

## Plan information



[blueshieldca.com](https://blueshieldca.com)

blue  
california 

## Plan information



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### **Ventura County Professional Firefighters**

**Effective Date: December 26, 2021**

- Custom Access+ HMO Per Admit 15-500
- Custom Access+ HMO Facility Coinsurance 35-30%
- Custom Trio HMO Facility Coinsurance 25-30%
- Custom Full PPO Savings Embedded Deductible 3500

when you feel great,  
you're unstoppable.

When you go with Blue Shield of California, you're on your way to quality health coverage, large provider networks and a wide range of programs and services that offer more value with your plan. Blue Shield offers you:



High-quality provider networks  
of doctors and facilities



Innovative plan designs with  
comprehensive benefits



Proven programs and resources  
that add value

This booklet offers the information you need to  
choose the right health plan for you and your family.  
Go with Blue Shield and be unstoppable.

To access medical plan information disclosures, visit  
**[blueshieldca.com/largegroupdisclosures](https://blueshieldca.com/largegroupdisclosures)**.

To access dental plan information disclosures, visit  
**[blueshieldca.com/largegroupdisclosures/dental](https://blueshieldca.com/largegroupdisclosures/dental)**.

To access vision plan information disclosures, visit  
**[blueshieldca.com/largegroupdisclosures/vision](https://blueshieldca.com/largegroupdisclosures/vision)**.

## Table of Contents

### What's inside

Browse through the sections below to read about the Blue Shield coverage available to you. You can learn more about our programs and services, as well as how different types of health plans work, at [blueshieldca.com/employercoverage](https://blueshieldca.com/employercoverage).

#### 1. choose a plan

Custom Access+ HMO Per Admit 15-500 .....	page 5
Enhanced Rx \$10/20/35 with \$0 Pharmacy Deductible .....	page 11
Additional Hearing Aid and Ancillary Equipment Benefit for your HMO Plan .....	page 13
Chiropractic Benefits Additional coverage for your HMO Plan.....	page 16
Custom Access+ HMO Facility Coinsurance 35-30% .....	page 19
Basic Rx \$15/30 with \$0 Pharmacy Deductible .....	page 25
Additional Hearing Aid and Ancillary Equipment Benefit for your HMO Plan .....	page 28
Custom Trio HMO Facility Coinsurance 25-30% .....	page 31
Enhanced Rx \$15/30/45 with \$0 Pharmacy Deductible .....	page 37
Additional Hearing Aid and Ancillary Equipment Benefit for your HMO Plan .....	page 39
Custom Full PPO Savings Embedded Deductible 3500 .....	page 42

#### 2. find a provider/Rx

Find A Provider .....	page 54
Notice of Privacy Practices .....	page 56
Language assistance and notice about non-discrimination and accessibility.....	page 62
Contact Us .....	page 67

# 1.

## choose a plan

Start here! In this section you can explore your Blue Shield benefit options.

# blue of california

## Summary of Benefits

Ventura County Professional  
Firefighters  
Effective December 26, 2021  
HMO Plan

### Custom Access+HMO® Per Admit 15-500

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:

#### Access+ HMO Network

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

##### When using a Participating Provider<sup>3</sup>

Calendar Year medical Deductible	Individual coverage	\$0
	Family coverage	\$0: individual
		\$0: Family

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

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

##### When using a Participating Provider<sup>3</sup>

Individual coverage	\$2,000
Family coverage	\$2,000: individual
	\$4,000: 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>5</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>6</sup></b>		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
<b>Physician services</b>		
Primary care office visit	\$15/visit	
Access+ specialist care office visit (self-referral)	\$30/visit	
Other specialist care office visit (referred by PCP)	\$15/visit	
Physician home visit	\$15/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
<b>Other professional services</b>		
Other practitioner office visit	\$15/visit	
<i>Includes nurse practitioners, physician assistants, and therapists.</i>		
Teladoc consultation	\$0	
Family planning		
• Counseling, consulting, and education	\$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0	
• Tubal ligation	\$0	
• Vasectomy	\$0	
Podiatric services	\$15/visit	
<b>Pregnancy and maternity care</b>		
Physician office visits: prenatal and postnatal	\$0	
Physician services for pregnancy termination	\$0	
<b>Emergency Services</b>		
Emergency room services	\$100/visit	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>		
Emergency room Physician services	\$0	

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Urgent care center services</b>	\$15/visit	
<b>Ambulance services</b> <i>This payment is for emergency or authorized transport.</i>	\$100/transport	
<b>Outpatient Facility services</b>		
Ambulatory Surgery Center	\$125/surgery	
Outpatient Department of a Hospital: surgery	\$250/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
<b>Inpatient facility services</b>		
Hospital services and stay	\$500/admission	
Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>		
• Special transplant facility inpatient services	\$500/admission	
• Physician inpatient services	\$0	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b> <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>		
Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	\$0	
• Outpatient Department of a Hospital	\$0	
X-ray and imaging services <i>Includes diagnostic mammography.</i>		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
Other outpatient diagnostic testing <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>		
• Office location	\$0	
• Outpatient Department of a Hospital	\$0	



