blue of california

## Summary of Benefits

**Irvine Unified School District**
**Effective January 1, 2022**
**HMO Plan**

# Custom HMO Per Admit 250

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

## Medical Provider Network: Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. 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 Plan.

| | | When using a Participating Provider[3] |
|---|---|---|
| **Calendar Year medical Deductible** | *Individual coverage* | $0 |
| | *Family coverage* | $0: individual |
| | | $0: Family |

## Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

| | When using a Participating Provider[3] |
|---|---|
| *Individual coverage* | $5,000 |
| *Family coverage* | $5,000: individual |
| | $7,500: Family |

## No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

| Benefits[5] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** |
| **Preventive Health Services[6]** | | |
| Preventive Health Services | $0 | |
| California Prenatal Screening Program | $0 | |
| **Physician services** | | |
| Primary care office visit | $40/visit | |
| Access+ specialist care office visit (self-referral) | $40/visit | |
| Other specialist care office visit (referred by PCP) | $40/visit | |
| Physician home visit | $40/visit | |
| Physician or surgeon services in an Outpatient Facility | $0 | |
| Physician or surgeon services in an inpatient facility | $0 | |
| **Other professional services** | | |
| Other practitioner office visit<br>*Includes nurse practitioners, physician assistants, and therapists.* | $40/visit | |
| Teladoc consultation | $5/consult | |
| Family planning | | |
| • Counseling, consulting, and education | $0 | |
| • Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. | $0 | |
| • Tubal ligation | $0 | |
| • Vasectomy | $75/surgery | |
| Podiatric services | $40/visit | |
| **Pregnancy and maternity care** | | |
| Physician office visits: prenatal and postnatal | $0 | |
| Physician services for pregnancy termination | $0 | |
| **Emergency Services** | | |
| Emergency room services<br>*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.* | $250/visit | |
| Emergency room Physician services | $0 | |

| Benefits[5] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** |
| **Urgent care center services** | $40/visit | |
| **Ambulance services**<br>*This payment is for emergency or authorized transport.* | $100/transport | |
| **Outpatient Facility services** | | |
| Ambulatory Surgery Center | $0 | |
| Outpatient Department of a Hospital: surgery | $0 | |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | $0 | |
| **Inpatient facility services** | | |
| Hospital services and stay | $250/admission | |
| Transplant services<br>*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.* | | |
| • Special transplant facility inpatient services | $250/admission | |
| • Physician inpatient services | $0 | |
| **Diagnostic x-ray, imaging, pathology, and laboratory services**<br>*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.* | | |
| Laboratory services<br>*Includes diagnostic Papanicolaou (Pap) test.* | | |
| • Laboratory center | $0 | |
| • Outpatient Department of a Hospital | $0 | |
| X-ray and imaging services<br>*Includes diagnostic mammography.* | | |
| • Outpatient radiology center | $0 | |
| • Outpatient Department of a Hospital | $0 | |
| Other outpatient diagnostic testing<br>*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.* | | |
| • Office location | $0 | |
| • Outpatient Department of a Hospital | $0 | |

| Benefits[5] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** |
| Radiological and nuclear imaging services | | |
| • Outpatient radiology center | $0 | |
| • Outpatient Department of a Hospital | $0 | |
| **Rehabilitative and Habilitative Services** | | |
| *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.* | | |
| Office location | $40/visit | |
| Outpatient Department of a Hospital | $40/visit | |
| **Durable medical equipment (DME)** | | |
| DME | 20% | |
| Breast pump | $0 | |
| Orthotic equipment and devices | $0 | |
| Prosthetic equipment and devices | $0 | |
| **Home health care services** | $40/visit | |
| *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. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.* | | |
| **Home infusion and home injectable therapy services** | | |
| Home infusion agency services | $0 | |
| *Includes home infusion drugs and medical supplies.* | | |
| Home visits by an infusion nurse | $40/visit | |
| Hemophilia home infusion services | $0 | |
| *Includes blood factor products.* | | |
| **Skilled Nursing Facility (SNF) services** | | |
| *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.* | | |
| Freestanding SNF | $0 | |
| Hospital-based SNF | $0 | |
| **Hospice program services** | $0 | |
| *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.* | | |

| Benefits[5] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** |
| **Other services and supplies** | | |
| Diabetes care services | | |
| • Devices, equipment, and supplies | 20% | |
| • Self-management training | $40/visit | |
| Dialysis services | $0 | |
| PKU product formulas and special food products | $0 | |
| Allergy serum billed separately from an office visit | 50% | |

