



## Summary of Benefits

Group Plan  
POS Plan

### Added Advantage POS<sup>SM</sup> 500-100/80/60

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).<sup>1</sup> Please read both documents carefully for details.

#### Medical Provider Network:

#### POS Added Advantage Network

This Plan uses a specific network of Health Care Providers, called the POS Added Advantage provider network. This Plan provides benefits at three different levels:

- **Level I (HMO Participating Providers):** Services must be provided or prior authorized by your primary care Physician or medical group/IPA, with some exceptions. 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. Any Copayment or Coinsurance is calculated from the Allowable Amount.
- **Level III (Non-Participating Providers):** Services are provided by Non-Participating Providers.

You are responsible for any Copayment or Coinsurance and any charges over the Allowable Amount. You pay less for Covered Services when you use a Level I or Level II provider than when you use a Level III provider. 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 Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

|                                  |                     | Level I <sup>3</sup> | Level II <sup>3</sup> | Level III <sup>4</sup> |
|----------------------------------|---------------------|----------------------|-----------------------|------------------------|
| Calendar Year medical Deductible | Individual coverage | \$0                  |                       | \$500                  |
|                                  | Family coverage     | \$0: individual      |                       | \$500: individual      |
|                                  |                     | \$0: Family          |                       | \$1,000: Family        |

#### Calendar Year Out-of-Pocket Maximum<sup>5</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 <sup>3</sup> | Level II <sup>3</sup> | Level II <sup>3</sup> and Level III <sup>4</sup> |
|---------------------|----------------------|-----------------------|--|
| Individual coverage | \$1,500              | \$3,500               | \$5,500  |
| Family coverage     | \$1,500: individual  | \$3,500: individual   | \$5,500: individual                              |
|                     | \$4,500: Family      | \$10,000: Family      | \$16,000: 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.

Blue Shield of California is an independent member of the Blue Shield Association

**Benefits<sup>6</sup>**
**Your payment**

|   | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup> | CYD <sup>2</sup><br>applies |
|---|----------------------|-----------------------------|-----------------------|-----------------------------|------------------------|-----------------------------|
| <b>Preventive Health Services<sup>7</sup></b>   |                      |                             |                       |                             |                        |                             |
| Preventive Health Services  | \$0                  |                             | Not covered           |                             | Not covered            |                             |
| California Prenatal Screening Program   | \$0                  |                             | \$0                   |                             | \$0                    |                             |
| <b>Physician services</b>   |                      |                             |                       |                             |                        |                             |
| Primary care office visit   | \$10/visit           |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| Specialist care office visit  | \$15/visit           |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| Physician home visit  | \$10/visit           |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| Physician or surgeon services in an Outpatient Facility   | \$0                  |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| Physician or surgeon services in an inpatient facility  | \$0                  |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| <b>Other professional services</b>  |                      |                             |                       |                             |                        |                             |
| Other practitioner office visit<br><i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>  | \$10/visit           |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| Teladoc consultation  | \$0                  |                             | \$0                   |                             | Not covered            |                             |
| Family planning   |                      |                             |                       |                             |                        |                             |
| • Counseling, consulting, and education   | \$0                  |                             | Not covered           |                             | Not covered            |                             |
| • Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. | \$0                  |                             | Not covered           |                             | Not covered            |                             |
| • Tubal ligation  | \$0                  |                             | Not covered           |                             | Not covered            |                             |
| • Vasectomy   | \$0                  |                             | Not covered           |                             | Not covered            |                             |
| Medical nutrition therapy, not related to diabetes  | \$0                  |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| <b>Pregnancy and maternity care</b>   |                      |                             |                       |                             |                        |                             |
| Physician office visits: prenatal and postnatal   | \$0                  |                             | 20%                   | ✓                           | 40%                    | ✓                           |
| Abortion and abortion-related services  | \$0                  |                             | \$0                   |                             | \$0                    |                             |

**Benefits<sup>6</sup>**
**Your payment**

|   | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup>                           | CYD <sup>2</sup><br>applies |
|---|----------------------|-----------------------------|-----------------------|-----------------------------|--|-----------------------------|
| <b>Emergency Services</b>   |                      |                             |                       |                             |  |                             |
| Emergency room services   | \$100/visit          |                             | \$100/visit           |                             | \$100/visit                                      |                             |
| <i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Level I member payment under Inpatient facility services/ Hospital services and stay.</i> |                      |                             |                       |                             |  |                             |
| Emergency room Physician services   | \$0                  |                             | \$0                   |                             | \$0  |                             |
| <b>Urgent care center services</b>  | \$10/visit           |                             | 20%                   | ✓                           | 40%  | ✓                           |
| <b>Ambulance services</b>   | \$100/transport      |                             | \$100/transport       |                             | \$100/transport                                  |                             |
| <i>This payment is for emergency or authorized transport.</i>   |                      |                             |                       |                             |  |                             |
| <b>Outpatient Facility services</b>   |                      |                             |                       |                             |  |                             |
| Ambulatory Surgery Center   | \$100/surgery        |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| Outpatient Department of a Hospital: surgery  | \$150/surgery        |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies  | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| <b>Inpatient facility services</b>  |                      |                             |                       |                             |  |                             |
| Hospital services and stay  | \$200/admission      |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$600/day | ✓                           |

**Benefits<sup>6</sup>**
**Your payment**

|  | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup> | CYD <sup>2</sup><br>applies |
|--|----------------------|-----------------------------|-----------------------|-----------------------------|------------------------|-----------------------------|
| <b>Transplant services</b><br><br><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>   |                      |                             |                       |                             |                        |                             |
| <ul style="list-style-type: none"> <li>Special transplant facility inpatient services</li> </ul>   | \$200/admission      |                             | Not covered           |                             | Not covered            |                             |
| <ul style="list-style-type: none"> <li>Physician inpatient services</li> </ul>   | \$0                  |                             | Not covered           |                             | Not covered            |                             |
| <b>Bariatric surgery services, designated California counties</b><br><br><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  | \$200/admission      |                             | 20%                   | ✓                           | Not covered            |                             |
| Outpatient Facility services   | \$150/surgery        |                             | 20%                   | ✓                           | Not covered            |                             |
| Physician services   | \$0                  |                             | 20%                   | ✓                           | Not covered            |                             |

|  | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup>                           | CYD <sup>2</sup><br>applies |
|--|----------------------|-----------------------------|-----------------------|-----------------------------|--|-----------------------------|
| <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. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i> |                      |                             |                       |                             |  |                             |
| Laboratory and pathology services  |                      |                             |                       |                             |  |                             |
| <i>Includes diagnostic Papanicolaou (Pap) test.</i>  |                      |                             |                       |                             |  |                             |
| • Laboratory center  | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |
| • Outpatient Department of a Hospital  | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| Basic imaging services   |                      |                             |                       |                             |  |                             |
| <i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>  |                      |                             |                       |                             |  |                             |
| • Outpatient radiology center  | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |
| • Outpatient Department of a Hospital  | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| Other outpatient non-invasive diagnostic testing   |                      |                             |                       |                             |  |                             |
| <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>  |                      |                             |                       |                             |  |                             |
| • Office location  | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |

**Benefits<sup>6</sup>**
**Your payment**

|   | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup>                           | CYD <sup>2</sup><br>applies |
|---|----------------------|-----------------------------|-----------------------|-----------------------------|--|-----------------------------|
| <ul style="list-style-type: none"> <li>Outpatient Department of a Hospital</li> </ul>   | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| Advanced imaging services<br><br><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i> |                      |                             |                       |                             |  |                             |
| <ul style="list-style-type: none"> <li>Outpatient radiology center</li> </ul>   | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |
| <ul style="list-style-type: none"> <li>Outpatient Department of a Hospital</li> </ul>   | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| <b>Rehabilitative and Habilitative Services</b>   |                      |                             |                       |                             |  |                             |
| <i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>                                 |                      |                             |                       |                             |  |                             |
| Office location   | \$10/visit           |                             | 20%                   | ✓                           | 40%  | ✓                           |
| Outpatient Department of a Hospital   | \$10/visit           |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| <b>Durable medical equipment (DME)</b>  |                      |                             |                       |                             |  |                             |
| DME   | 50%                  |                             | 50%                   | ✓                           | 50%  | ✓                           |
| Breast pump   | \$0                  |                             | \$0                   |                             | Not covered                                      |                             |
| Orthotic equipment and devices  | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |
| Prosthetic equipment and devices  | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |

Benefits<sup>6</sup>

## Your payment

|   | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup>                           | CYD <sup>2</sup><br>applies |
|---|----------------------|-----------------------------|-----------------------|-----------------------------|--|-----------------------------|
| <b>Home health care services</b><br><i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.</i> | \$10/visit           |                             | 20%                   | ✓                           | Not covered                                      |                             |
| <b>Home infusion and home injectable therapy services</b><br>Home infusion agency services<br><i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>   | \$0                  |                             | 20%                   | ✓                           | Not covered                                      |                             |
| Hemophilia home infusion services<br><i>Includes blood factor products.</i>   | \$0                  |                             | 20%                   | ✓                           | Not covered                                      |                             |
| <b>Skilled Nursing Facility (SNF) services</b><br><i>Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>  |                      |                             |                       |                             |  |                             |
| Freestanding SNF  | \$0                  |                             | 20%                   | ✓                           | 40%  | ✓                           |
| Hospital-based SNF  | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$600/day | ✓                           |
| <b>Hospice program services</b><br><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           |                             | Not covered                                      |                             |