	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
Radiological and nuclear imaging services		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
<b>Rehabilitative and Habilitative Services</b>		
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>		
Office location	\$15/visit	
Outpatient Department of a Hospital	\$15/visit	
<b>Durable medical equipment (DME)</b>		
DME	\$0	
Breast pump	\$0	
Orthotic equipment and devices	\$0	
Prosthetic equipment and devices	\$0	
<b>Home health care services</b>	\$15/visit	
<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>		
<b>Home infusion and home injectable therapy services</b>		
Home infusion agency services	\$0	
<i>Includes home infusion drugs and medical supplies.</i>		
Home visits by an infusion nurse	\$15/visit	
Hemophilia home infusion services	\$0	
<i>Includes blood factor products.</i>		
<b>Skilled Nursing Facility (SNF) services</b>		
<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	\$100/day	
Hospital-based SNF	\$100/day	
<b>Hospice program services</b>	\$0	
<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>		

**Benefits<sup>5</sup>****Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Other services and supplies</b>		
Diabetes care services		
• Devices, equipment, and supplies	\$0	
• Self-management training	\$15/visit	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	

**Mental Health and Substance Use Disorder Benefits****Your payment**

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	<b>When using a MHSA Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Outpatient services</b>		
Office visit, including Physician office visit	\$15/visit	
Teladoc behavioral health	\$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	\$0	
Partial Hospitalization Program	\$0	
Psychological Testing	\$0	
<b>Inpatient services</b>		
Physician inpatient services	\$0	
Hospital services	\$500/admission	
Residential Care	\$500/admission	

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

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

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

## Notes

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### 2 Calendar Year Deductible (CYD):

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

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

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### 3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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

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

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

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

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

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### 5 Separate Member Payments When Multiple Covered Services are Received:

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

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### 6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. 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.

PENDING REGULATORY APPROVAL

## Enhanced Rx \$10/20/35 with \$0 Pharmacy Deductible Summary of Benefits

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

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

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

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

#### When using a Participating<sup>2</sup> Pharmacy

Calendar Year Pharmacy Deductible

Per Member \$0

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

#### Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$10/prescription	
Tier 2 Drugs	\$20/prescription	
Tier 3 Drugs	\$35/prescription	
Tier 4 Drugs	20% up to \$250/prescription	
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$30/prescription	
Tier 2 Drugs	\$60/prescription	
Tier 3 Drugs	\$105/prescription	
Tier 4 Drugs	20% up to \$750/prescription	
<b>Mail service pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$20/prescription	
Tier 2 Drugs	\$40/prescription	
Tier 3 Drugs	\$70/prescription	
Tier 4 Drugs	20% up to \$500/prescription	

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

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

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

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

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

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### 2 Using Participating Pharmacies:

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

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

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

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### 3 Outpatient Prescription Drug Coverage:

#### Medicare Part D-creditable coverage-

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

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### 4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

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

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

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

PENDING REGULATORY APPROVAL



Hearing Aid Services Rider

Group Rider  
HMO/POS

Summary of Benefits

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

Benefits	Your Payment
<i>Up to a \$2,000 maximum per Member in any 24-month period. Services are not subject to the Calendar Year Deductible.</i>	
<b>Hearing Aid Services</b>	<b>When using any provider</b>
Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments	
Hearing aid device checks	
Electroacoustic evaluations for hearing aids	All charges above \$2,000
Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords	

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

PENDING REGULATORY APPROVAL

## Introduction

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

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

## Benefits

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

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

## Submitting a Claim Form

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

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

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

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

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

## Exclusions

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Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or
- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.



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

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

Summary of Benefits

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

Benefits		Your Payment
<i>Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).</i>		
<i>Up to 30 visits per Member, per Calendar Year.</i>		
<i>Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.</i>		
	When using an ASH Participating Provider	When using a Non-Participating Provider
<b>Chiropractic Services</b>		
Office visit	\$10/visit	Not covered
Chiropractic Appliances	All charges above \$50	Not covered

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

PENDING REGULATORY APPROVAL

## Introduction

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

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

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

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

## Benefits

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### Chiropractic Services

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

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

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

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

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

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

## Member Services

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

Contact ASH Plans at:

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

ASH Plans can answer many questions over the telephone.

## Definitions

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

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

# blue of california

## Summary of Benefits

Ventura County Professional  
Firefighters  
Effective December 26, 2021  
HMO Plan

### Custom Access+HMO® Facility Coinsurance 35-30%

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:

#### Access+ HMO Network

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

#### When using a Participating Provider<sup>3</sup>

<b>Calendar Year medical Deductible</b>	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual
		\$0: Family

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

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

#### When using a Participating Provider<sup>3</sup>

<i>Individual coverage</i>	\$2,000
<i>Family coverage</i>	\$2,000: individual
	\$4,000: 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>5</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>6</sup></b>		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
<b>Physician services</b>		
Primary care office visit	\$35/visit	
Access+ specialist care office visit (self-referral)	\$40/visit	
Other specialist care office visit (referred by PCP)	\$35/visit	
Physician home visit	\$35/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
<b>Other professional services</b>		
Other practitioner office visit	\$35/visit	
<i>Includes nurse practitioners, physician assistants, and therapists.</i>		
Teladoc consultation	\$0	
Family planning		
• Counseling, consulting, and education	\$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0	
• Tubal ligation	\$0	
• Vasectomy	\$0	
Podiatric services	\$35/visit	
<b>Pregnancy and maternity care</b>		
Physician office visits: prenatal and postnatal	\$0	
Physician services for pregnancy termination	\$0	
<b>Emergency Services</b>		
Emergency room services	\$100/visit	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>		
Emergency room Physician services	\$0	