| Mental Health and Substance Use Disorder Benefits | Your payment | |
|---|---|---|
| *Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).* | **When using a MHSA Participating Provider[3]** | **CYD[2] applies** |
| **Outpatient services** | | |
| Office visit, including Physician office visit | $40/visit | |
| Teladoc behavioral health | $5/consult | |
| Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, 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 | $0 | |
| Partial Hospitalization Program | $0 | |
| Psychological Testing | $0 | |
| **Inpatient services** | | |
| Physician inpatient services | $0 | |
| Hospital services | $250/admission | |
| Residential Care | $250/admission | |

## Notes

**1 Evidence of Coverage (EOC):**

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this 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.

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

## Notes

**2 Calendar Year Deductible (CYD):**

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

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

**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.

*Teladoc.* Teladoc mental health and substance use disorder (behavioral health) consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

**4 Calendar Year Out-of-Pocket Maximum (OOPM):**

*Calendar Year Out-of-Pocket Maximum explained.* The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year.

*Your payment after you reach the Calendar Year OOPM.* You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

*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.

**5 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 payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

**6 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.

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

PENDING REGULATORY APPROVAL

PENDING REGULATORY APPROVAL

blue of california

**Group Rider**
**HMO/POS**

# Outpatient Prescription Drug Rider

## Enhanced Rx 10% $150 max/25% $150 max/50% $150 max - $5/50/75 with $250 Pharmacy Deductible
## Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

| | |
|---|---|
| **Pharmacy Network:** | **Irvine Unified School District (IUSD) Pharmacy Network** |
| **Drug Formulary:** | **Plus Formulary** |

### Calendar Year Pharmacy Deductible (CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

| | When using an In-Network[2] Pharmacy |
|---|---|
| **Calendar Year Pharmacy Deductible** | *Per Member* $250 |

### Calendar Year Pharmacy Out-of-Pocket Maximum[3]

A Pharmacy Out-of-Pocket Maximum is the most a Member will pay each Calendar Year for covered Drugs under the outpatient prescription Drug Benefit. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

| | When using an In-Network[2] Or Out-of-Network Pharmacy |
|---|---|
| **Calendar Year Pharmacy Out-of-Pocket Maximum** | *Per Member* $3,550 |
| | *Per Family* $9,600 |

### Prescription Drug Benefits[4,5]

| | Your payment | |
|---|---|---|
| | **When using an In-Network Pharmacy[2]** | **CYPD[1] applies** |
| **Retail pharmacy prescription Drugs** | | |
| *Per prescription, up to a 30-day supply.* | | |
| *Available only through the Irvine Unified School District (IUSD) Pharmacy Network.* | | |
| Contraceptive Drugs and devices | $0/prescription | |
| Tier 1 Drugs | 10% up to $150/prescription | |
| Tier 2 Drugs | 25% up to $150/prescription | ✔ |
| Tier 3 Drugs | 50% up to $150/prescription | ✔ |
| Tier 4 Drugs | 30% up to $150/prescription | ✔ |

| Prescription Drug Benefits[4,5] | Your payment | |
|---|---|---|
| | When using an In-Network Pharmacy[2] | CYPD[1] applies |
| **Retail pharmacy prescription Drugs** | | |
| *Per prescription, up to a 90-day supply from a 90-day retail pharmacy.* | | |
| Contraceptive Drugs and devices | $0/prescription | |
| Tier 1 Drugs | 10% up to $450/prescription | |
| Tier 2 Drugs | 25% up to $450/prescription | ✔ |
| Tier 3 Drugs | 50% up to $450/prescription | ✔ |
| Tier 4 Drugs | 30% up to $450/prescription | ✔ |
| **Mail service pharmacy prescription Drugs** | | |
| *Per prescription, up to a 90-day supply.* | | |
| Contraceptive Drugs and devices | $0/prescription | |
| Tier 1 Drugs | $5/prescription | |
| Tier 2 Drugs | $50/prescription | ✔ |
| Tier 3 Drugs | $75/prescription | ✔ |
| Tier 4 Drugs | 30% up to $300/prescription | ✔ |

## Notes

**1 Calendar Year Pharmacy Deductible (CYPD):**

*Calendar Year Pharmacy Deductible explained.* A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

*Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible.* Some outpatient prescription Drugs received from In-Network Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

**2 Using In-Network Pharmacies:**

*In-Network Pharmacies have a contract to provide outpatient prescription Drugs to Members.* When you obtain covered prescription Drugs from an In-Network Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

*In-Network Pharmacies and Drug Formulary.* You can find the Drug Formulary by visiting www.blueshieldca.com/wellness/drugs/formulary#heading2.

