important legal information

Limitations and exclusions

For Individual and Family Plans

Effective February 1, 2009

Plan benefits for Shield Spectrum PPO Savings Plan 1800/3600 are effective January 1, 2009.

This booklet describes what our plans for individuals and families do and don't cover, and other helpful information, including:

- Which healthcare providers are available to you
- Ways to access care
- What members pay
- What you should know about terminating coverage
- Ways to file a grievance

You'll find general information that applies to all Blue Shield and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) plans, as well as information specific to HMO or PPO health plans and dental plans.

Explanations of many of the terms used in this document may be found in the Glossary section of the *Choosing Your Health Plan* booklet. These explanations can help you choose a plan. For the actual definitions of terms and a complete description of any plan, please contact us at **(800) 431-2809** to request the plan's *Evidence of Coverage and Health Service Agreement* (EOC) or *Policy for Individuals and Families* (Policy).

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Accessing care

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. The following benefit information applies to all of our health plans.

Reproductive health services

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call us at (800) 431-2809, to ensure that you can obtain the healthcare services that you need.

Blue Shield provider network, including facilities

We update our provider directories periodically to reflect changes in our provider networks. For the most up-to-date listings, check our online directories in the *Find a Provider* section of **blueshieldca.com**. You can also request a directory from your Blue Shield authorized account representative, or by calling Member Services at **(800) 431-2809**.

Obtaining emergency services worldwide

With all Blue Shield plans, emergency services are covered anywhere in the world. An emergency is defined as an medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Your life or health may be in serious jeopardy;
- Serious impairment to your bodily functions;
- Serious dysfunctions of any bodily organ or part.

Obtaining urgent care away from home – the BlueCard Program

For HMO members, urgent services are covered services rendered outside of the Personal Physician's service area (other than emergency services) which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury, or complications of an existing medical condition for which treatment can not reasonably be delayed until the member returns to the Personal Physician's service area.

With the BlueCard® Program, all members can access urgent care through the BlueCard network of providers when they are away from home (members can access urgent care from any provider, but they will pay less when they go to a BlueCard network provider). The program has specific guidelines for obtaining care, and these guidelines are explained in each health plan's *Evidence of Coverage* (EOC) or *Policy for Individuals and Families* (Policy). More than 85% of all hospitals and physicians nationwide participate in the BlueCard Program.

Please note it is not necessary to obtain emergency or urgent care solely from BlueCard providers.

Mental health and substance abuse services

Blue Shield has contracted with a specialized healthcare service plan to act as our mental health services administrator (MHSA). Mental health and substance abuse services are delivered to our members through this network of MHSA participating providers.

The MHSA must provide prior authorization for all inpatient mental health services, except for emergency services, for them to be covered by the plan.

Prior authorization of selected drugs

Selected drugs and drug dosages require prior authorization by Blue Shield for medical necessity, appropriateness of therapy, or cost-effectiveness. Your physician can request prior authorization from Blue Shield Pharmacy Services.

What members pay

Prepayment fees

The monthly rates for each plan are shown in the brochure *Monthly Rates for Individuals and Families*. The rates are subject to change following at least 30 days' written notice from Blue Shield.

Other charges

You are responsible for paying any applicable deductible, copayment, or coinsurance up to a certain limit each calendar year. The plan's deductible, copayment, coinsurance, and copayment maximum are shown in the *Choosing Your Health Plan* booklet.

Copayment maximum and out-of-pocket maximum

To limit the total amount you might have to pay for certain medical expenses in a calendar year, the Shield Spectrum PPO Savings plans include an out-of-pocket maximum, and Shield Spectrum PPO℠ plans, Vital Shield℠ plans, Vital Shield℠ Plus plans, Essential℠ plans, Balance℠ plans, Active Start℠ plans, Access+ HMO,® and Access+ Value℠ HMO include a copayment maximum. Bear in mind that copayments for some services do not count toward the copayment maximum, or out-of-pocket maximum, and continue to apply after the maximum amount has been met.