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Urgent care center services</b>	\$35/visit	
<b>Ambulance services</b> <i>This payment is for emergency or authorized transport.</i>	\$100/transport	
<b>Outpatient Facility services</b>		
Ambulatory Surgery Center	30%	
Outpatient Department of a Hospital: surgery	30%	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
<b>Inpatient facility services</b>		
Hospital services and stay	30%	
Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>		
• Special transplant facility inpatient services	30%	
• Physician inpatient services	\$0	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b> <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>		
Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	\$0	
• Outpatient Department of a Hospital	\$0	
X-ray and imaging services <i>Includes diagnostic mammography.</i>		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
Other outpatient diagnostic testing <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>		
• Office location	\$0	
• Outpatient Department of a Hospital	\$0	



	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
Radiological and nuclear imaging services		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
<b>Rehabilitative and Habilitative Services</b>		
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>		
Office location	\$35/visit	
Outpatient Department of a Hospital	\$35/visit	
<b>Durable medical equipment (DME)</b>		
DME	\$0	
Breast pump	\$0	
Orthotic equipment and devices	\$0	
Prosthetic equipment and devices	\$0	
<b>Home health care services</b>	\$35/visit	
<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>		
<b>Home infusion and home injectable therapy services</b>		
Home infusion agency services	\$0	
<i>Includes home infusion drugs and medical supplies.</i>		
Home visits by an infusion nurse	\$35/visit	
Hemophilia home infusion services	\$0	
<i>Includes blood factor products.</i>		
<b>Skilled Nursing Facility (SNF) services</b>		
<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	30%	
Hospital-based SNF	30%	
<b>Hospice program services</b>	\$0	
<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>		

## Benefits<sup>5</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Other services and supplies</b>		
Diabetes care services		
• Devices, equipment, and supplies	\$0	
• Self-management training	\$35/visit	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	

## Mental Health and Substance Use Disorder Benefits

## Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	When using a MHSA Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>		
Office visit, including Physician office visit	\$35/visit	
Teladoc behavioral health	\$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	\$0	
Partial Hospitalization Program	\$0	
Psychological Testing	\$0	
<b>Inpatient services</b>		
Physician inpatient services	\$0	
Hospital services	30%	
Residential Care	30%	

## 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.

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### 3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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

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

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

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

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

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### 5 Separate Member Payments When Multiple Covered Services are Received:

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

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### 6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. 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.

PENDING REGULATORY APPROVAL



## Outpatient Prescription Drug Rider

Group Rider  
HMO/POS

### Basic Rx \$15/30 with \$0 Pharmacy Deductible Summary of Benefits

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

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

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

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

#### When using a Participating<sup>2</sup> Pharmacy

Calendar Year Pharmacy Deductible

Per Member \$0

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

#### Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$15/prescription	
Tier 2 Drugs	\$30/prescription	
Tier 3 Drugs	Not covered	
Tier 4 Drugs	20% up to \$250/prescription	
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$45/prescription	
Tier 2 Drugs	\$90/prescription	
Tier 3 Drugs	Not covered	
Tier 4 Drugs	20% up to \$750/prescription	
<b>Mail service pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$30/prescription	
Tier 2 Drugs	\$60/prescription	
Tier 3 Drugs	Not covered	
Tier 4 Drugs	20% up to \$500/prescription	

## Notes

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

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

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

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

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

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### 2 Using Participating Pharmacies:

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

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

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

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### 3 Outpatient Prescription Drug Coverage:

#### Medicare Part D-creditable coverage-

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

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### 4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

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

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

## Notes

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Tier 3 Drugs. All tier 3 Drugs require a formulary exception. If approved, you pay your applicable Tier 2 Copayment or Coinsurance.

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

PENDING REGULATORY APPROVAL



Hearing Aid Services Rider

Group Rider  
HMO/POS

Summary of Benefits

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

Benefits	Your Payment
<i>Up to a \$2,000 maximum per Member in any 24-month period. Services are not subject to the Calendar Year Deductible.</i>	
<b>Hearing Aid Services</b>	<b>When using any provider</b>
Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments	
Hearing aid device checks	
Electroacoustic evaluations for hearing aids	All charges above \$2,000
Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords	

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

PENDING REGULATORY APPROVAL



## Introduction

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

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

## Benefits

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

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

## Submitting a Claim Form

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

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

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

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

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

## Exclusions

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Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or
- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

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

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

# blue of california

## Summary of Benefits

Ventura County Professional  
Firefighters  
Effective December 26, 2021  
HMO Plan

### Custom Trio HMO Facility Coinsurance 25-30%

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:

#### Trio ACO HMO Network

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

##### When using a Participating Provider<sup>3</sup>

<b>Calendar Year medical Deductible</b>	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual
		\$0: Family

