



## Summary of Benefits

Teamsters Local 1932 Health and  
Welfare Trust

Effective July 29, 2023  
HMO Platinum POS Plan

### HMO Platinum POS Plan

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

#### Medical Provider Network:

#### HMO and PPO Networks

This Plan provides benefits at two different levels:

- **Level I (HMO Participating Providers):** Services must be provided or prior authorized by your Primary Care Physician or Medical Group/IPA, except in an Emergency or otherwise specified. Please review your EOC for details about how to access care under this level.
- **Level II (PPO Participating Providers):** Services are provided by Participating Providers for outpatient professional services provided in an office setting. Any Copayment or Coinsurance is calculated from the Allowable Amount.

You are responsible for any Copayment or Coinsurance and any charges over the Allowable Amount. You can find Participating Providers in this network at [blueshieldca.com](https://blueshieldca.com).

#### Calendar Year Deductibles (CYD)<sup>2</sup>

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

	Level I HMO Plan Providers <sup>3</sup>	Level II Participating Providers <sup>3</sup>
<b>Calendar Year medical Deductible</b>		
<i>Individual coverage</i>	\$0	\$0
<i>Family coverage</i>	\$0: individual \$0: Family	\$0: individual \$0: Family

#### Calendar Year Out-of-Pocket Maximum<sup>4</sup>

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

	Level I HMO Plan Providers <sup>3</sup>	Level II Participating Providers <sup>3</sup>
<i>Individual coverage</i>	\$1,500	\$8,000
<i>Family coverage</i>	\$1,500: individual \$3,000: Family	\$8,000: individual \$16,000: Family

#### No Annual or Lifetime Dollar Limit

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

Benefits<sup>5</sup>

## Your payment

	Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>6</sup></b>				
Preventive Health Services	\$0		\$30/visit	
California Prenatal Screening Program	\$0		\$0	
<b>Physician services</b>				
Primary care office visit	\$10/visit		\$30/visit	
Specialist care office visit	\$10/visit		\$30/visit	
Physician home visit	\$10/visit		\$30/visit	
Physician or surgeon services in an Outpatient Facility	\$0		Not covered	
Physician or surgeon services in an inpatient facility	\$0		Not covered	
<b>Other professional services</b>				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$10/visit		\$30/visit	
Acupuncture services	Not covered		Not covered	
Chiropractic services	Not covered		Not covered	
Teladoc consultation	\$0		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Injectable contraceptive	\$0		\$30/visit	
• <i>Under Level II, services are only covered if received in a Physician's office.</i>				
• Tubal ligation	\$0		Not covered	
• Vasectomy	\$10/surgery		Not covered	
Podiatric services	\$10/visit		\$30/visit	
Medical nutrition therapy, not related to diabetes	\$0		Not covered	
<b>Pregnancy and maternity care</b>				
Physician office visits: prenatal and postnatal	\$0		20%	

	Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
Abortion and abortion-related services	\$0		\$0	
<b>Emergency Services</b>				
Emergency room services	\$50/visit		\$50/visit	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.</i>				
Emergency room Physician services	\$0		\$0	
<b>Urgent care center services</b>	\$10/visit		\$10/visit	
<b>Ambulance services</b>	\$0		\$0	
<i>This payment is for emergency or authorized transport.</i>				
<b>Outpatient Facility services</b>				
Ambulatory Surgery Center	\$0		Not covered	
Outpatient Department of a Hospital: surgery	\$0		Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0		Not covered	
<b>Inpatient facility services</b>				
Hospital services and stay	\$0		Not covered	
Transplant services				
<i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>				
• Special transplant facility inpatient services	\$0		Not covered	
• Physician inpatient services	\$0		Not covered	

	Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
<b>Bariatric surgery services, designated California counties</b>  <i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.</i>				
Inpatient facility services	\$0		Not covered	
Outpatient Facility services	\$0		Not covered	
Physician services	\$0		Not covered	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b>  <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
<ul style="list-style-type: none"> <li>Laboratory center</li> </ul>				
Under Level II, services are only covered if received in a Physician's office.	\$0		\$0	
<ul style="list-style-type: none"> <li>Outpatient Department of a Hospital</li> </ul>	\$0		Not covered	
X-ray and imaging services				
Includes diagnostic mammography.				
<ul style="list-style-type: none"> <li>Outpatient radiology center</li> </ul>				
Under Level II, services are only covered if received in a Physician's office.	\$0		\$0	

	Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
<ul style="list-style-type: none"> <li>Outpatient Department of a Hospital</li> </ul> <p>Other outpatient diagnostic testing</p> <p><i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i></p>	\$0		Not covered	
<ul style="list-style-type: none"> <li>Office location</li> </ul> <p><i>Under Level II, services are only covered if received in a Physician's office.</i></p>	\$0		\$0	
<ul style="list-style-type: none"> <li>Outpatient Department of a Hospital</li> </ul> <p>Radiological and nuclear imaging services</p>	\$0		Not covered	
<ul style="list-style-type: none"> <li>Outpatient radiology center</li> </ul>	\$0		Not covered	
<ul style="list-style-type: none"> <li>Outpatient Department of a Hospital</li> </ul>	\$0		Not covered	
<b>Rehabilitative and Habilitative Services</b>  <i>Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy services. Under Level II, up to 12 visits per Member, per Calendar Year.</i>				
Office location	\$10/visit		\$30/visit	
Outpatient Department of a Hospital	\$0		Not covered	
<b>Speech therapy services</b>				
Office location	\$10/visit		\$30/visit	
Outpatient Department of a Hospital	\$0		Not covered	
<b>Durable medical equipment (DME)</b>				
DME	\$0		Not covered	
Breast pump	\$0		Not covered	
Orthotic equipment and devices	\$0		Not covered	
Prosthetic equipment and devices	\$0		Not covered	

	Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
<b>Home health care services</b> <i>Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i>	\$0		Not covered	
<b>Home infusion and home injectable therapy services</b> Home infusion agency services <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i> Hemophilia home infusion services <i>Includes blood factor products.</i>	\$0 \$0		Not covered Not covered	
<b>Skilled Nursing Facility (SNF) services</b> Freestanding SNF Hospital-based SNF	\$0 \$0		Not covered Not covered	
<b>Hospice program services</b> <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0		Not covered	
<b>Other services and supplies</b> Diabetes care services <ul style="list-style-type: none"> <li>Devices, equipment, and supplies</li> <li>Self-management training</li> <li>Medical nutrition therapy</li> </ul> Dialysis services PKU product formulas and special food products Allergy serum billed separately from an office visit Travel immunizations and vaccinations Eye examination <i>One comprehensive eye examination in a consecutive 12-month period provided through the contracted VPA.</i>	\$0 \$0 \$0 \$0 \$0 \$0 \$10/injection		Not covered \$30/visit \$30/visit Not covered Not covered \$0 \$30/injection	
<ul style="list-style-type: none"> <li>Ophthalmologic exam</li> </ul>	\$10/visit		\$0 up to \$60/year plus 100% of additional charges	

Benefits<sup>5</sup>

## Your payment

	Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
• Optometric exam	\$10/visit		\$0 up to \$50/year plus 100% of additional charges	

## Mental Health and Substance Use Disorder Benefits

## Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>		Level I HMO Plan Providers <sup>3</sup>	CYD <sup>2</sup> applies	Level II Participating Providers <sup>3</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>					
Office visit, including Physician office visit	\$10/visit			\$10/visit	
Teladoc mental health	\$0			Not covered	
Intensive outpatient care	\$0			Not covered	
Behavioral Health Treatment in an office setting	\$0			\$0	
Behavioral Health Treatment in home or other non-institutional facility setting	\$0			\$0	
Office-based opioid treatment	\$0			\$0	
Partial Hospitalization Program	\$0			Not covered	
Psychological Testing	\$0			Not covered	
<b>Inpatient services</b>					
Physician inpatient services	\$0			Not covered	
Hospital services	\$0			Not covered	
Residential Care	\$0			Not covered	

## Notes

## 1 Evidence of Coverage (EOC):

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

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

### 2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A 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.

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### 3 Using Level I and Level II Participating Providers:

Level I and Level II 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 consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

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

- Coinsurance is calculated from the Allowable Amount.

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### 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 Allowable Amount 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 and charges above the Allowable Amount.

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

This Plan has a separate Level I HMO Plan Provider and Level II Participating Provider OOPM. Any amounts you pay that count towards the Level I OOPM also count towards the Level II OOPM. Applicable Level II Cost Shares only count towards the Level II OOPM.

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

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### 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.

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### 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 under the Level 1 provider network. 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.

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

## HMO Platinum POS, HMO Platinum Trio Enhanced Rx \$5/10/25 Summary of Benefits

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

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

### Calendar Year Pharmacy Deductible(CYPD)<sup>1</sup>

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 a Participating<sup>2</sup> Pharmacy

<b>Calendar Year Pharmacy Deductible</b>	Per Member	\$0
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### Prescription Drug Benefits<sup>3,4</sup>

#### Your payment

When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
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#### Retail pharmacy prescription Drugs

Per prescription, up to a 30-day supply.

Contraceptive Drugs and devices	\$0
Tier 1 Drugs	\$5/prescription
Tier 2 Drugs	\$10/prescription
Tier 3 Drugs	\$25/prescription
Tier 4 Drugs	\$10/prescription

#### Retail pharmacy prescription Drugs

Per prescription, up to a 90-day supply from a 90-day retail pharmacy.

Contraceptive Drugs and devices	\$0
Tier 1 Drugs	\$15/prescription
Tier 2 Drugs	\$30/prescription
Tier 3 Drugs	\$75/prescription
Tier 4 Drugs	\$30/prescription

#### Mail service pharmacy prescription Drugs

Per prescription, up to a 90-day supply.

## Prescription Drug Benefits<sup>3,4</sup>

## Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$10/prescription	
Tier 2 Drugs	\$20/prescription	
Tier 3 Drugs	\$50/prescription	
Tier 4 Drugs	\$20/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 Participating 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 Participating Pharmacies:

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

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting [www.blueshieldca.com/pharmacy](http://www.blueshieldca.com/pharmacy).

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

### 3 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.

### 4 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

## Notes

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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.

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

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

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

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California  
Civil Rights Coordinator  
P.O. Box 629007  
El Dorado Hills, CA 95762-9007

**Phone: (844) 831-4133 (TTY: 711)**

**Fax: (844) 696-6070**

**Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.com)**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW.  
Room 509F, HHH Building  
Washington, DC 20201  
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

# Notice of the Availability of Language Assistance Services

## Blue Shield of California

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

**重要通知：** 您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

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

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

**Baa' ákohwiindzindooígí:** Díí naaltsoosish yíiniłta'go bííniłhah? Doo bííniłhahgóó éí, naaltsoos nich'í' yíidóoltałhígíí ła' nihee hółó. Díí naaltsoos áldó' t'áá Diné k'ehjí ádoolníł nínízingo bííghah. Doo ɓaah ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodiłnih dóó námboo éí díí Blue Shield bee néiho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jì' hodiłnih. (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/مشتري تماس بگیرید. (Persian)

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

**ប្រការសំខាន់៖** តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ 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 โปรดขอความช่วยเหลือจากผู้อ่านได้  
คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย  
โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร  
(866) 346-7198 (Thai)

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

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