*Out-of-Network Pharmacies.* Drugs from Out-of-Network Pharmacies are not covered except in emergency situations.

## Notes

**3 Calendar Year Pharmacy Out-of-Pocket Maximum**

*Your payment after you reach the Calendar Year Pharmacy OOPM.* You will continue to pay all charges above a Benefit maximum.

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

**4 Outpatient Prescription Drug Coverage:**

**Medicare Part D-creditable coverage-**

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

**5 Outpatient Prescription Drug Coverage:**

*Brand Drug coverage when a Generic Drug is available.* If you 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. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

*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.

*Specialty Drugs.* Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

*Oral Anticancer Drugs.* You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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

# Prescription Drug Benefits

This Prescription Drug Benefit is separate from the medical Plan coverage. The Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Rider. However, the Calendar Year Out-of-Pocket Maximum, general provisions and exclusions of the Group Health Service Contract apply.

Outpatient prescription Drugs are self-administered Drugs approved by the U.S. Food and Drug Administration (FDA) for sale to the public through retail or mail-order pharmacies that are prescribed and are not provided for use on an inpatient basis. Drugs also include diabetic testing supplies.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. You must obtain all Drugs from an In-Network Pharmacy, except as noted below. Drugs, items, and services that are not covered under this Benefit are listed in the *Exclusions and limitations* section.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization to be covered. The prior authorization process is described in the *Prior authorization/exception request process/step therapy* section. You or your Physician may request prior authorization from Blue Shield.

## Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of FDA-approved preferred Generic and Brand Drugs. This list helps Physicians or Health Care Providers prescribe Medically Necessary and cost-effective Drugs.

Blue Shield's Formulary is established and maintained by Blue Shield's Pharmacy and Therapeutics (P&T) Committee. This committee consists of Physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, evidence-based health benefit, and comparative cost. The committee also reviews new Drugs, dosage forms, usage, and clinical data to update the Formulary four times a year.

Your Physician or Health Care Provider might prescribe a Drug even though it is not included in the Blue Shield Formulary.

The Formulary is divided into Drug tiers. The tiers are described in the chart below. Your Copayment or Coinsurance will vary based on the Drug tier. Drugs are placed into tiers based on recommendations made by the P&T Committee.

| Formulary Drug tiers | |
|---|---|
| ***Drug Tier*** | ***Description*** |
| Tier 1 | • Most Generic Drugs or low cost preferred Brand Drugs |
| Tier 2 | • Non-preferred Generic Drugs<br>• Preferred Brand Drugs<br>• Any other Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost |
| Tier 3 | • Non-preferred Brand Drugs<br>• Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost<br>• Drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier |
| Tier 4 | • Drugs that are biologics, and Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies<br>• Drugs that require you to have special training or clinical monitoring<br>• Drugs that cost the plan more than $600 (net of rebates) for a one-month supply |

Visit ***blueshieldca.com/pharmacy***, use the Blue Shield mobile app, or contact Customer Service for more information on the ***Drug Formulary*** or to request a printed copy of the Formulary.

## Obtaining outpatient prescription Drugs at an In-Network Pharmacy

You must present a Blue Shield ID Card at an In-Network Pharmacy to obtain prescription Drugs. You can obtain prescription Drugs at any retail In-Network Pharmacy unless the Drug is a Specialty Drug. See the *Obtaining Specialty Drugs from a Network Specialty Pharmacy* section for more information. If you obtain Drugs at an Out-of-Network Pharmacy, Blue Shield will deny the claim and will not pay anything toward the cost of the Drugs, unless they are for a covered emergency.

Visit ***blueshieldca.com/pharmacy*** or use the Blue Shield mobile app to locate a *retail In-Network Pharmacy*.

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from an In-Network Pharmacy. When the In-Network Pharmacy's contracted rate is

less than your Copayment or Coinsurance, you only pay the contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum.

There is no Copayment or Coinsurance for generic, FDA-approved contraceptive Drugs and devices obtained from an In-Network Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance only when Medically Necessary.

If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance.