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

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

##### When using a Participating Provider<sup>3</sup>

<i>Individual coverage</i>	\$2,000
<i>Family coverage</i>	\$2,000: individual
	\$4,000: 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>5</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>6</sup></b>		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
<b>Physician services</b>		
Primary care office visit	\$25/visit	
Trio+ specialist care office visit (self-referral)	\$40/visit	
Other specialist care office visit (referred by PCP)	\$25/visit	
Physician home visit	\$25/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
<b>Other professional services</b>		
Other practitioner office visit	\$25/visit	
<i>Includes nurse practitioners, physician assistants, and therapists.</i>		
Teladoc consultation	\$0	
Family planning		
• Counseling, consulting, and education	\$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0	
• Tubal ligation	\$0	
• Vasectomy	\$0	
Podiatric services	\$25/visit	
<b>Pregnancy and maternity care</b>		
Physician office visits: prenatal and postnatal	\$0	
Physician services for pregnancy termination	\$0	
<b>Emergency Services</b>		
Emergency room services	\$100/visit	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>		
Emergency room Physician services	\$0	

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Urgent care center services</b>	\$25/visit	
<b>Ambulance services</b> <i>This payment is for emergency or authorized transport.</i>	\$100/transport	
<b>Outpatient Facility services</b>		
Ambulatory Surgery Center	30%	
Outpatient Department of a Hospital: surgery	30%	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
<b>Inpatient facility services</b>		
Hospital services and stay	30%	
Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>		
• Special transplant facility inpatient services	30%	
• Physician inpatient services	\$0	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b> <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>		
Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	\$0	
• Outpatient Department of a Hospital	\$0	
X-ray and imaging services <i>Includes diagnostic mammography.</i>		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
Other outpatient diagnostic testing <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>		
• Office location	\$0	
• Outpatient Department of a Hospital	\$0	

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
Radiological and nuclear imaging services		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
<b>Rehabilitative and Habilitative Services</b>		
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>		
Office location	\$25/visit	
Outpatient Department of a Hospital	\$25/visit	
<b>Durable medical equipment (DME)</b>		
DME	\$0	
Breast pump	\$0	
Orthotic equipment and devices	\$0	
Prosthetic equipment and devices	\$0	
<b>Home health care services</b>	\$25/visit	
<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>		
<b>Home infusion and home injectable therapy services</b>		
Home infusion agency services	\$0	
<i>Includes home infusion drugs and medical supplies.</i>		
Home visits by an infusion nurse	\$25/visit	
Hemophilia home infusion services	\$0	
<i>Includes blood factor products.</i>		
<b>Skilled Nursing Facility (SNF) services</b>		
<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	30%	
Hospital-based SNF	30%	
<b>Hospice program services</b>	\$0	
<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>		

## Benefits<sup>5</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Other services and supplies</b>		
Diabetes care services		
• Devices, equipment, and supplies	\$0	
• Self-management training	\$25/visit	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	

## Mental Health and Substance Use Disorder Benefits

## Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	When using a MHSA Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>		
Office visit, including Physician office visit	\$25/visit	
Teladoc behavioral health	\$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	\$0	
Partial Hospitalization Program	\$0	
Psychological Testing	\$0	
<b>Inpatient services</b>		
Physician inpatient services	\$0	
Hospital services	30%	
Residential Care	30%	

## 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.

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### 3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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

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

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

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

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

---

### 5 Separate Member Payments When Multiple Covered Services are Received:

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

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### 6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. 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.

PENDING REGULATORY APPROVAL

## Enhanced Rx \$15/30/45 with \$0 Pharmacy Deductible Summary of Benefits

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

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

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

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

#### When using a Participating<sup>2</sup> Pharmacy

Calendar Year Pharmacy Deductible

Per Member \$0

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

#### Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$15/prescription	
Tier 2 Drugs	\$30/prescription	
Tier 3 Drugs	\$45/prescription	
Tier 4 Drugs	20% up to \$250/prescription	
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$45/prescription	
Tier 2 Drugs	\$90/prescription	
Tier 3 Drugs	\$135/prescription	
Tier 4 Drugs	20% up to \$750/prescription	
<b>Mail service pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$30/prescription	
Tier 2 Drugs	\$60/prescription	
Tier 3 Drugs	\$90/prescription	
Tier 4 Drugs	20% up to \$500/prescription	

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

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

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

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

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

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### 2 Using Participating Pharmacies:

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

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

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

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### 3 Outpatient Prescription Drug Coverage:

#### Medicare Part D-creditable coverage-

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

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### 4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

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

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

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

PENDING REGULATORY APPROVAL



Hearing Aid Services Rider

Group Rider  
HMO/POS

Summary of Benefits

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

Benefits	Your Payment
<i>Up to a \$2,000 maximum per Member in any 24-month period. Services are not subject to the Calendar Year Deductible.</i>	
<b>Hearing Aid Services</b>	<b>When using any provider</b>
Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments	
Hearing aid device checks	
Electroacoustic evaluations for hearing aids	All charges above \$2,000
Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords	

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

PENDING REGULATORY APPROVAL

## Introduction

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

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

## Benefits

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

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

## Submitting a Claim Form

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

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

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

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

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

## Exclusions

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Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or
- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

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

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

# blue of california

## Summary of Benefits

Ventura County Professional  
Firefighters  
Effective December 26, 2021  
PPO Savings Plan

### Custom Full PPO Savings Embedded Deductible 3500

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:

#### Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

#### Pharmacy Network:

#### Rx Ultra

#### Drug Formulary:

#### Plus Formulary

### 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.

#### When using a Participating<sup>3</sup> or Non-Participating<sup>4</sup> Provider

<b>Calendar Year medical and pharmacy Deductible</b>	<i>Individual coverage</i>	\$3,500
<i>This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible</i>	<i>Family coverage</i>	\$3,500: individual \$7,000: 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.

