, there is coverage for either a pair of eyeglasses or a set of contact lenses (a one year supply), but not both.</i></p> <p><i>For the Optional Lenses and Treatment section, Polycarbonate Lenses is given a full benefit line item as opposed to being described in text only in the Lenses section.</i></p> <p><i>For the Low-Vision Testing and Equipment section, two additional line items have been inserted to provide a comprehensive description of this benefit. These two benefits are:</i></p> <ul style="list-style-type: none"> <i>a) Comprehensive Low Vision Exam, once every five Calendar Years; and</i> <i>b) Low Vision Devices, one aid per calendar year.</i>
<p>Pediatric Dental</p>	<p><i>Due to requirements provided by the Department of Managed Health Care, the following clarifications have been made to the SOB:</i></p> <p><i>The entire benefit matrix for embedded Pediatric Dental has been brought into alignment with On Exchange plan designs. This entails a regrouping of dental benefits into the following sub-benefits:</i></p> <ul style="list-style-type: none"> <i>a) Diagnostic and Preventive;</i> <i>b) Basic Services;</i> <i>c) Major Services; and</i> <i>d) Orthodontics</i> <p><i>The Diagnostic and Preventive Dental section has been further expanded to provide a more comprehensive understanding of</i></p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

	<p><i>covered benefits, which are at no cost to the member. These services include: oral exams, preventive X-rays and cleanings, tooth sealants, topical fluoride applications, and fixed space maintainers.</i></p>
<p>Endnotes</p>	<p><i>Due to requirements provided by the Department of Managed Health Care, the following changes have occurred in the endnote section of the SOB across the entire portfolio:</i></p> <p><i>Three endnotes concerning specific Pediatric Dental benefits have been removed entirely. This includes:</i></p> <ul style="list-style-type: none"> <i>a) Caries-Risk Management Assessment (CAMBRA);</i> <i>b) Posterior Composite Resin, or Acrylic Restorations;</i> <i>and</i> <i>c) Medically Necessary Orthodontia.</i>
<p>Outpatient Prescription Drugs</p>	<p><i>Effective January 1, 2017, in accordance with California law, all contraceptive medication must be provided with no payment imposed upon the member. The "Outpatient Prescription Drug Benefits" section of the EOC has an addition that reads as follows:</i></p> <p><i>"There is no Copayment or Coinsurance for generic FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance when Medically Necessary. See Prior Authorization/Exception Request Process/Step Therapy section."</i></p> <p><i>There is also a new legislative requirement for the provision of step therapy, also in the "Outpatient Prescription Drug Benefits" section of the EOC:</i></p> <p><i>"Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. If step therapy coverage</i></p>

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage, the Summary of Benefits, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation

	<p><i>requirements are not met for a prescription and your Physician believes the medication is Medically Necessary, the prior authorization process may be utilized and timeframes previously described will also apply."</i></p>
--	--



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 naaltsoosish yíiniłta'go bíinígahah? Doo bíinígahgóó éí, naaltsoos nich'í' yiidóoltahígíí ła' nihee hółó. Díí naaltsoos áłdó' t'áá Diné k'ehjí ádoolníł nínízingo bíighah. Doo ąąąh ilínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodílnih dóó námboo éí díí Blue Shield bee néiho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodílnih. (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: Օտարությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

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

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

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات 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 បានដែរឬទេ? បើមិនអាចទេ យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ 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 nrhiv 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 मੈਂबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)