If you select a Brand Drug when a Generic Drug equivalent is available, you pay the difference in cost, plus your Tier 1 Copayment or Coinsurance. This is calculated by taking the difference between the In-Network Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Tier 1 Copayment or Coinsurance. For example, you select Brand Drug A when there is an equivalent Generic Drug A available. The In-Network Pharmacy's contracted rate for Brand Drug A is $300 and the contracted rate for Generic Drug A is $100. You would be responsible for paying the $200 difference in cost, plus the Tier 1 Copayment or Coinsurance. This difference in cost does not apply to your Calendar Year Pharmacy Deductible or your Out-of-Pocket Maximum responsibility.

If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you can request an exception to paying the difference in cost between the Brand Drug and Generic Drug equivalent through the Blue Shield prior authorization process. The request is reviewed for Medical Necessity. See the *Prior authorization/exception request/step therapy process* section for more information on the approval process and exception requests. If the request is approved, you pay only the applicable tier Copayment or Coinsurance.

Blue Shield created a Patient Review and Coordination (PRC) program to help reduce harmful prescription drug misuse and the potential for abuse. Examples of harmful misuse include obtaining an excessive number of prescription medications or obtaining very high doses of prescription opioids from multiple providers or pharmacies within a 90-day period. If Blue Shield determines a Member is using prescription drugs in a potentially harmful, abusive manner, Blue Shield may, subject to certain exemptions and upon 90 days' advance notice, restrict a Member to obtaining all non-emergent outpatient prescriptions drugs at a single pharmacy home. This restriction applies for a 12-month period and may be renewed. The pharmacy home, a single In-Network Pharmacy, will be assigned by Blue Shield or a Member may request to select a pharmacy home. Blue Shield may also require prior authorization for all opioid medications if sufficient medical justification for their use has not been provided. Members that disagree with their enrollment in the PRC program can file an appeal or submit a grievance to Blue Shield as described in the *Grievance process* section of your Evidence of Coverage. Members selected for participation in the PRC will receive a brochure with full program details, including participation exemptions. Any interested Member can request a PRC program brochure by calling Customer Service at the number listed on their Identification Card.

## Obtaining outpatient prescription Drugs at an Out-of-Network Pharmacy in an emergency

When you receive Drugs from an Out-of-Network Pharmacy for a covered emergency, you must pay for the prescription in full and then submit a claim form for reimbursement to:

Blue Shield of California
P.O. Box 52136
Phoenix, AZ 85072-2136

Blue Shield will reimburse you as shown on the Summary of Benefits, based on the price you paid for the Drugs.

Claim forms may be obtained by calling Customer Service or visiting blueshieldca.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

## Obtaining outpatient prescription Drugs from the mail service pharmacy

You have an option to receive prescription Drugs from the mail service pharmacy when you take maintenance Drugs for an ongoing condition. This allows you to receive up to a 90-day supply of the Drug, which may save you money. You may enroll in this program online, by phone, or by mail. Once enrolled, please allow up to 14 days to receive the Drug. If your Physician or Health Care Provider submits a prescription for less than a 90-day supply, the mail service pharmacy will only dispense the amount prescribed. Specialty Drugs are not available from the mail service pharmacy.

You must pay the applicable mail service prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit blueshieldca.com or use the Blue Shield mobile app for additional information about how to get prescription Drugs from the mail service pharmacy.

## Obtaining Specialty Drugs from a Network Specialty Pharmacy

Specialty Drugs are Drugs that require coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy, and that are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs generally have a higher cost.

Specialty Drugs are only available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, at your request, will transfer the Specialty Drug to an associated retail store for pickup.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA.

To be covered, most Specialty Drugs require prior authorization by Blue Shield, as described in the *Prior authorization/exception request/step therapy process* section.

Visit blueshieldca.com for a complete list of Specialty Drugs or to select a Network Specialty Pharmacy.

## Prior authorization/exception request/step therapy process

Some Drugs and Drug quantities require approval based on Medical Necessity before they are eligible for coverage under this Benefit. This process is prior authorization.

The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy; and
- Some brand contraceptives, in order to be covered without a Copayment or Coinsurance.

You pay the Tier 3 Copayment or Coinsurance for covered compounded medications.

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

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 requirements are not met for a prescription and your Physician or your Health Care Provider believes the Drug is Medically Necessary, the prior authorization process may be used and timeframes previously described will also apply.

