blue california

Plan information

CALIFORNIA HYDRONICS CORP., INC.

Effective Date: 1/1/2024

- Active Choice® Plus 300 20 80/60

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When you choose 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 give you more value with your plan. Blue Shield offers you:

High-quality provider networks of doctors and facilities

Innovative plan designs with comprehensive benefits

Programs and resources proven to add value

This booklet offers the information you need to choose the right health plan for you and your family. We look forward to helping you take care of what matters most.

- To access medical plan information disclosures, visit **blueshieldca.com/largegroupdisclosures**.

- To access dental plan information disclosures, visit **blueshieldca.com/largegroupdisclosures/dental**.

- To access vision plan information disclosures, visit **blueshieldca.com/largegroupdisclosures/vision**.

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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**.

1.

Choose a plan

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

blue of california

Summary of Benefits

Group Plan
PPO Plan

Active Choice® Plus 300 20 80/60

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] 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.

How Your Active Choice Plan Works

Active Choice is a PPO plan with three categories of Benefits impacting the Deductible:

- Preventive Care Category – Available at no cost to you. These services are not subject to any Deductible.
- Category 1 – Certain routine care services. You can use your First Dollar Services credit towards these services before any Deductible applies.
- Category 2 – All other Covered Services. These services are subject to any Deductible.

Calendar Year Deductibles (CYD)[2]

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[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[5]

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.

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$3,000	$10,000
Family coverage	$3,000: individual	$10,000: individual
	$6,000: Family	$20,000: 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.

Preventive Care Category	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
Preventive Health Services[6]		
Preventive Health Services	$0	Not covered
California Prenatal Screening Program	$0	$0
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
Durable medical equipment (DME)		
Breast pump	$0	Not covered

Category 1: First Dollar Services – Outpatient Professional and Diagnostic[7]

		When using a Participating[3] or Non-Participating[4] Provider
First Dollar Services credit	*Individual coverage*	$300
	Family coverage	$600

Blue Shield credits you with a dollar amount each year to use for certain routine care services. These routine care services are called First Dollar Services.

You do not have to meet any Calendar Year Deductible before Blue Shield provides Benefits for First Dollar Services. When you receive services listed under First Dollar Services, Blue Shield pays 100% of the Allowable Amount for the first $300 per Member or $600 per Family, each Calendar Year.

After the first $300 per Member or $600 per Family First Dollar Services credit maximum is reached, you pay any applicable Deductible, Copayment or Coinsurance, as noted below in the Category 1 First Dollar Services Benefit chart. Once your Calendar Year Out-of-Pocket Maximum amount has been reached, Blue Shield pays 100% of the Allowable Amount for subsequent services.

Note: Only services listed as First Dollar Services are reimbursed as described above. The Preventive Care Category is covered at no charge and is not applied to your First Dollar Services credit. For more about First Dollar Services, see the *Paying for Covered Services* section of the EOC.

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	Your payment			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Physician services				
Primary care office visit	$20/visit		40%	
Specialist care office visit	$25/visit		40%	

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	Your payment			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Physician home visit	$20/visit		40%	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, Physicians assistants, therapists, and podiatrists.*	$20/visit		40%	
Acupuncture services *Up to 20 visits per Member, per Calendar Year.*	$20/visit		40%	
Chiropractic services *Up to 12 visits per Member, per Calendar Year.*	$20/visit		40%	
Urgent care center services	$20/visit		40%	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*				
Laboratory and pathology services, except emergency and surgery *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	$20/visit		40%	
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day	
Basic imaging services, except emergency and surgery *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	$20/visit		40%	
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day	

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	Your payment			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Other outpatient non-invasive diagnostic testing, except emergency and surgery *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	$20/visit		40%	
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day	
Advanced imaging services, except emergency *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	20%		40%	
• Outpatient Department of a Hospital	20%		40% Subject to a Benefit maximum of $350/day	
Rehabilitative and habilitative services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.*				
Office location	20%		40%	
Outpatient Department of a Hospital	20%		40% Subject to a Benefit maximum of $350/day	
Durable medical equipment (DME)				
DME not listed under preventive care	20%		40%	
Orthotic equipment and devices	20%		40%	
Prosthetic equipment and devices	20%		40%	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%		40%	
• Self-management training	$20/visit		40%	
• Medical nutrition therapy	$20/visit		40%	