#### 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.

	When using a Participating Provider <sup>3</sup>	When using a Non-Participating Provider <sup>4</sup>
<i>Individual coverage</i>	\$5,000	\$10,000
<i>Family coverage</i>	\$5,000: individual \$10,000: Family	\$10,000: individual \$20,000: Family

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	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>7</sup></b>				
Preventive Health Services	\$0		Not covered	
California Prenatal Screening Program	\$0		\$0	
<b>Physician services</b>				
Primary care office visit	20%	✓	50%	✓
Specialist care office visit	20%	✓	50%	✓
Physician home visit	20%	✓	50%	✓
Physician or surgeon services in an Outpatient Facility	20%	✓	50%	✓
Physician or surgeon services in an inpatient facility	20%	✓	50%	✓
<b>Other professional services</b>				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	20%	✓	50%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	20%	✓	50%	✓
Chiropractic services <i>Up to 20 visits per Member, per Calendar Year.</i>	20%	✓	50%	✓
Teladoc consultation	\$0	✓	Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	20%	✓	Not covered	
Podiatric services	20%	✓	50%	✓
<b>Pregnancy and maternity care</b>				
Physician office visits: prenatal and postnatal	20%	✓	50%	✓
Physician services for pregnancy termination	20%	✓	50%	✓



	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Emergency Services</b>				
Emergency room services	\$100/visit plus 20%	✓	\$100/visit plus 20%	✓
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>				
Emergency room Physician services	20%	✓	20%	✓
<b>Urgent care center services</b>	20%	✓	50%	✓
<b>Ambulance services</b>	20%	✓	20%	✓
<i>This payment is for emergency or authorized transport.</i>				
<b>Outpatient Facility services</b>				
Ambulatory Surgery Center	20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: surgery	20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
<b>Inpatient facility services</b>				
Hospital services and stay	\$100/admission plus 20%	✓	50% Subject to a Benefit maximum of \$600/day	✓
Transplant services				
<i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>				
• Special transplant facility inpatient services	\$100/admission plus 20%	✓	Not covered	
• Physician inpatient services	20%	✓	Not covered	

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Bariatric surgery services, designated California counties</b>				
<i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.</i>				
Inpatient facility services	\$100/admission plus 20%	✓	Not covered	
Outpatient Facility services	20%	✓	Not covered	
Physician services	20%	✓	Not covered	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b>				
<i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>				
Laboratory services				
<i>Includes diagnostic Papanicolaou (Pap) test.</i>				
• Laboratory center	20%	✓	50%	✓
• Outpatient Department of a Hospital	\$25/visit plus 20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
X-ray and imaging services				
<i>Includes diagnostic mammography.</i>				
• Outpatient radiology center	20%	✓	50%	✓
• Outpatient Department of a Hospital	\$25/visit plus 20%	✓	50% Subject to a Benefit maximum of \$350/day	✓

Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
Other outpatient diagnostic testing				
<i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>				
• Office location	20%	✓	50%	✓
• Outpatient Department of a Hospital	\$25/visit plus 20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✓	50%	✓
• Outpatient Department of a Hospital	\$100/visit plus 20%	✓	50% 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	20%	✓	50%	✓
Outpatient Department of a Hospital	20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
<b>Durable medical equipment (DME)</b>				
DME	20%	✓	50%	✓
Breast pump	\$0		Not covered	
Glucose monitor	\$0		50%	✓
Peak Flow Meter	\$0		50%	✓
Orthotic equipment and devices	20%	✓	50%	✓
Prosthetic equipment and devices	20%	✓	50%	✓

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Home health care services</b> <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>	20%	✓	Not covered	
<b>Home infusion and home injectable therapy services</b> Home infusion agency services <i>Includes home infusion drugs and medical supplies.</i>	20%	✓	Not covered	
Home visits by an infusion nurse	20%	✓	Not covered	
Hemophilia home infusion services <i>Includes blood factor products.</i>	20%	✓	Not covered	
<b>Skilled Nursing Facility (SNF) services</b> <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	20%	✓	20% 50%	✓
Hospital-based SNF	20%	✓	Subject to a Benefit maximum of \$600/day	✓
<b>Hospice program services</b> <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0	✓	Not covered	
<b>Other services and supplies</b> Diabetes care services <ul style="list-style-type: none"> <li>Devices, equipment, and supplies</li> <li>Self-management training</li> </ul>	20%	✓	50%	✓
	20%	✓	50%	✓
Dialysis services	20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
PKU product formulas and special food products	20%	✓	20%	✓

## Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
Allergy serum billed separately from an office visit	20%	✓	50%	✓
Hearing aid services				
<ul style="list-style-type: none"> <li>Hearing aids and equipment</li> </ul>	\$0	✓	\$0	✓
Up to \$2,000 combined maximum per Member, per 24-month period.				

