blue california

2024 Summary of Benefits

Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for CalPERS

Effective January 1, 2024 – December 31, 2024

blueshieldca.com/medicare

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2024 Summary of Benefits

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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 former employer group/union or call Blue Shield Medicare Customer Service** at **(888) 802-4599** [TTY: **711**], 7 a.m. to 8 p.m., 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 be entitled to Medicare Part A, be enrolled in Medicare Part B, meet your former employer group/union's eligibility requirements, and live in our service area. 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 https://www.medicare.gov 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 and the District of Columbia.

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

- Provider Directory **– blueshieldca.com/medicare/providerdirectory**
- Pharmacy Directory **– blueshieldca.com/medpharmacy2024**
- Formulary (List of covered drugs) **– blueshieldca.com/medformulary2024**

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You pay the following:

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Monthly plan premium	Your former employer group/union is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any contribution to the premiums, your benefits administrator will tell you the amount you and your former employer group/union contribute to the premium.		You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Annual out-of-pocket maximum amount	$1,500 for services you receive from both in- and out-of-network providers combined.		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.
Health Plan Deductible	$0	$0	
Inpatient hospital care	$0 copay per admission	$0 copay per admission	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$50 copay for each visit to an emergency room (this copay is waived if you are admitted to the hospital within one day for the same condition) $0 copay for each visit to an outpatient hospital facility $0 copay for observation services	$50 copay for each visit to an emergency room (this copay is waived if you are admitted to the hospital within one day for the same condition) $0 copay for each visit to an outpatient hospital facility $0 copay for observation services	Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Prior authorization may be required and is the responsibility of your provider.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Outpatient surgery	$0 copay for each visit to an ambulatory surgical center $0 copay for each visit to an outpatient hospital facility	$0 copay for each visit to an ambulatory surgical center $0 copay for each visit to an outpatient hospital facility	Prior authorization may be required and is the responsibility of your provider.
Doctor visits • Physician of choice (POC) • Specialists	For all covered services: $0 copay per visit $0 copay per visit	For all covered services: $0 copay per visit $0 copay per visit	
Preventive care	$0 copay	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care • **Worldwide coverage**	$50 copay per visit No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories		This copay is waived if you are admitted to a hospital within one day for the same condition.
Urgently needed services • **Worldwide coverage**	$0 copay for each visit to a network urgent care center within your plan service area $0 copay for each visit to an urgent care center outside your plan service area but within the United States and its territories $50 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories $50 copay for each visit to an emergency room, $0 copay for urgent care center that is outside the United States and its territories No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories		These copays are waived if you are admitted to the hospital within one day for the same condition.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Diagnostic services, labs, and imaging			Prior authorization may be required for diagnostic services and is the responsibility of your provider.
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$0 copay for each diagnostic radiology service	$0 copay for each diagnostic radiology service	
• Lab services	$0 copay	$0 copay	
• Diagnostic tests and procedures	$0 copay	$0 copay	
• Outpatient X-rays	$0 copay	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay for each therapeutic radiology service	$0 copay for each therapeutic radiology service	
Hearing services			
• Hearing exam (Medicare covered)	$10 copay per visit	$10 copay per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay (limited to 1 exam per year)	$0 copay (limited to 1 exam per year)	
• Hearing aids	You will be reimbursed up to $1,000 every 3 years for hearing aids	You will be reimbursed up to $1,000 every 3 years for hearing aids	Applies to both ears combined; cost of hearing aids does not apply to plan's maximum out-of-pocket limit.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Vision services			
• Exam to diagnose and treat diseases and conditions of the eye	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit	Prior authorization may be required for an exam, treatment of diseases and conditions of the eye, and yearly glaucoma screenings and is the responsibility of your provider.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	$0 copay	$0 copay	
• Routine (non-Medicare covered) eye exam, including refraction	$10 copay	$10 copay	One exam every 12 months.
Mental health services			Prior authorization may be required and is the responsibility of your provider. There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital.
• Inpatient mental health care	$0 copay per stay for days 1 to 150 100% of the cost for days 151 and over, unless a new benefit period begins.	$0 copay per day for days 1 to 150 100% of the cost for days 151 and over, unless a new benefit period begins.	
• Outpatient group therapy visit	$0 copay per visit	$0 copay per visit	
• Outpatient individual therapy visit	$0 copay per visit	$0 copay per visit	
Skilled nursing facility (SNF) care	$0 copay per day for days 1 through 100	$0 copay per day for days 1 through 100	Prior authorization may be required and is the responsibility of your provider. If you go over the 100-day limit, you will be responsible for all cost; no prior hospitalization required with network provider.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Rehabilitation services • Occupational therapy services • Physical therapy and speech • Language therapy services	 $0 copay per visit $0 copay per visit $0 copay per visit	 $0 copay per visit $0 copay per visit $0 copay per visit	
Ambulance services	$0 copay per trip (one way)	$0 copay per trip (one way)	
Transportation Services (non-Medicare covered)	$0 copay for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips per year)	$0 copay for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips per year)	
Medicare Part B drugs	$0 copay	$0 copay	Some Part B drugs may require a prior authorization from your provider. Insulin obtained under Part B (when taken with an insulin pump) should not exceed $35 copay for a one-month supply.