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	Your payment			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Allergy serum billed separately from an office visit	20%		40%	
Outpatient medical treatment of the teeth, gums, jaw joints, or jaw bones office visit, except surgery	$20/visit		40%	

Category 1: First Dollar Services - Mental Health and Substance Use Disorder Benefits[7]	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Outpatient services				
Office visit, including Physician office visit	$0		40%	
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%		40%	
Partial Hospitalization program	20%		40%	
Psychological Testing	20%		40%	

Category 2: Outpatient and Inpatient Facility-Based Services[8]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Physician services				
Physician or surgeon services in an Outpatient Facility, except for Category 1 services	20%		40%	
Physician or surgeon services in an inpatient facility	20%		40%	
Other Professional services				
Teladoc consultation	$0		Not covered	
Medical nutrition therapy, not related to diabetes	20%		40%	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%		40%	

Category 2: Outpatient and Inpatient Facility-Based Services[8]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Abortion and abortion-related services	$0		$0	
Emergency Services				
Emergency room services *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.*	$100/visit plus 20%		$100/visit plus 20%	
Emergency room Physician services	20%		20%	
Ambulance services *This payment is for emergency or authorized transport.*	20%		20%	
Outpatient Facility services				
Ambulatory Surgery Center	$250/surgery plus 20%		40% Subject to a Benefit maximum of $350/day	
Outpatient Department of a Hospital: surgery	$400/surgery plus 20%		40% 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%		40% Subject to a Benefit maximum of $350/day	
Inpatient facility services				
Hospital services and stay	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day	
Transplant services *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.*				
• Special transplant facility inpatient services	$500/admission plus 20%		Not covered	
• Physician inpatient services	20%		Not covered	

Category 2: Outpatient and Inpatient Facility-Based Services[8]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services, designated California counties *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.*				
Inpatient facility services	$500/admission plus 20%		Not covered	
Outpatient Facility services	$400/surgery plus 20%		Not covered	
Physician services	20%		Not covered	
Home health care services *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.*	20%		Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	20%		Not covered	
Skilled Nursing Facility (SNF) services *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.*				
Freestanding SNF	20%		20%	
Hospital-based SNF	20%		40% Subject to a Benefit maximum of $600/day	

Category 2: Outpatient and Inpatient Facility-Based Services[8]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Hospice program services *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.*	$0		Not covered	
Other services and supplies				
Dialysis services	20%		40% Subject to a Benefit maximum of $350/day	
PKU product formulas and special food products	20%		20%	
Vasectomy	$0		Not covered	

Category 2: Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Outpatient services				
Teladoc mental health	$0		Not covered	
Inpatient services				
Physician inpatient services	$0		40%	
Hospital services	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day	
Residential care	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day	

Prior Authorization

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

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

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

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

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

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

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 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.

Notes

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.

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

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.

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.

7 First Dollar Services:

Family coverage has a combined FDS credit maximum. Each Calendar Year when you or one of your Dependents incurs allowed charges for FDS, the amount paid by Blue Shield for those services is deducted from the Family FDS credit amount.

Carryover credit. Any unused portion of the FDS credit may be carried over for use in the next Calendar Year. For more about carryover credit, see the *Paying for Covered Services* section of the EOC.

8 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 after the First Dollar Services credit maximum is exhausted.