## Mental Health and Substance Use Disorder Benefits

## Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	When using a MHSA Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a MHSA Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>				
Office visit, including Physician office visit	20%	✓	50%	✓
Teladoc behavioral 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	20%	✓	50%	✓
Partial Hospitalization Program	20%	✓	50% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	20%	✓	50%	✓
<b>Inpatient services</b>				
Physician inpatient services	\$0	✓	50%	✓
Hospital services	\$100/admission plus 20%	✓	50% Subject to a Benefit maximum of \$600/day	✓
Residential Care	\$100/admission plus 20%	✓	50% Subject to a Benefit maximum of \$600/day	✓

	When using a Participating Pharmacy <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Pharmacy <sup>4</sup>	CYD <sup>2</sup> applies
<b>Retail pharmacy prescription Drugs</b>				
<i>Per prescription, up to a 30-day supply.</i>				
Contraceptive Drugs and devices	\$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	\$10/prescription	✓	25% plus \$10/prescription	✓
Tier 2 Drugs	\$25/prescription	✓	25% plus \$25/prescription	✓
Tier 3 Drugs	\$40/prescription	✓	25% plus \$40/prescription	✓
Tier 4 Drugs	30% up to \$250/prescription	✓	30% up to \$250/prescription plus 25% of purchase price	✓
<b>Retail pharmacy prescription Drugs</b>				
<i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$30/prescription	✓	Not covered	
Tier 2 Drugs	\$75/prescription	✓	Not covered	
Tier 3 Drugs	\$120/prescription	✓	Not covered	
Tier 4 Drugs	30% up to \$750/prescription	✓	Not covered	
<b>Mail service pharmacy prescription Drugs</b>				
<i>Per prescription, up to a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$20/prescription	✓	Not covered	
Tier 2 Drugs	\$50/prescription	✓	Not covered	
Tier 3 Drugs	\$80/prescription	✓	Not covered	
Tier 4 Drugs	30% up to \$500/prescription	✓	Not covered	

## Prior Authorization

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

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see [blueshieldca.com/pharmacy](https://blueshieldca.com/pharmacy))

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

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## Notes

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### 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.

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

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

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.

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### 3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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

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

- Coinsurance is calculated from the Allowable Amount.
-

### 4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a 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 Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM. Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the Participating Provider OOPM.

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

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### 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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### 8 Outpatient Prescription Drug Coverage:

#### Medicare Part D-creditable coverage-

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



### 9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

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

Oral Anticancer Drugs. After the Deductible is met, you pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply.

High Deductible Health Plan (HDHP) preventive Drugs. HDHP preventive Drugs obtained from a Participating Pharmacy are covered at the applicable Drug tier Copayment but are not subject to the Deductible. HDHP preventive Drugs do not include those preventive Drugs that are required by Health Care Reform to be covered at no charge. Visit [blueshieldca.com/pharmacy](http://blueshieldca.com/pharmacy) for lists of these Drugs.

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

PENDING REGULATORY APPROVAL

# 2.

## find a provider/Rx

Use the information in this section  
to help you find a doctor and learn  
about your prescription drug options.

# Find the doctor of your choice

Blue Shield believes that finding a doctor shouldn't give you a headache. That's why [blueshieldca.com](https://blueshieldca.com) features our most up-to-date listings of doctors, specialists, pharmacies, and hospitals.

## We're making it easier!

Finding the latest listing of doctors, specialists, mental health providers, hospitals, dentists, vision care providers, or pharmacies is easy. Go to **blueshieldca.com** and select *Find a Doctor* from the menu. Here are some helpful shortcuts:

1. How you start depends on the type of plan:

- For Access+ HMO®: Go to **blueshieldca.com/networkhmo**.
- For Local Access+ HMO®: Go to **blueshieldca.com/networklocalaccess**.
- For Access+ HMO SaveNet®: Go to **blueshieldca.com/networksavenet**.
- For Trio HMO: Go to **blueshieldca.com/networktriohmo**.

- For PPO: Go to **blueshieldca.com/pponetwork**.

- For Tandem PPO: Go to **blueshieldca.com/networktandemppo**.

2. Select the type of provider you need (e.g., doctor, facility, mental health).
3. Enter your preferred location.
4. Select whether you want to search by provider specialty or provider name.
5. Relevant results will be displayed.

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## Special considerations for each plan type

### If you are enrolling in an HMO plan

When you enroll in an HMO plan, you and your dependents must choose a primary care physician (PCP) within 15 miles or a 30-minute drive\* from where you live or work. You can either search for your PCP using Blue Shield of California's *Find a Doctor* tool found at **blueshieldca.com**, or call Member Services for assistance. If you do not select a PCP when you enroll, we will assign you one. You can then change your PCP at any time. PCPs provide routine checkups, immunizations, and urgent care and refer you to specialists.

### If you are enrolling in a PPO plan

As a PPO plan member, you can choose your own doctor and do not need a referral to see a specialist. Choosing a provider in the PPO networks can save you money and ensure that you receive the highest level of benefits available to you.