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Additional benefits included in your plan

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Annual physical exam	$0 copay	**$0 copay**	One every 12 months.
Opioid treatment program services	$0 copay	$0 copay	Prior authorization may be required and is the responsibility of your provider.
Foot care (podiatry services) (Medicare-covered)			
• Foot exams and treatment	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit	
• Routine foot care (non-Medicare covered)	You will be reimbursed up to $100 every year for routine (non-Medicare covered) foot care	You will be reimbursed up to $100 every year for routine (non-Medicare covered) foot care	Limited to 6 visits per year.
Diabetic Supplies & Services			Prior authorization from the plan may be required for diabetes supplies, services and self-management training and is the responsibility of your provider. See the plan EOC for more information.
• Blood glucose monitors	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance of Medicare-allowed amount for all other manufacturers	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance of Medicare-allowed amount for all other manufacturers	
• Diabetes self-management training, diabetic services and supplies	$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Durable Medical Equipment (DME) and Related Supplies • Durable medical equipment (e.g., wheelchairs, oxygen)	$0 copay	$0 copay	Prior authorization from the plan may be required. See the plan EOC for more information.
Prosthetics/Medical Supplies • Prosthetics (e.g., braces, artificial limbs)	$0 copay	$0 copay	Prior authorization from your doctor may be required.
Health and Wellness programs • NurseHelp 24/7℠ (telephone and online support) • Basic gym access through SilverSneakers Fitness • LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue • Personal Emergency Response System (PERS)	$0 copay $0 copay $0 copay $0 copay	$0 copay $0 copay $0 copay $0 copay	
Acupuncture (non-Medicare covered)	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	
Over-the-Counter (OTC items)	You have an $80 allowance per quarter to spend on covered items	You have an $80 allowance per quarter to spend on covered items	You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Some limitations may apply. Refer to the OTC Items catalog for more information.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Routine chiropractic services (non-Medicare covered)	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	

Part D Prescription Drug Coverage

You pay the following:

Annual Deductible Stage	This stage does not apply because there is no deductible.
Initial Coverage Stage	You pay the following until you have paid $8,000 out-of-pocket for Part D drugs.
Annual Mail Service Out-of-Pocket Maximum	Once you've paid $1,000 a year for Tier 1, Tier 2 and Tier 4 formulary drugs through the plan's mail service pharmacy, you pay $0 for Tier 1, Tier 2 and Tier 4 formulary mail service drugs.

What you pay:	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**90-day supply*NDS**	**30-day supply***	**90-day supplyNDS**
Tier 1: Generic Drugs	$5 copay	$10 copay	$5 copay	$15 copay
Tier 2: Preferred Brand Drugs	$20 copay	$40 copay	$20 copay	$60 copay
Tier 3: Non-Preferred Brand Drugs	$50 copay	$100 copay	$50 copay	$150 copay
Tier 3: Covered Insulins**	$35 copay	$100 copay	$35 copay	$105 copay
Tier 4: Specialty Tier Drugs	$20 copay	Not covered	$20 copay	Not covered

***** Three-month supply preferred retail cost-sharing also applies to Blue Shield's mail service pharmacy, with the exception of Tier 4.

**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").

NDS A long-term (up to a 90-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.

^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.

Coverage Gap Stage
Because there is no coverage gap for the plan, this payment stage does not apply to you.

Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach $8,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 1: Generic Drugs copayments 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 Part D vaccines at no cost to you. Call Customer Service for more information.

Mail Service Pharmacy
CVS Caremark® is our network mail service pharmacy where you can get a 90-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. After enrolling in your Blue Shield Medicare plan, you can log in to your Blue Shield of California member account at blueshieldca.com/login.

Tier 4 drugs are limited to a 30-day supply by mail 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) 932-7948 [TTY: 711]
Costco (You do not have to be a member to use the pharmacy.)	(800) 955-2292 [TTY: 711]
Ralphs, Walmart, and other pharmacies are also available in our network of pharmacies with preferred cost-sharing. You do not have to be a Costco member to use Costco pharmacies. Other pharmacies are available in our network.	

‡Accepts e-prescribing

Out-of-network/non-contracted providers are under no obligation to treat Blue Shield Medicare 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. Out-of-network/non-contracted providers who provide covered services to Blue Shield Medicare members will be paid according to the Medicare Fee Schedules.

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas, benefits and provider networks.

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
MG00007-CalPERS_1023

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

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

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

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

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

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

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

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

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

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

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

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

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

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

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

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

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

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)