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

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Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx $15/30/45 with $250 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)[1]

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[2] or Non-Participating[3] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$250

Prescription Drug Benefits[4,5]

	Your payment			
	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYPD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$15/prescription		25% plus $15/prescription	
Tier 2 Drugs	$30/prescription	✔	25% plus $30/prescription	✔
Tier 3 Drugs	$45/prescription	✔	25% plus $45/prescription	✔
Tier 4 Drugs	30% up to $250/prescription	✔	30% up to $250/prescription plus 25% of purchase price	✔
Retail pharmacy prescription Drugs				
Per prescription, up to a 90-day supply from a 90-day retail pharmacy.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$45/prescription		Not covered	

Prescription Drug Benefits[4,5]	Your payment			
	When using a Participating Pharmacy[2]	CYPD[1] applies	When using a Non-Participating Pharmacy[3]	CYPD[1] applies
Tier 2 Drugs	$90/prescription	✔	Not covered	
Tier 3 Drugs	$135/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $750/prescription	✔	Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$30/prescription		Not covered	
Tier 2 Drugs	$60/prescription	✔	Not covered	
Tier 3 Drugs	$90/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $500/prescription	✔	Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

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

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

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

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

2 Using Participating Pharmacies:

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

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

Notes

4 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.

5 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.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the EOC for more information about how a brand contraceptive may be covered without a 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.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

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 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.

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.**

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** and go to the *Pharmacy networks* section.
- If you want to locate a pharmacy where your prescription is covered, go to **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**.

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**, and choose *Drug formularies* to find a drug formulary that applies to you.

3.

Sign up

It’s time to apply for Blue Shield coverage.
In this section you’ll find your enrollment application and legal disclosure. Sign up today and learn more about your benefits.

Health Plan Employee Enrollment Application

Blue Shield plans for 101+ employees

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

Please note: Failure to complete this enrollment application legibly and completely may result in a delay in the enrollment process.

Reason for application:

☐ New hire ☐ Rehire date _____	☐ Loss of coverage date _____ ☐ Open enrollment	☐ Late enrollment ☐ Other qualifying event type_____ Date above event occurred _____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental and vision insurance – An employee may enroll in a dental and/or vision plan without enrolling in a health plan. In order for a dependent to enroll in a dental or vision plan, the employee must be enrolled in the same dental or vision plan.

Section 2 – Plan(s) Select and fill in plan name(s) as appropriate.

Medical benefits without ABHP (account-based health plan) plan options:

☐ Active Choice® Plus _____ ☐ Active Choice® Classic _____ ☐ Access+ HMO® _____
☐ Access+ HMO® SaveNet℠ _____ ☐ Local Access+ HMO® _____ ☐ Trio HMO _____
☐ Added Advantage POS℠ _____ ☐ Full PPO _____ ☐ Full PPO Savings† _____
☐ Full EPO _____ ☐ Tandem PPO _____ ☐ Virtual Blue℠ _____ ☐ Tandem PPO Savings† _____
☐ Tandem EPO _____ ☐ Blue Shield 65 Plus℠ (HMO) _____

Medical benefits with ABHP (account-based health plan) plan options:

Active Choice® Plus: ☐ HRA ☐ HIA ☐ FSA
Active Choice® Classic: ☐ HRA ☐ HIA ☐ FSA
Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
Access+ HMO® SaveNet℠: ☐ HRA ☐ HIA ☐ FSA
Local Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
Trio HMO: ☐ HRA ☐ HIA ☐ FSA
Full PPO: ☐ HRA ☐ HIA ☐ FSA
Full PPO Savings†: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA‡
Full EPO: ☐ HRA ☐ HIA ☐ FSA
Tandem PPO: ☐ HRA ☐ HIA ☐ FSA
Virtual Blue℠: ☐ HRA ☐ HIA ☐ FSA
Tandem PPO Savings†: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA‡
Tandem EPO: ☐ HRA ☐ HIA ☐ FSA
Blue Shield 65 Plus℠ (HMO): ☐ HRA ☐ HIA ☐ FSA

Specialty Benefits: ☐ Dental PPO _____ ☐ Dental HMO _____ ☐ Dental INO _____
☐ Vision* _____ ☐ Other _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
† Full PPO Savings and Tandem PPO Savings plans are HSA-eligible high-deductible health plans.
‡ Must be paired with an HSA plan only.
Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, HIAs, FSAs, or LPFSAs.