When you visit doctors outside the PPO network, you may be responsible for higher copayments plus any charges in excess of Blue Shield's allowed amount for the services.

### If you access care outside California

PPO members who access care outside California may do so through the BlueCard® Program Network, which includes access to more than 95% of doctors and 96% of hospitals nationwide. Whenever possible, you should choose a doctor or hospital from the BlueCard network to save you money and ensure you receive the highest level of benefits available to you. When you visit doctors who are not in the BlueCard network, you may be responsible for higher copayments plus any charges in excess of Blue Shield's allowed amount for the services.

To find a BlueCard physician or hospital in the United States, go to **provider.bcbs.com** or call BlueCard Access toll-free at **(800) 810-BLUE (2583)**.

To find an international Blue Shield Global Core Network physician or hospital, go to **bcbsglobalcore.com**. You can also call the Blue Shield Global Core Service Center at **(800) 810-BLUE (2583)** from within the United States, or call collect at **(804) 673-1177** from outside the country.

\* Primary care physician service areas vary by contract.

## Prescription drug program

Our prescription drug program provides access to a network of chain and independent pharmacies, as well as a mail service pharmacy and specialty pharmacies. For more information, visit **[blueshieldca.com/pharmacy](https://blueshieldca.com/pharmacy)**.

### Chain and independent pharmacies

The Blue Shield pharmacy network includes all major pharmacy chains and most independent pharmacies in California. It's easy to find a local network pharmacy. Search our online listing of pharmacies, where you'll find the most up-to-date information:

- Visit **[blueshieldca.com/pharmacy](https://blueshieldca.com/pharmacy)** and go to the *Pharmacy networks* section.
- If you want to locate a pharmacy where your prescription is covered, go to **[blueshieldca.com](https://blueshieldca.com)** and select *Find a Doctor* from the menu, then choose *Pharmacies*.

### Mail service pharmacy

We offer a mail service pharmacy benefit that gives you up to a 90-day supply of covered maintenance drugs through the mail. This service is available if you are taking stabilized dosages of covered maintenance drugs on an ongoing basis for treatment of chronic health conditions, such as high blood pressure. For more information, go to **[blueshieldca.com/90dayRX](https://blueshieldca.com/90dayRX)**.

### Specialty pharmacy

Network specialty pharmacies are available to Blue Shield members. These pharmacies provide convenient delivery of specialty medications, including self-administered injectables. All supplies required for administration of specialty medications that are injectable (such as needles/syringes, alcohol swabs, sharps containers) are included at no additional charge.

Prior authorization is required for specialty medications. Members prescribed self-administered injectables with a specialty drug benefit are required to get these drugs from a network specialty pharmacy.

### Learn if your prescription is covered

The Blue Shield drug formulary is a list of preferred generic and brand-name drugs.

It's easy to learn if your medication is covered in our formulary. Go to **[blueshieldca.com/pharmacy](https://blueshieldca.com/pharmacy)**, and choose *Drug formularies* to find a drug formulary that applies to you.

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el numero que se encuentra en su tarjeta de identificación de Blue Shield.

# Notice of privacy practices

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

**This Notice describes how medical information about you, as a Blue Shield member, may be used and disclosed, and how you can get access to your information.**

## Our privacy commitment

At Blue Shield, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously.

In the normal course of doing business, we create records about you, your medical treatment, and the services we provide to you. The information in those records is called protected health information (PHI) and includes your individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We are required by federal and state law to provide you with this Notice of our legal duties and privacy practices as they relate to your PHI. We are required to maintain the privacy of your PHI and to notify you in the event that you are affected by a breach of unsecured PHI. When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI.

## How we protect your privacy

We maintain physical, technical, and administrative safeguards to ensure the privacy of your PHI. To protect your privacy, only Blue Shield workforce members who are authorized and trained are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures, including how paper and electronic records are labeled, stored, filed, and accessed.
- Physical, technical, and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow our privacy policies and procedures, and educates our organization on this important topic.

## How we use and disclose your PHI

### Uses of PHI without your authorization.

We may disclose your PHI without your written authorization if necessary while providing health benefits and services

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to you. We may disclose your PHI for the following purposes:

- **Treatment:**

- To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
- To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
- To coordinate your health care and related services with a healthcare facility or professional.

- **Payment:**

- To obtain payment of premiums for your coverage.
- To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
- To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
- To obtain payment from a third party that may be responsible for payment, such as a family member.
- To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.

- **Healthcare operations:**

- To provide customer service.
- To support and/or improve the programs or services we offer you.
- To assist you in managing your health – for example, to provide you

with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.

- To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
- For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**

- If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
- If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement

with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.

- We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.

- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.

- **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.

- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.

- **Public health activities.** We may disclose your PHI to:

- Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
- Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
- Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
- Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.

- **Health oversight activities.** We may disclose your PHI to:

- A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.



- Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

#### **Uses of PHI that require your authorization.**

Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

**Uses and disclosure of certain PHI deemed "highly confidential."** For certain kinds of PHI, federal and state law may require enhanced privacy protection. This includes PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis, or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law.