If you reach a calendar-year copayment maximum or out-of-pocket maximum for any plan, Blue Shield will start to pay 100% of the allowable amount for all the applicable covered services you receive through the remainder of the calendar year, up to specified benefit maximums. The lifetime maximum for Active Start plans, Essential plans, Balance plans and Shield Spectrum PPO plan members is $6,000,000 per person. For Vital Shield and Vital Shield Plus plans plans it is $3,000,000, and there is no lifetime maximum for Access+ HMO and Access+ Value HMO members.

Termination of benefits

Termination by the member

Members can terminate their coverage with Blue Shield by giving 30 days' prior written notice.

Termination by Blue Shield

Blue Shield will not individually terminate or rescind plan coverage for any cause except those outlined in the EOC/Policy. We can terminate the EOC/Policy for nonpayment of dues/premium by giving 15 days' prior notice to the subscriber. (If you are hospitalized or undergoing treatment for an ongoing condition and your plan is cancelled, you will no longer receive benefits of the plan.)

Blue Shield may terminate any subscriber's EOC/Policy, together with all like EOCs/Policies for the plan type, by giving 90 days' written notice. Blue Shield may also terminate the EOC/Policy upon 30 days' written notice under certain circumstances, including:

- The subscriber moves out of the service area (HMO plans) or California (all other plans)
- Coverage is arranged through a bona fide association, and the subscriber's association membership ends
- A member fails or refuses to provide access to documents and other information that was requested in the application for coverage

Blue Shield may also terminate the subscriber's Service Agreement/Policy for cause, effective immediately, upon written notice under certain circumstances, including:

- Fraud or material misrepresentation
- Permitting use of your ID card by someone other than yourself or your enrolled family
- Obtaining or attempting to obtain services by means of false, materially misleading, or fraudulent information, acts, or omissions
- Certain abusive or disruptive behavior

Continuity of care by a terminated provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies, or terminal illness; who are children under 36 months of age; or who have received authorization for surgery or another procedure from a provider who is no longer in the Blue Shield or Blue Shield Life provider network, as part of

a documented course of treatment, can request completion of care from this provider by calling **(800) 431-2809**.

Financial responsibility for continuity of care services

For PPO plan members who are entitled to receive services from a terminated provider under the continuity of care provision, the financial responsibility of the member to that provider for services rendered under that provision shall be no greater than for the same services rendered by a preferred provider in the same geographic area.

Renewal provisions

Blue Shield health coverage is "guaranteed renewable," which means it cannot be cancelled by Blue Shield and will remain in effect as long as your dues/premiums are paid in advance – except under the conditions listed in the Termination of Benefits section. Blue Shield may modify or amend the EOC/Policy or dues/premium amount by giving you at least 30 days' prior written notice.

Utilization review process

State law requires that health plans disclose to plan members and health plan providers the process used to authorize or deny healthcare services under the plan. Blue Shield has documented its Utilization Review process. To learn more, please see your EOC or Policy, or call Member Services at **(800) 431-2809** to request a copy.

Grievance process

Blue Shield of California and Blue Shield Life have established a grievance procedure for receiving, resolving, and tracking members' grievances with Blue Shield. For more information on this process, see the Grievance Process section in the plan's EOC/Policy.

External independent medical review

State law requires Blue Shield to disclose to members the availability of an external independent review process when a member's grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not medically necessary or is experimental/investigational. Members of Access+ HMO, Access+ Value HMO, and Shield Spectrum PPO plans, Shield Spectrum PPO Savings Plans 2400/4800, and dental plans can make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members of Vital Shield plans, Vital Shield Plus plans, Active Start plans, Essential plans, Balance plans, Blue Shield Life PPO Plan 1500 or 2000, Shield Spectrum PPO Savings Plans 1800/3600 and 4000/8000, or Shield Spectrum PPO Plan 5000 can request an external independent review through the California Department of Insurance.

Ratio of healthcare services

For individual and family health plans in 2007, the ratio of the value of health services provided to the amount Blue Shield and Blue Shield Life collected in dues was 70.3%, which means that for each $1.00 of dues/premium it collected, Blue Shield paid $0.703 for health care services. This ratio was calculated after provider discounts were applied. The provider discounts exceeded 30% of billed charges.