## Benefits<sup>6</sup>

## Your payment

|  | Level I <sup>3</sup> | CYD <sup>2</sup><br>applies | Level II <sup>3</sup> | CYD <sup>2</sup><br>applies | Level III <sup>4</sup>                           | CYD <sup>2</sup><br>applies |
|--|----------------------|-----------------------------|-----------------------|-----------------------------|--|-----------------------------|
| <b>Other services and supplies</b>                   |                      |                             |                       |                             |  |                             |
| Diabetes care services                               |                      |                             |                       |                             |  |                             |
| • Devices, equipment, and supplies                   | 50%                  |                             | 50%                   | ✓                           | 50%  | ✓                           |
| • Self-management training                           | \$10/visit           |                             | 20%                   | ✓                           | 40%  | ✓                           |
| • Medical nutrition therapy                          | \$10/visit           |                             | 20%                   | ✓                           | 40%  | ✓                           |
| Dialysis services                                    | \$0                  |                             | 20%                   | ✓                           | 40%<br>Subject to a Benefit maximum of \$350/day | ✓                           |
| PKU product formulas and special food products       | \$0                  |                             | 20%                   | ✓                           | 20%  | ✓                           |
| Allergy serum billed separately from an office visit | 50%                  |                             | 50%                   | ✓                           | 50%  | ✓                           |

## Mental Health and Substance Use Disorder Benefits

## Your payment

|   | Level I <sup>3</sup><br>Care authorized by the MHSA or provided by MHSA participating providers | CYD <sup>2</sup><br>applies | Level II <sup>3</sup><br>There are no separate benefit payments under Level II | CYD <sup>2</sup><br>applies | Level III <sup>4</sup><br>When using MHSA Non-Participating Providers | CYD <sup>2</sup><br>applies |
|---|---|-----------------------------|--|-----------------------------|---|-----------------------------|
| <i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>   |   |                             |  |                             |   |                             |
| <b>Outpatient services</b>  |   |                             |  |                             |   |                             |
| Office visit, including Physician office visit  | \$10/visit  |                             |  |                             | 40%   | ✓                           |
| Teladoc mental health   | \$0   |                             |  |                             | Not covered   |                             |
| 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   |                             |  |                             | 40%   | ✓                           |



## Mental Health and Substance Use Disorder Benefits

## Your payment

|   | <b>Level I<sup>3</sup></b><br>Care authorized by the MHSa or provided by MHSa participating providers | <b>CYD<sup>2</sup> applies</b> | <b>Level II<sup>3</sup></b><br>There are no separate benefit payments under Level II | <b>CYD<sup>2</sup> applies</b> | <b>Level III<sup>4</sup></b><br>When using MHSa Non-Participating Providers | <b>CYD<sup>2</sup> applies</b> |
|---|---|--------------------------------|--|--------------------------------|---|--------------------------------|
| <i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSa).</i> |   |                                |  |                                |   |                                |
| Partial Hospitalization Program   | \$0   |                                |  |                                | 40%<br>Subject to a Benefit maximum of \$350/day                            | ✓                              |
| Psychological Testing   | \$0   |                                |  |                                | 40%   | ✓                              |
| <b>Inpatient services</b>   |   |                                |  |                                |   |                                |
| Physician inpatient services  | \$0   |                                |  |                                | 40%   | ✓                              |
| Hospital services   | \$200/admission   |                                |  |                                | 40%<br>Subject to a Benefit maximum of \$600/day                            | ✓                              |
| Residential Care  | \$200/admission   |                                |  |                                | 40%<br>Subject to a Benefit maximum of \$600/day                            | ✓                              |

## Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

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

## Notes

### 1 Evidence of Coverage (EOC):

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

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

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

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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 Level I or Level II 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 Using Level III Non-Participating Providers:

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

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

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
  - Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
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### 5 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 Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

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

## Notes

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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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### **6 Separate Member Payments When Multiple Covered Services are Received:**

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

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### **7 Preventive Health Services:**

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

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

## NOTICES AVAILABLE ONLINE

### Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: [blueshieldca.com/notices](https://blueshieldca.com/notices). You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

### Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en [blueshieldca.com/notices](https://blueshieldca.com/notices). Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

### 非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 [blueshieldca.com/notices](https://blueshieldca.com/notices)。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。