Small Business Request for Contract Change

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

Effective July 1, 2020

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**

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 number of employees _____ **Total number of eligible employees** _____ **Total number of enrolled employees** _____
Total number 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	**New employer contribution amount**
For employees _____ % or $ _____	For employees _____ % or $ _____
For dependents _____ % or $ _____	For dependents _____ % or $ _____

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	**New employee eligibility**
☐ Full time (average of 30 hours per week)	☐ 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)	☐ 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.

☐ As of January 1, 2020, our COBRA status is Cal-COBRA **OR** ☐ As of January 1, 2020, our COBRA status is Federal COBRA.

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 48 plans.

☐ 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 32 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 0/0 OffEx
☐ Platinum Full PPO 0/10 OffEx
☐ Platinum Full PPO 250/15 OffEx
☐ Gold Full PPO 0/20 OffEx
☐ Gold Full PPO 500/30 OffEx
☐ Gold Full PPO 750/30 OffEx
☐ Gold Full PPO 1200/35 OffEx
☐ Silver Full PPO 1800/55 OffEx
☐ Silver Full PPO 2300/45 OffEx
☐ Bronze Full PPO 5000/70 OffEx
☐ Bronze Full PPO 6850/65 OffEx
☐ Bronze Full PPO 6500/50 OffEx

HSA-compatible HDHP plans – Full PPO Network

☐ Silver Full PPO Savings 2000/25% OffEx
☐ Silver Full PPO Savings 2500/35% OffEx
☐ Bronze Full PPO Savings 5300/40% OffEx
☐ Bronze Full PPO Savings 6900 OffEx

HSA-compatible HDHP plans – Tandem PPO Network

☐ Silver Tandem PPO Savings 2000/25% OffEx
☐ Silver Tandem PPO Savings 2500/35% OffEx
☐ Bronze Tandem PPO Savings 5300/40% OffEx
☐ Bronze Tandem PPO Savings 6900 OffEx

Tandem PPO plans – Tandem PPO Network

☐ Platinum Tandem PPO 0/0 OffEx
☐ Platinum Tandem PPO 0/10 OffEx
☐ Platinum Tandem PPO 250/15 OffEx
☐ Gold Tandem PPO 0/20 OffEx
☐ Gold Tandem PPO 500/30 OffEx
☐ Gold Tandem PPO 750/30 OffEx
☐ Gold Tandem PPO 1200/35 OffEx
☐ Silver Tandem PPO 1800/55 OffEx
☐ Silver Tandem PPO 2300/45 OffEx
☐ Bronze Tandem PPO 5000/70 OffEx
☐ Bronze Tandem PPO 6500/50 OffEx
☐ Bronze Tandem PPO 6850/65 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.

HMO plans – Access+ HMO plans, Local Access+ HMO plans, and Trio HMO plans have different provider networks. Local Access+ and Trio are select networks and Access+ is a full network. Access+ and Local Access+ networks may not be offered together.

Choose up to 16 plans from the Access+ HMO Network and the Trio ACO HMO Network or up to 16 plans from the Local Access+ HMO Network and the Trio ACO HMO Network.

☐ Choose all Trio and Local Access+ plans **OR**
☐ Choose all Trio and Access+ Plans **OR**
☐ Individually choose Trio/Access+ or Trio/Local Access+ from 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® 0/30 OffEx
☐ Gold Access+ HMO® 500/35 OffEx
☐ Gold Access+ HMO® 1000/35 OffEx
☐ Gold Access+ HMO® 1500/35 OffEx
☐ Silver Access+ HMO® 2350/65 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 0/30 OffEx
☐ Gold Trio HMO 500/35 OffEx
☐ Gold Trio HMO 1000/35 OffEx
☐ Gold Trio HMO 1500/35 OffEx
☐ Silver Trio HMO 2350/65 OffEx

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® 0/30 OffEx
☐ Gold Local Access+ HMO® 500/35 OffEx
☐ Gold Local Access+ HMO® 1000/35 OffEx
☐ Gold Local Access+ HMO® 1500/35 OffEx
☐ Silver Local Access+ HMO® 2350/65 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.)

Platinum Mirror Plans
- ☐ Blue Shield Trio Platinum 90 HMO 0/15 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental

Gold Mirror Plans
- ☐ Blue Shield Trio Gold 80 HMO 250/25 + Child Dental
- ☐ Blue Shield Gold 80 PPO 250/25 + Child Dental

Silver Mirror Plans
- ☐ Blue Shield Trio Silver 70 HMO 2250/50 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2250/50 + Child Dental

Bronze Mirror Plans
- ☐ Blue Shield Bronze 60 PPO 6300/65 + 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.