**Authorization cancellation.** At any time, you may cancel a written authorization that you previously gave us. When submitted to us in writing, the cancellation will apply to future uses and disclosures of your PHI. It will not affect uses or disclosures made previously, while your authorization was in effect.

## **Your individual rights**

You have the following rights regarding the PHI that Blue Shield creates, obtains, and/or maintains about you:

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment, and healthcare operations, as explained in this Notice. We are not required to agree to your restriction requests, but we will consider them carefully.

If we agree to a restriction request, we will abide by it until you request or agree to terminate the restriction. We may also inform you that we are terminating our agreement to a restriction. In that case, the termination will apply only to PHI created or received after we have informed you of the termination.



- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a "designated record set." This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request.
  - Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
  - Certain other disclosures that we are allowed by law to exclude from the accounting.

If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have agreed to receive the Notice electronically. See the "Notice Availability and Duration" section of this Notice.

## Actions you may take

**Contact Blue Shield.** If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us:

**Blue Shield of California Privacy Office**  
**P.O. Box 272540**  
**Chico, CA 95927-2540**

**Phone:** (888) 266-8080 (toll-free)

**Fax:** (800) 201-9020 (toll-free)

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

For certain types of requests, you must complete and mail us a form that is available either by calling the customer service number on your Blue Shield member ID card or by visiting our website at [blueshieldca.com/privacyforms](http://blueshieldca.com/privacyforms).

**Contact a government agency.** You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe we may have violated your privacy rights. Your complaint may be sent by email, fax, or mail to the HHS Office for Civil Rights (OCR).

For more information, or to file a complaint with the Secretary of HHS, visit the OCR website at [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

If you are a California resident, you may contact the OCR Regional Manager for California as follows:

**Region IX Regional Manager**  
**Office for Civil Rights**  
**U.S. Department of Health & Human Services**  
**90 7th St., Suite 4-100**  
**San Francisco, CA 94103**

**Phone:** (800) 368-1019

**Fax:** (202) 619-3818

**TTY:** (800) 537-7697

We will not take any action against you if you exercise your right to file a complaint, either with us or with HHS.

## Notice availability and duration

**Notice availability.** A copy of this Notice is available by calling the customer service number on your Blue Shield member ID card or by visiting our website at [blueshieldca.com/privacynotice](http://blueshieldca.com/privacynotice).

**Right to change terms of this Notice.** We are required to abide by the terms of this Notice as long as it remains in effect. We may change the terms of this Notice at any time, and, at our discretion, we may make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will update the Notice on our website, and if you are enrolled in a Blue Shield benefit plan at that time, we will send you the new Notice when and as required by law.

**Effective date.** This Notice is effective as of August 16, 2013.

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 cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡或殘障為由而進行歧視。

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

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

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

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

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

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

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

# Notice of the Availability of Language Assistance Services

## Blue Shield of California

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

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

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

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

**MAHALAGA:** Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa 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 naaltsoosish yíniłta'go bííniǵhah? Doo bííniǵhahgóó éí, naaltsoos nich'í' yíidóoltaǵíí ła' nihee hółǫ. Díí naaltsoos áldó' t'áá Diné k'ehjí ádoolníł nínízingo bíiǵhah. Doo ɓaah ílínígó shíká' adoowoł nínízingó nihich'í' béésh bee hodíłnih dóó námboo éí díí Blue Shield bee néího'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodíłnih. (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 اختیاراتان 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 شناسایی Blue Shield تان درج شده است و یا از طریق شماره تلفن (866) 346-7198 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। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់៖** តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្ទង់ប័ណ្ណសម្គាល់ 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 (866) 346-7198. (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 kias rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

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

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

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



# Notice of the Availability of Language Assistance Services

## Blue Shield of California Life & Health Insurance Company

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。**您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

**Անվճար Լեզվական Ծառայություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

**خدمات مجانی مربوط به زبان.** می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ 'ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាភូតិកផ្នែក៖** អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយសូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

**خدمات ترجمة بدون تكلفة.** يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากสาม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

**Doo bááh ílínígó saad bee yát'i' bee aná'áwo'.** Díí shá ata'halne'dooígí hólóqodoo nínízingo éí bííghah. Naaltsoos naanínáhájeehígí shich'í' yíidooltah éí doodagó ła' shich'í' ádoolníí nínízingo bííghah. Shíká a'doowoł nínízingo nihich'í' béesh bee hodílnih dóo námbóo éí díí ninaaltsoos dootł'ízhígí bee néího'dílnízingo bine'déé' bikáá' éí doodagó éí (866)346-7198jí' hodílnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'áah naa'nil bíł haz'áají' 1-800-927-4357jí' hodílnih. Navajo

**ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ.** ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີ ໃນບັດປະຈຳຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ 1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ 1-800-927-4357. Laotian

# How to contact us

If you have questions about the information included in this booklet, please contact a Blue Shield representative at one of the numbers below. Service is available in multiple languages.

Member Services	(888) 256-1915	8 a.m. to 5 p.m PST, Monday through Friday
Trio HMO Member Services	(855) 829-3566	7 a.m. to 7 p.m PST, Monday through Friday

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Or, you can always visit us online at [blueshieldca.com](https://www.blueshieldca.com), anytime, day or night.