Internal use only. Do not write in this section and skip to Section 3.				
Department code	Group ID	Subgroup ID	Class ID	Effective date _____

Section 3 – Employee information

Social Security number	**Employer (group) name**	
Last name	**First name**	**MI**
Employment status: ☐ Full time ☐ Part time ☐ Retiree	**Date of hire:** _____	Job title/classification

Home address (street, city, state, ZIP code)

Mailing address (if different from home address)

Cell phone number	Landline phone number	**Email address (required for electronic communications)**

I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply. ☐ Yes ☐ No
Participation is voluntary, and you can opt out any time; for more information, visit **blueshieldca.com/terms**.

Communication preference: ☐ Electronic ☐ Paper

Date of birth _____ **Gender** ☐ Male ☐ Female **Marital status** ☐ Single ☐ Married ☐ Domestic partner

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other _____

Are you enrolling your spouse/domestic partner and/or child dependents ☐ Yes ☐ No If "yes," complete Section 4 of application.

Please tell us about yourself. How would you describe your race or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?	2. If yes, please select one:	3. Which race(s) do you identify with? (select one)	
☐ Yes ☐ No ☐ Unknown ☐ Declined	☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more ethnicities ☐ Other Hispanic, Latino, Spanish: _____	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong ☐ Japanese	☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ 2 or more races ☐ Other ☐ Unknown ☐ Declined

HMO provider information: Blue Shield of California directory website: **blueshieldca.com/fap/app/search.html**

Name of primary care physician (PCP):		Provider number:
IPA/medical group name:	IPA/medical group number:	Existing patient? ☐ Yes ☐ No
Name of dental provider:	Dental provider number:	Existing patient? ☐ Yes ☐ No

Section 4 – Dependent spouse/domestic partner/children information If you, your spouse/domestic partner, or your dependents are refusing coverage, please complete and sign the Refusal of Coverage form.

Dependent's address, if different from employee's address – please indicate which dependent(s) this applies to:

Are all your dependents of the same Race and Ethnicity as the subscriber? ☐ Yes ☐ No
If you answered "No", please include the race and ethnicity for each of your dependents.

Enrolling spouse/domestic partner information	**Enroll in (please check all that apply)**	**HMO and Added Advantage POS only – name of primary care physician**	**Dental HMO only – dental provider**
What race or ethnicity does this member identify with:			
☐ Spouse ☐ Domestic partner ☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy)	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Enrolling dependent child(ren) information	**Enroll in (please check all that apply)**	**HMO and Added Advantage POS only – name of primary care physician**	**Dental HMO only – dental provider**
What race or ethnicity does this member identify with:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Enrolling dependent child(ren) information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Enrolling dependent child(ren) information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Section 5 – Medicare information

1. Are you or any of your dependents currently covered by Medicare? ☐ Yes ☐ No
   If "yes," please attach a copy of your Medicare card(s) and/or select the type of coverage below:
   Part A: ☐ Effective date: _____ (mm/dd/yyyy)
   Part B: ☐ Effective date: _____ (mm/dd/yyyy)
2. Is Medicare eligibility due to end-stage renal disease (ESRD)? ☐ Yes ☐ No
   If "yes," please answer the following questions:
   a) What was the first date of dialysis treatment, and what type of dialysis are you receiving?
      Date _____
      Type: ☐ Hemo ☐ Self-dialysis (peritoneal)
   b) If you have had a kidney transplant, what was the date of the transplant: _____ (mm/dd/yyyy)

Section 6 – Authorization

The following authorization section is to be signed by **all** employees applying for coverage with Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield Life").

This enrollment cannot be processed without your signed authorization.

I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application Blue Shield of California/Blue Shield Life may pursue one of the following remedies within the first 24 months of coverage: my coverage may be canceled, or following 30-day notice, rescinded. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life.

Signature of employee_____ Date _____

Print employee name _____

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Signature of employee _____ Date _____

Print employee name _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Disclosure of personal and health information

At Blue Shield of California/Blue Shield Life, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. We are required by law to maintain the privacy and security of your personal information in whatever format it is held – paper, electronic, or oral. This statement applies to personal information that Blue Shield obtains, creates, and/or maintains about you and your covered dependents.