☐ Add Infertility benefits rider – If selected, infertility benefits rider will be added to all medical plans – PPO and HMO.

☐ Remove infertility benefits rider – If selected, infertility benefits rider will be removed from all medical plans – PPO and HMO.

* 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.

☐ **No change to dental benefits**

☐ 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:

- ☐ 2 Dental HMO plans and 1 Dental PPO plan
- ☐ 3 Dental HMO plans

The following Triple Choice Dental Plan option is only available when purchased with a Blue Shield medical plan:

☐ 2 Dental PPO plans and 1 Dental HMO plan (The two Dental PPO plans must have the same Orthodontic benefit.)

Dental HMO plans

- ☐ DHMO Basic
- ☐ DHMO Standard
- ☐ DHMO Plus
- ☐ DHMO Deluxe
- ☐ DHMO Voluntary

Dental PPO plans

- ☐ Smile℠ Value 50/1500/No Ortho/MAC/NR
- ☐ Smile℠ 50/1500/No Ortho/MAC/NR
- ☐ Smile℠ Plus 50/1500/Ortho/MAC/NR
- ☐ Smile℠ Basic 75/1000/No Ortho/MAC/NR
- ☐ Smile℠ Basic 50/1000/No Ortho/MAC
- ☐ Smile℠ Basic 50/1000/Ortho/U85
- ☐ Smile℠ Plus 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus 50/1500/No Ortho/MAC/WP*
- ☐ Smile℠ Deluxe 50/1500/Ortho/MAC/NR
- ☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC/NR
- ☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC/NR
- ☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85/NR
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U85/NR
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U80
- ☐ Smile℠ Plus Gold 50/1500/No Ortho/U80
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U80/ADV
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/1500/No Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/2500/Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/2500/No Ortho/U90/ADV
- ☐ Ultimate Dental PPO for Small Business 50/2000/MAC/NR
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000/MAC/NR
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80
- ☐ Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/ U90
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90

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Voluntary Dental PPO Plans*

☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC/NR	☐ Smile℠ Basic Voluntary 50/1500/Ortho/U80
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/MAC	☐ Smile℠ Basic Voluntary 50/1000/No Ortho/U80 (No Wait)†

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 $ _____

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

† This Voluntary plan does not include Waiting Periods submission of proof of any prior coverage is not required.

ADV stands for Advantage and incentivize members to use INN providers. NR stands for No Rollover.

Section SB2 – Vision coverage

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

☐ **No change to vision benefits**

☐ 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.

Ultimate Vision for Small Business (12-12-12)	**Preferred Vision for Small Business (12-12-24)**	**Basic Vision for Small Business (12-24-24)**
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Basic Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Basic Vision 0/0/150
☐ Ultimate Vision Plus 10/25/150/120	☐ Preferred Vision Plus 10/25/150/120	☐ Basic Vision Plus 10/25/150/120
☐ Ultimate Vision 10/25/150	☐ Preferred Vision 10/25/150	☐ Basic Vision 10/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Basic Vision 0/0/120
☐ Ultimate Vision 10/25/120	☐ Preferred Vision 10/25/120	☐ Basic Vision 10/25/120
☐ Ultimate Vision Voluntary 10/25/150[1]	☐ Preferred Vision Voluntary 10/25/120[1]	☐ Basic Vision Voluntary 10/25/120[1]

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.

☐ **No change to life benefits**

☐ When adding flat 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 (except for multiple of salary or graded plans). 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-$35,000 or $50,000

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, $250,000*, $300,000*

* The benefit amounts of $250,000 and $300,000 are only available with a multiple of salary plan and not for flat amount plans.

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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 _____ amount $ _____
- ☐ 2. Class description _____ amount $ _____
- ☐ 3. Class description _____ amount $ _____
- ☐ 4. Class description _____ 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 ☐ $7,500 ☐ $10,000 ☐ $20,000

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 100% is paid by the employer (non-contributory), all eligible employees must enroll.

For employees _____% or $ _____ For dependents _____% or $ _____

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

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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)

General agent information

General agency name	General agency tax ID number (for commission payments)
General agency producer name	General agency producer email

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**.

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。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' 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)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? 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

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ 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 ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. 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 คุณสามารถรับบริการจากล่าม 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 hóló̱o̱doo nínízingo éí bíighah. Naaltsoos naanin——áhájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'a̱a̱h naa'nil bił haz'á̱a̱jį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian