



---

# 2027 Summary of Benefits

## Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for San Francisco Health Service System

For San Francisco Health Service System Members Enrolled Under Medicare Contract Number: H4937-801

Effective January 1, 2027 - December 31, 2027

# 2027 Summary of Benefits

## Blue Shield Medicare (PPO)

### H4937-801

Effective January 1, 2027 - December 31, 2027

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, **please contact your Plan Sponsor or call Blue Shield Medicare Customer Service at (800) 370-8852 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week.

**Blue Shield Medicare** includes Medicare health care (Part C) and prescription drug (Part D) coverage offering you the convenience of having both your medical services and prescription drugs covered through one plan.

To join **Blue Shield Medicare** you must have both Medicare Part A and B, meet your Plan Sponsor's eligibility requirements, permanently live in the plan service area, and be a United States citizen or national, or an eligible noncitizen. Your Medicare-eligible dependents may also join Blue Shield Medicare if they meet these requirements.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at [www.medicare.gov/medicare-and-you](http://www.medicare.gov/medicare-and-you) or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

**Our service area includes all 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.**

**Look up providers, pharmacies, and covered drugs on our website:**

- *Provider Directory* – [blueshieldca.com/sfhss](http://blueshieldca.com/sfhss)
- *Pharmacy Directory* – [blueshieldca.com/sfhss](http://blueshieldca.com/sfhss)
- *Formulary* (List of covered drugs) – [blueshieldca.com/sfhss](http://blueshieldca.com/sfhss)

Blue Shield of California's pharmacy network includes limited lower-cost, pharmacies with preferred cost sharing. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call Customer Service at **(800) 370-8852 (TTY: 711)**, 8 a.m. to 8 p.m., PT, seven days a week, or consult the online pharmacy directory at [blueshieldca.com/sfhss](http://blueshieldca.com/sfhss).

# Summary of Benefits

Effective January 1, 2027 - December 31, 2027

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

H4937-801

| Premiums and benefits                                                             |                                                                                                                                                                                    | In-network<br>you pay                                                                                                                                                                                                                                                                                                                                                | Out-of-network<br>you pay |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
|  | <b>Monthly plan premium</b><br>You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.                                               | Your Plan Sponsor is responsible for paying premiums beyond your monthly Medicare Part B premium, Medicare Part A premium (if applicable), and extra amounts (i.e. IRMAA, Part D Late Enrollment Penalties (LEP), etc.). If you are responsible for any contribution to the premiums, your Plan Sponsor will tell you the amount you must contribute to the premium. |                           |
|                                                                                   | <b>Health plan deductible</b>                                                                                                                                                      | \$0                                                                                                                                                                                                                                                                                                                                                                  |                           |
|                                                                                   | <b>Annual maximum out-of-pocket amount</b><br>Does not include Part D prescription drugs. This is the most you would pay for the year for covered Medicare Parts A and B services. | \$3,750 for services you receive from both in- and out-of-network providers combined.                                                                                                                                                                                                                                                                                |                           |

\* Prior authorization and/or a referral from your provider may be required.  
† Services do not apply to the plan’s maximum out-of-pocket limit.  
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

# Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

H4937-801

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | In-network<br>you pay | Out-of-network<br>you pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------|
|  <b>Inpatient hospital care*</b><br>Copay per admission.<br>Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.                                                                                                                                                                                                                                   |                       | \$150                     |
|  <b>Outpatient hospital services*</b><br>Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery. <ul style="list-style-type: none"> <li>• Emergency room visit<br/>Waived if you are admitted to the hospital within one day for the same condition</li> <li>• Outpatient hospital facility</li> <li>• Observation services</li> </ul> |                       | \$65                      |
|  <b>Outpatient surgery*</b> <ul style="list-style-type: none"> <li>• Ambulatory surgical center</li> <li>• Outpatient hospital facility</li> </ul>                                                                                                                                                                                                                                          |                       | \$100                     |
|  <b>Doctor visits</b> <ul style="list-style-type: none"> <li>• Primary care physician (PCP)</li> <li>• Specialists</li> </ul>                                                                                                                                                                                                                                                              |                       | \$5                       |
|  <b>Preventive care</b><br>Any additional preventive services approved by Medicare during the contract year will be covered.                                                                                                                                                                                                                                                               |                       | \$0                       |
|  <b>Emergency care</b> <ul style="list-style-type: none"> <li>• Worldwide coverage†</li> </ul> This copay is waived if you are admitted to the hospital within one day for the same condition. No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories.                                                             |                       | \$65                      |

\* Prior authorization and/or a referral from your provider may be required.

† Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

# Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

H4937-801

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | In-network<br>you pay | Out-of-network<br>you pay |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------|
|  <b>Urgently needed services</b> <ul style="list-style-type: none"> <li>Worldwide coverage<sup>†</sup></li> </ul> <p>These copays are waived if you are admitted to the hospital within one day for the same condition.<br/>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories.</p> <ul style="list-style-type: none"> <li>- Network urgent care center within the plan service area</li> <li>- Urgent care center outside your plan service area</li> <li>- Emergency room within your plan service area</li> <li>- Emergency room outside your plan service area</li> </ul> |                       |                           |
|  <b>Diagnostic services, labs, and imaging*</b> <ul style="list-style-type: none"> <li>Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)</li> <li>Lab services</li> <li>Diagnostic tests and procedures</li> <li>Outpatient X-rays</li> <li>Therapeutic radiology services (such as radiation treatment for cancer)</li> </ul>                                                                                                                                                                                                                                                                                                      |                       |                           |
|  <b>Hearing services</b> <ul style="list-style-type: none"> <li>Hearing exam (Medicare-covered)</li> <li>Hearing exam (non-Medicare covered)<sup>†</sup><br/>Limited to one in- or out-of-network exam per year.</li> <li>Hearings aids<sup>†</sup></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                          |                       |                           |
| <p>You will be reimbursed up to \$2,500 every 3 years for:</p> <ul style="list-style-type: none"> <li>Up to two hearing aids (one hearing aid, per ear) and two hearing aid fittings and evaluations (applies to both ears combined)</li> <li>Hearing supplies and accessories (including batteries)</li> <li>Hearing aid repairs and modifications</li> </ul> <p>You may obtain these services at the hearing aid provider of your choice.</p>                                                                                                                                                                                                                                                                                            |                       |                           |

\* Prior authorization and/or a referral from your provider may be required.

<sup>†</sup> Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

# Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

H4937-801

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | In-network<br>you pay | Out-of-network<br>you pay |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------|
|  <b>Dental services (Medicare-covered)</b><br>Medicare currently pays for dental services in a limited number of circumstances. <ul style="list-style-type: none"> <li>• Performed by your primary care physician (PCP)</li> <li>• Performed at a specialist's office</li> </ul>                                                                                                                                                                                                                     |                       |                           |
|  <b>Vision services</b> <ul style="list-style-type: none"> <li>• Exam to diagnose and treat diseases and conditions of the eye*<br/>Copay for each Medicare-covered visit.</li> <li>• Yearly glaucoma screening</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens</li> <li>• Routine (non-Medicare covered) eye exam, including refraction†<br/>Limited to one in-network or out-of-network exam every year.</li> </ul> |                       |                           |
|  <b>Mental health services</b> <ul style="list-style-type: none"> <li>• Inpatient services in a psychiatric hospital*<br/>Copay per admission.<br/>Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.</li> <li>• Outpatient group therapy visit</li> <li>• Outpatient individual therapy visit</li> </ul>                                                                                                                                              |                       |                           |
|  <b>Skilled nursing facility (SNF) care*</b><br>For each stay in a Medicare-certified skilled nursing facility. If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.                                                                                                                                                                                                                                                  |                       |                           |

\* Prior authorization and/or a referral from your provider may be required.

† Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

## Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

H4937-801

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

| Benefits                                                                          |                                                                                                                                                            | In-network<br>you pay | Out-of-network<br>you pay |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------|
|  | <b>Rehabilitation services</b>                                                                                                                             |                       |                           |
|                                                                                   | • Occupational therapy                                                                                                                                     |                       | \$20                      |
|                                                                                   | • Physical therapy                                                                                                                                         |                       | \$20                      |
|                                                                                   | • Speech and language therapy                                                                                                                              |                       | \$20                      |
|  | <b>Ambulance services*</b><br>Per trip (one way)                                                                                                           |                       | \$50                      |
|  | <b>Medicare Part B prescription drugs*</b><br>Insulin obtained under Part B (when taken with an insulin pump) will not exceed \$35 for a one-month supply. |                       | \$15                      |

\* Prior authorization and/or a referral from your provider may be required.

† Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

# Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

H4937-801

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

## Additional benefits included in your plan

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | In-network<br>you pay                      | Out-of-<br>network<br>you pay |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------|
|  <b>Annual physical exam<sup>†</sup></b><br>Limited to one in- or out-of-network exam every 12 months.                                                                                                                                                                                                                                                                                                                                                                                          | \$0                                        |                               |
|  <b>Opioid treatment program services*</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0                                        |                               |
|  <b>Podiatry services (foot care)</b> <ul style="list-style-type: none"> <li>• Foot exams and treatment (Medicare-covered)</li> </ul>                                                                                                                                                                                                                                                                                                                                                           | \$15                                       |                               |
| <ul style="list-style-type: none"> <li>• <b>Routine (non-Medicare covered) foot care<sup>†</sup></b><br/>You will be reimbursed up to \$100 per visit for routine foot care (limited to 6 visits per year, combined in- and out-of-network).</li> </ul>                                                                                                                                                                                                                                                                                                                          | \$0                                        |                               |
|  <b>Diabetic supplies and services*</b> <ul style="list-style-type: none"> <li>• ACCU-CHEK® and One Touch blood glucose monitors</li> <li>• Blood glucose monitors from all other manufacturers</li> <li>• Continuous glucose monitors</li> <li>• Continuous glucose monitor supplies</li> <li>• Continuous glucose monitor sensors</li> <li>• Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors and continuous glucose monitors)</li> </ul> | \$0<br>\$15<br>\$15<br>\$15<br>\$15<br>\$0 |                               |
|  <b>Durable medical equipment (DME) and related supplies</b> (e.g., wheelchairs, oxygen)*                                                                                                                                                                                                                                                                                                                                                                                                     | \$15                                       |                               |
|  <b>Prosthetic and orthotic devices and related supplies*</b> <ul style="list-style-type: none"> <li>• Prosthetic and orthotic devices (e.g., braces, artificial limbs)</li> <li>• Medical supplies (e.g., splints, casts)</li> </ul>                                                                                                                                                                                                                                                         | \$15<br>\$15                               |                               |

\* Prior authorization and/or a referral from your provider may be required.

† Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

# Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

H4937-801

Blue Shield Medicare (PPO)  
San Francisco Health Service  
System

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | In-network<br>you pay                                               | Out-of-network<br>you pay                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
|  <b>Health and wellness programs<sup>†</sup></b> <ul style="list-style-type: none"> <li>• Basic gym access through SilverSneakers<sup>†</sup></li> <li>• NurseHelp 24/7<sup>SM</sup> (telephone and online support)<sup>†</sup></li> <li>• LifeReferrals 24/7 – Access to counselors, consultations information, and referrals for a wide range of family and personal issues<sup>†</sup></li> <li>• Personal Emergency Response System (PERS) (24/7 medical alert)<sup>†</sup></li> <li>• Acupuncture services (non-Medicare covered)<sup>†</sup><br/>Limited to 24 in- and out-of-network visits combined, per year.</li> <li>• Chiropractic services (non-Medicare covered)<sup>†</sup><br/>Limited to 24 in- and out-of-network visits combined, per year.</li> </ul> | <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$15</p> <p>\$15</p> | <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p></p> <p></p> |
|  <b>Transportation services (non-Medicare covered)<sup>†</sup></b><br>24 one-way trips to plan approved health-related locations every year and each trip may not exceed 70 miles.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0                                                                 | Not covered                                                                                 |

\* Prior authorization and/or a referral from your provider may be required.

† Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

## Part D prescription drug coverage (cont'd)

Blue Shield Medicare (PPO)  
San Francisco Health  
Service System

Effective January 1, 2027 - December 31, 2027

H4937-801

### You pay the following

| Part D prescription drug benefit     |                                            |                                                                                   |                                            |                                       |
|--------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------|
| <b>Stage 1: Annual deductible</b>    |                                            | This stage does not apply because there is no deductible.                         |                                            |                                       |
| <b>Stage 2: Initial coverage</b>     |                                            | You pay the following until you have paid \$2,400 out-of-pocket for Part D drugs. |                                            |                                       |
|                                      | Preferred retail cost-sharing (in-network) |                                                                                   | Standard retail cost-sharing (in-network)^ |                                       |
|                                      | 30-day supply                              | Up to a 100-day supply <sup>NDS</sup>                                             | 30-day supply                              | Up to a 100-day supply <sup>NDS</sup> |
| <b>Tier 1: Generic drugs</b>         | \$5                                        | \$10                                                                              | \$5                                        | \$15                                  |
| <b>Tier 2: Preferred brand drugs</b> | \$20                                       | \$40                                                                              | \$20                                       | \$60                                  |
| <b>Tier 2: Covered insulins**</b>    | \$20                                       | \$40                                                                              | \$20                                       | \$60                                  |
| <b>Tier 3: Non-preferred drugs</b>   | \$45                                       | \$90                                                                              | \$45                                       | \$135                                 |
| <b>Tier 3: Covered insulins**</b>    | \$35                                       | \$90                                                                              | \$35                                       | \$105                                 |
| <b>Tier 4: Specialty tier drugs</b>  | \$20                                       | \$40 (up to a 90-day supply)                                                      | \$20                                       | \$60 (up to a 90-day supply)          |

\*\*Covered Insulins are marked with the symbol **INS** on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help"). A long-term (up to a 90- or 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol **NDS** in our Drug List. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

^ If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost sharing pharmacy. There are limited situations where you may be able to get drugs from an out-of-network pharmacy at the same cost as an in-network standard retail cost-sharing pharmacy.

## Part D prescription drug coverage (cont'd)

Blue Shield Medicare (PPO)  
San Francisco Health  
Service System

Effective January 1, 2027 - December 31, 2027

H4937-801

### Catastrophic coverage stage

After your yearly out-of-pocket costs for covered Part D drugs (including drugs purchased through your retail pharmacy and through home delivery) reaches \$2,400, the plan pays the full cost for your covered Part D drugs at no cost to you.

For excluded drugs covered under our enhanced benefit, you pay the cost sharing amounts listed in the table shown above.

(This stage protects you from any additional costs once you have paid your yearly out-of-pocket drug costs).



**Important message about what you pay for vaccines:** Our plan covers most adult Part D vaccines at no cost to you. Call Customer Service for more information.

### Home delivery service

Amazon Pharmacy is our prescription home delivery service provider where you can get a 100-day supply of maintenance drugs on Tier 1 through Tier 3 at a lower cost share. Your order will be delivered with \$0 shipping. If you have questions about this, please contact **Amazon Pharmacy's Blue Shield-dedicated Customer Care team at (856) 208-4665**, 24 hours a day, 7 days a week. TTY users call **711**. See the plan EOC for more information.

Tier 4 drugs are limited to a 90-day supply by home delivery service.

### Network pharmacies that offer preferred cost-sharing

You may pay less when you visit one of our network pharmacies that offer preferred cost-sharing. Here's just a few:

- |                                                     |                           |
|-----------------------------------------------------|---------------------------|
| • CVS Pharmacy®‡ (including CVS pharmacy at Target) | (888) 607-4287 (TTY: 711) |
| • Safeway and Vons pharmacies‡                      | (877) 723-3929 (TTY: 711) |
| • Albertsons/Sav-on/Osco pharmacies‡                | (877) 276-9637 (TTY: 711) |
| • Costco‡                                           | (800) 955-2292 (TTY: 711) |
| • Ralphs‡, Walmart‡, and many more                  |                           |

‡ Accepts e-prescribing.

You do not have to be a Costco member to use Costco Pharmacies. Other pharmacies are available in our network.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC at [blueshieldca.com/sfhss](https://blueshieldca.com/sfhss).

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

Blue Shield Medicare and NurseHelp 24/7 are service marks of Blue Shield of California. Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.

Amazon Pharmacy is independent of Blue Shield of California and is contracted to provide prescription home delivery services to members with Blue Shield pharmacy benefits. Members are responsible for their share of costs, as stated in their benefit plan details.

SilverSneakers is a registered trademarks of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved.

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability. La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。

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