In the course of administering your Blue Shield coverage, we collect, use, and disclose information about you and your covered dependents, and we create records about you, your medical treatment, and the services we provide to you. The information in these records is called protected health information ("PHI") and includes 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 obtain PHI about you and/or your covered dependents from you, at your direction, and/or with your permission. We also obtain your PHI from other sources as permitted by law, including, for example, from your healthcare provider, insurer, insurance support organization, health information exchange, health plan, or insurance agent. We use and disclose your PHI to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your PHI to others including, for example, a healthcare provider, insurer, insurance support organization, health information exchange, health plan, or your insurance agent.

Blue Shield maintains a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use your PHI with and without your specific authorization. When we use or disclose your PHI, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI. You will receive our Notice when you enroll for Blue Shield insurance coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at: **blueshieldca.com/bsca/about-blue-shield/privacy/confidentiality.sp**.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Agent/Broker Attestation

Attestation of Agent/Broker assisting in the submission of this application: (1) to the best of my knowledge, the information on the application is complete and accurate; and (2) I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Signature of Agent/Broker_____ Date _____

If an Agent/Broker willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

blue california

Subscriber Change Request

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

All changes must be received within 31 days of the effective date of change. This form cannot be used for primary care physician changes – subscriber must call the Member Services phone number on the back of their ID card.

Employee identification – this section must be completed

Subscriber ID number (from ID card)	Social Security number	Group number (from ID card)
Cell phone number	Landline phone number	
Last name	First name	MI
Home street address – City	State	ZIP code
Group/employer name (if applicable)	Email address	

Changes

Note: If transferring coverage to HMO, POS, or DHMO, please complete Section A.

☐ Yes ☐ No Is this a change/correction of address?

☐ Yes ☐ No Is the change/correction of address for a dependent? (Note: Dependent's address will default to subscriber's address if 'No' is indicated here.)

If yes, please indicate dependent name and address change:

☐ Correct my Social Security number to: _____
(Copy of Social Security card, a photo ID, a letter of verification from the Social Security office, and a written statement of why the employee is requesting the change must be attached.)

☐ This is a change made during open enrollment.

☐ Transfer/add my health coverage to: ☐ Access+ HMO® _____ ☐ Access+ HMO® SaveNet℠ _____
☐ Local Access+ HMO _____ ☐ Trio HMO _____ ☐ Full PPO _____
☐ Active Choice® Plus _____ ☐ Active Choice® Classic _____
☐ Full PPO Savings _____ ☐ Tandem PPO _____ ☐ Tandem PPO Savings _____
☐ Added Advantage POS℠ _____ ☐ Virtual Blue℠ _____

☐ Transfer my Account-Based Health Plan (ABHP) benefits coverage to:

For Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
For Access+ HMO® SaveNet℠: ☐ HRA ☐ HIA ☐ FSA
For Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
For Trio HMO: ☐ HRA ☐ HIA ☐ FSA
For Full PPO: ☐ HRA ☐ HIA ☐ FSA
For Active Choice® Plus: ☐ HRA ☐ HIA ☐ FSA
For Active Choice® Classic: ☐ HRA ☐ HIA ☐ FSA
For Full PPO Savings: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA
For Tandem PPO: ☐ HRA ☐ HIA ☐ FSA
For Tandem PPO Savings: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA
For Added Advantage POS℠: ☐ HRA ☐ HIA ☐ FSA
For Virtual Blue℠: ☐ HRA ☐ HIA ☐ FSA

☐ Transfer my dental benefits coverage to:

☐ DHMO _____ ☐ DPPO _____ ☐ DINO _____

☐ Transfer my vision benefits coverage from Plan Name _____ to Plan Name_____

☐ Change the amount of Basic Group Term Life or Supplemental Life and Supplemental AD&D insurance coverage: (provide prior coverage amount and new coverage amount)
Prior amount of Basic Group Term Life coverage: $ _____
New amount of coverage: $ _____
Prior amount of Supplemental Life and/or Supplemental AD&D coverage: $ _____
New amount of coverage: $ _____
Any increase is subject to approval via Evidence of Insurability (EOI)