If Blue Shield denies a request for prior authorization or an exception request, you, your representative, your Physician, or your Health Care Provider can file a grievance with Blue Shield. See the *Grievance process* section of your Evidence of Coverage for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

## Limitation on quantity of Drugs that may be obtained per prescription or refill

Except as otherwise stated in this section, you may receive up to a 30-day supply of outpatient prescription Drugs. If a Drug is available only in supplies greater than 30 days, you must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

If you, your Physician, or your Health Care Provider request a partial fill of a Schedule II Controlled Substance prescription, your Copayment or Coinsurance will be pro-rated. The remaining balance of any partially filled prescription cannot be dispensed more than 30 days from the date the prescription was written.

Blue Shield has a short cycle Specialty Drug program. With your agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for the initial prescription. This program allows you to receive a 15-day supply of

the Specialty Drug to help determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save money if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program, which you can elect at that time. You, your Physician, or your Health Care Provider may choose a full 30-day supply for the first fill.

If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug.

Visit ***blueshieldca.com/pharmacy*** for a list of *Specialty Drugs* in the *short cycle Specialty Drug program*.

You may receive up to a 90-day supply of Drugs from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable mail service Copayment or Coinsurance listed in the *Summary of Benefits* section. Refill authorizations cannot be combined to reach a 90-day supply.

Select over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.

You may receive up to a 12-month supply of contraceptive Drugs.

You may refill covered prescriptions at a Medically Necessary frequency.

## Exclusions and limitations

This section describes the exclusions and limitations that apply to this Outpatient prescription Drug Benefit. You may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your Evidence of Coverage to determine if the plan covers Drugs under that Benefit.

| | Outpatient prescription Drug exclusions and limitations |
|---|---|
| 1 | Drugs obtained from an Out-of-Network Pharmacy. This exclusion does not apply to Drugs obtained on an emergency or urgent basis. |
| 2 | Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Evidence of Coverage. |
| 3 | Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital services* and *Skilled Nursing Facility (SNF) services* sections of your Evidence of Coverage. |
| 4 | Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs and devices when prescribed by a Physician. |
| 5 | Drugs that are Experimental or Investigational in nature. |
| 6 | Medical devices or supplies, except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Durable medical equipment* section of your Evidence of Coverage. |
| 7 | Blood or blood products. See the *Hospital services* section of your Evidence of Coverage. |
| 8 | Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, Drugs used to slow or reverse the effects of skin aging or to treat hair loss. |
| 9 | Medical food, dietary, or nutritional products. See the *Home health services, Home infusion and injectable medication services, PKU formulas and special food products* sections of your Evidence of Coverage. |

## Outpatient prescription Drug exclusions and limitations

| | |
|---|---|
| 10 | Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home health services, Home infusion and injectable medication services, Hospice program services,* or *Family Planning* sections of your Evidence of Coverage. |
| 11 | All Drugs related to assisted reproductive technology. |
| 12 | Appetite suppressants or Drugs for body weight reduction. This exclusion does not apply to Medically Necessary Drugs for the treatment of morbid obesity when prior authorized. |
| 13 | Compounded medications which do not meet all of the following requirements:<br>• A compounded medication includes at least one Drug;<br>• There are no FDA-approved, commercially available, medically appropriate alternatives;<br>• The compounded medication is self administered; and<br>• Medical literature supports its use for the requested diagnosis. |
| 14 | Replacement of lost, stolen or destroyed Drugs. |
| 15 | If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice program services* section of your Evidence of Coverage. |
| 16 | Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to antibiotics prescribed to treat infection, Drugs prescribed to treat pain, or Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints. |
| 17 | Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy or included on a government exclusion list. |
| 18 | Immunizations and vaccinations solely for the purpose of travel. |
| 19 | Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs. |

## Outpatient prescription Drug exclusions and limitations

| | |
|---|---|
| 20 | Prescription Drugs that are repackaged by an entity other than the original manufacturer. |

## Definitions

| | |
|---|---|
| **Anticancer Medications** | Drugs used to kill or slow the growth of cancerous cells. |
| **Brand Drugs** | Drugs that are FDA-approved after a new drug application and/or registered under a brand or trade name by its manufacturer. |
| **Calendar Year Pharmacy Deductible** | The amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. |
| **Drugs** | Drugs include the following:<br>• FDA-approved medications that require a prescription either by California or Federal law;<br>• Insulin;<br>• Pen delivery systems for the administration of insulin, as Medically Necessary;<br>• Diabetic testing supplies including the following:<br>  ○ Lancets,<br>  ○ Lancet puncture devices,<br>  ○ Blood and urine testing strips, and<br>  ○ Test tablets;<br>• Over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;<br>• Contraceptive drugs and devices, including the following:<br>  ○ Diaphragms,<br>  ○ Cervical caps,<br>  ○ Contraceptive rings,<br>  ○ Contraceptive patches,<br>  ○ Oral contraceptives,<br>  ○ Emergency contraceptives, and<br>  ○ Female OTC contraceptive products when ordered by a Physician or Health Care Provider;<br>• Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers. |
| **Formulary** | A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically. |
| **Generic Drugs** | Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency |

| | |
|---|---|
| | as a therapeutic equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs. |
| **In-Network Pharmacy** | A retail pharmacy that participates in the IUSD Pharmacy Network as defined below. These pharmacies include CVS, Costco and independently owned pharmacies that are not directly affiliated with any chain of pharmacies and have agreed to a more competitive contracted rate for covered prescriptions for Blue Shield Members. To select an In-Network Pharmacy, you need to use the directories located on the IUSD Intranet. Do not use the Blue Shield Pharmacy provider search as it will not provide the correct listing of IUSD In-Network Pharmacies. The IUSD Pharmacy Network is only available to IUSD medical plan participants. |
| **Network Specialty Pharmacy** | Select In-Network Pharmacies contracted by Blue Shield to provide covered Specialty Drugs. |
| **Out-of-Network Pharmacy** | A pharmacy that does not participate in the IUSD Pharmacy Network. |
| **Schedule II Controlled Substance** | Prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence. |
| **Specialty Drugs** | Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy and are available exclusively at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high-cost. |

Please be sure to retain this document. It is not a Contract but is a part of your Evidence of Coverage.

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## Chiropractic Services Rider

**Group Rider**
**Effective January 1, 2022**
**HMO/POS**

# Irvine Unified School District Custom Chiropractic Benefits Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this chiropractic services Benefit.

| Benefits | Your Payment | |
|---|---|---|
| *Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).*<br><br>*Up to 30 visits per Member, per Calendar Year.*<br><br>*Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.* | **When using an ASH Participating Provider** | **When using a Non-Participating Provider** |
| **Chiropractic Services** | | |
| Office visit | $15/visit | Not covered |
| Chiropractic Appliances | All charges above $50 | Not covered |

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

PENDING REGULATORY APPROVAL

## Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Services, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Services received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

## Benefits

### Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

## Member Services

For all chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's chiropractic services administrator. Contact ASH Plans with questions about chiropractic services, ASH Participating Providers, or chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

## Definitions

| | |
|---|---|
| **American Specialty Health Plans of California, Inc. (ASH Plans)** | ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of chiropractic services. |
| **ASH Participating Provider** | A chiropractor under contract with ASH Plans to provide Covered Services to Members. |
| **Musculoskeletal and Related Disorders** | Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation. |

Please be sure to retain this document. It is not a contract but is a part of your EOC.

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# Hearing Aid Services Rider

**Group Rider**
**Effective January 1, 2022**
**HMO/POS**

## Irvine Unified School District Hearing Aid and Ancillary Equipment Benefit Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California hearing aid services Benefit.

| Benefits | Your Payment |
|---|---|
| *Up to a $2,000 maximum per Member in any 36-month period. Services are not subject to the Calendar Year Deductible.* | **When using any provider** |
| **Hearing Aid Services** | |
| Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments<br>Hearing aid device checks<br>Electroacoustic evaluations for hearing aids<br>Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords | 50%<br>Subject to a Benefit maximum of $2,000/member /36 months |

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

PENDING REGULATORY APPROVAL

## Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for hearing aid services, as described in this supplement. These hearing aid services Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply.

Because Blue Shield does not maintain a network of contracted providers for these services, the Benefits covered under this supplement can be received from any provider and you may submit a claim to Blue Shield for reimbursement.

## Benefits

Benefits are available for hearing aid services as shown on the Summary of Benefits. Services are limited to a maximum payment per Member in any period, are not subject to the Calendar Year Deductible.

Blue Shield will reimburse you for Covered Services up to the maximum shown on the Summary of Benefits.

## Submitting a Claim Form

Blue Shield will pay Members directly for services rendered. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to:

Blue Shield
P.O. Box 272540
Chico, CA 95927-2540

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the Subscriber's name, home address, group contract number, Subscriber number, a copy of the provider's bill showing the services rendered, dates of treatment and the patient's name.

Blue Shield provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

## Exclusions

Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or

- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 36-month period.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

# 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)