☐ Correct/change name to:

☐ Correct/change email address to:

☐ Correct/change my date of birth from: _____ to: _____

☐ Additional changes/comments: _____

☐ Subscriber cancellation: I decline health plan coverage for myself (and dependents, if any) effective: _____

☐ Check here if you are a COBRA participant
☐ Qualifying event: _____
☐ Effective date of above qualifying event: _____
☐ Is this a termination? If yes, list name(s): _____

Spouse/domestic partner/dependent child(ren) coverage changes

Add spouse/domestic partner/dependent child(ren) – Complete section A – Requested effective date for additions: _____

☐ Date of marriage if adding spouse: _____

☐ Domestic partner – date of domestic partnership if adding: _____

☐ If court ordered custody/coverage, enter date and attach copy of legal documents: _____
☐ If adoption, enter date of adoption or date placed for adoption, and attach copy of legal documents: _____
☐ Disabled dependent over the age of 25 (Attach a 'Declaration of disability for over age dependent child' form (C3674) or confirmation that your current health carrier is providing coverage for this disabled dependent.)
☐ Change the Supplemental Group Term Life and AD&D insurance coverage amount of the spouse or domestic partner: (provide prior coverage amount and new coverage amount) Prior amount of coverage: $ _____ New amount of coverage: $ _____ (subject to EOI)
☐ Change the Supplemental Group Term Life and AD&D insurance coverage amount of the child(ren): (provide prior coverage amount and new coverage amount) Prior amount of coverage: $ _____
New amount of coverage: $ _____ (subject to EOI)

Cancel dependent(s) – Complete section A – Requested effective date for deletions: _____

For cancellation of spouse or domestic partner: (select appropriate cancellation reason and provide date of event)
☐ Divorce or termination of domestic partnership: Date: _____
☐ Death: Date: _____
☐ Other reason (please specify): _____ Date: _____

For cancellation of dependent children: (select appropriate cancellation reason and provide date of event)
☐ Death: Date: _____
☐ Other reason (please specify) _____ Date: _____

Note: Newborn/adopted children or children placed for adoption require a completed Subscriber Change Request to be submitted within 31 days from the date of birth/adoption/placement for adoption to be added to your coverage.

Please be sure to return this form as the fifth page contains your signature, which is necessary to process these changes.

Section A

Complete this section if adding/canceling coverage for yourself or your dependents. Provide primary care physician/dental provider information if the change pertains to HMO/POS/DHMO coverage. Please fill in which benefit the change applies to:

Add	Cancel	Self			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Basic Life/ AD&D** ☐ **Dep. Life** ☐ **Supp. Life**† ☐ **Supp. Life/ AD&D**†	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Basic Life/ AD&D** ☐ **Dep. Life** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		Please tell us about yourself. How would you describe your race or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.			
		1. Are you of Hispanic or Latino origin?	2. If yes, please select one:	3. Which race(s) do you identify with? (select one)	
		☐ Yes ☐ No ☐ Unknown ☐ Declined	☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: _____	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong	☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ 2 or more Races ☐ Other ☐ Unknown ☐ Declined
		Social Security number:		Date of birth (mm/dd/yyyy)	
		Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other _____			
		Job title/classification		Annual earnings (not including bonuses, overtime, etc.) $ _____	
		If adding Basic Life and AD&D insurance, please indicate amount requested: $ _____ If adding Supp. Life and/or Supp. AD&D insurance, please indicate amount requested: $ _____ Subject to approval via Evidence of Insurability (EOI) If adding Basic Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

Add	Cancel	Spouse/domestic partner			
☐ Dental ☐ Medical ☐ Vision ☐ Supp. Life† ☐ Supp. Life/ AD&D†	☐ Dental ☐ Medical ☐ Vision ☐ Supp. Life ☐ Supp. Life/ AD&D	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy)	
		If adding Supp. Life and/or Supp. AD&D insurance, please indicate amount requested: $ _____ Subject to approval via Evidence of Insurability (EOI)			
		HMO/POS primary care physician name Doctor's name: _____ _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

Add	Cancel	Child			
☐ Dental ☐ Medical ☐ Vision ☐ Supp. Life† ☐ Supp. Life/ AD&D†	☐ Dental ☐ Medical ☐ Vision ☐ Supp. Life ☐ Supp. Life/ AD&D	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy)	
		If adding Supp. Life and/or Supp AD&D insurance, please indicate amount: $ _____ Subject to approval via Evidence of Insurability (EOI) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		HMO/POS primary care physician name Doctor's name: _____ _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

Add	Cancel	Child			
☐ Dental ☐ Medical ☐ Vision ☐ Supp. Life† ☐ Supp. Life/ AD&D†	☐ Dental ☐ Medical ☐ Vision ☐ Supp. Life ☐ Supp. Life/ AD&D	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy)	
		If adding Supp. Life and/or Supp AD&D insurance, please indicate amount: $ _____ Subject to approval via Evidence of Insurability (EOI) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		HMO/POS primary care physician name Doctor's name: _____ _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life**† ☐ **Supp. Life/ AD&D**†	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy)	
		If adding Supp. Life and/or Supp AD&D insurance, please indicate amount: $ _____ Subject to approval via Evidence of Insurability (EOI) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		HMO/POS primary care physician name Doctor's name: _____ _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

All information I have provided on this form is accurate and complete. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage/Certificate of Insurance* and Health Service Agreement/policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

If an Agent/Broker willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

Employee signature _____Date _____

If faxing this form, keep this document for your files.

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal information. Personal and health information, which may be individually identifiable, such as your name, address, telephone number, Social Security number, and health information. We will not disclose this information except as permitted by law.

Please be sure to return this form as the fifth page contains your signature, which is necessary to process these changes.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Evidence of Insurability form is required for Supplemental Life. Approval must be received for any added Supplemental Life coverage. The effective date of coverage will be the first of the month following approval.

Refusal of Coverage form

blue california

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. ***Note: The employee's Social Security number is required for all eligible employees and dependents.**

Employee name	**Social Security number**	**Date of birth**
Employer (Group) name	**Hire date** ____ /____ /_____	**State of residence**
Marital status Married ☐ Yes ☐ No Domestic partnership ☐ Yes ☐ No	Job title	

Is the employee a full-time employee, working at least 30 hours per week for this employer? ☐ Yes ☐ No **Or**
Is the employee a part-time employee, working at least 20 hours per week for this employer? ☐ Yes ☐ No

Declining coverage for:

I decline health plan coverage for:
- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:

_____

If dental plan offered, I decline dental plan coverage for:
- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision plan coverage for:
- ☐ Myself and all dependents
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If life insurance plan offered, I decline life plan coverage for:
- ☐ Myself

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE
- ☐ Enrolling as a dependent or an employee on this group health plan
- ☐ Covered by this employer's other health plan (through another carrier)
- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE
- ☐ Covered by an individual health plan.
  - Carrier name _____
  - ID number _____
- ☐ Covered California or other State Health Exchange
- ☐ Medicare, Medi-Cal, Healthy Families Program
- ☐ Other _____

OTHER DENTAL COVERAGE
- ☐ Enrolling as a dependent or an employee on this group dental plan
- ☐ Covered by another employer's dental plan (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Other _____

OTHER VISION COVERAGE
- ☐ Enrolling as a dependent or an employee on this group vision plan
- ☐ Covered by another employer's vision plan (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Other _____

OTHER LIFE INSURANCE COVERAGE
- ☐ Covered by another employer's life insurance coverage (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Other _____

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/domestic partner, and/or my child dependent(s) in my employer's group health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 60 days after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 60 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 60 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of employee **Date**

Print name

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**

Or, you can always visit us online at **blueshieldca.com,** anytime, day or night.

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

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

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**.

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**.

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**.

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.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

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

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

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

Servicios de asistencia en idiomas y avisos de no discriminación

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

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

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

非歧視通知和語言協助服務

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

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

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