Department of Managed Health Care review

This information is relevant to all plans underwritten by Blue Shield of California:

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at the telephone number on your Blue Shield ID Card, or **(800) 431-2809**, and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes

for emergency or urgent medical services. The department also has a toll-free telephone number **(888) HMO-2219**, and a TDD line **(877) 688-9891** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

Department of Insurance review

This information is relevant for all plans underwritten by Blue Shield Life:

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number – (800) 927-HELP (4357) or TDD (800) 482-4833 – to receive complaints regarding health insurance from either the insured or his or her provider. If you have a complaint against your insurer, you should contact the insurer first and use their grievance process. If you need the department's help with a complaint or grievance that has not been satisfactorily resolved by the insurer, you may call the department's toll-free telephone number 8 a.m. to 6 p.m., Monday through Friday, excluding holidays. You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring St., South Tower, Los Angeles, CA 90013, or through the Web site https://interactive.web.insurance.ca.gov/contactCSD/ContactUs.jsp.

Confidentiality and privacy

Your personal and health information

Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, and Social Security number. We will not disclose this information, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. These policies and procedures are contained in our Notice of Privacy Practices, which you can obtain by calling Member Services at **(800) 431-2809**, or via **blueshieldca.com**.

If you are concerned that Blue Shield may have violated your confidentiality or privacy rights, or you disagree with a decision that we have made about access to your personal and health information, you may contact us at:

Blue Shield Privacy Official
P.O. Box 272540
Chico, CA 95927-2540
Toll-free telephone contact:
(888) 266-8080
E-mail contact:
BlueShieldCA_Privacy@blueshieldca.com

Blue Shield PPO plan specifics

This information applies only to Blue Shield PPO plans.

Choice of physicians and providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Blue Shield PPO plans allow you to choose a preferred (network) or non-preferred (non-network) provider each time you access care. However, our PPO plans are specifically designed for you to use our preferred providers, which are listed in our provider directories and online in the *Find a Provider* section of **blueshieldca.com**.

Member liability for payment

Preferred providers

Preferred providers agree to accept Blue Shield's payment, plus your payment of any applicable deductible and copayment/coinsurance, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered services.

Non-preferred providers

Blue Shield's payment for non-preferred providers may be substantially less than the amount billed. You are responsible for the difference between the amount we pay and the amount billed by non-preferred providers. In some instances, we cover services only if rendered by a preferred provider, so using a non-preferred provider could result in lower or no payment by Blue Shield for these services.

If you need emergency care from a non-preferred provider, we will pay the provider's billed charge for covered services, less any applicable deductible or copayment/coinsurance.

Reimbursement provisions

When you use preferred providers, you generally won't have to pay for services at the time of your visit. Most preferred providers will bill Blue Shield directly, and then bill you for your payment responsibility. We will apply the appropriate amount toward any applicable deductible.

When you use non-preferred providers, you must pay the provider directly for the entire cost of your care, either at the time of your visit or when they bill you. Once you receive the bill, simply submit a copy of it with a claim form to Blue Shield. We will apply the appropriate amount to your plan deductible, or reimburse you for the applicable percentage of the Blue Shield allowable amount if you've already met your plan deductible.

How a plan deductible works

With a calendar-year deductible, you will pay 100% of the costs for services that are subject to the deductible, until you meet the deductible.

The full amount you pay – up to the allowable amount for that service – will count toward your deductible. Once you meet a plan deductible, you will become eligible for all your plan's benefits and will start to pay the applicable copayments for covered services.

Some covered services, such as preventive care, are never subject to any plan deductible, so you can receive benefits for these medical services right away.

Payment of providers

Providers do not receive financial incentives or bonuses from Blue Shield. If you want to know more about this payment system, contact Member Services at **(800) 431-2809**.

Mental health and substance abuse services

MHSA participating providers agree to accept the MHSA's payment, plus your payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. To find an MHSA participating provider, refer to the *Blue Shield of California Behavioral Health Provider Directory,* or call **(877) 263-9952** toll-free.

Enrolling new dependents

Newborn infants and children placed with the subscriber for adoption automatically will receive inpatient care/delivery coverage on your plan for a 31-day grace period starting at birth or the date you or your spouse gains the right to control an adopted child's health care. If dues/premiums aren't received, all other services will be denied. You must officially add the child to your plan to continue the child's coverage. A new spouse may be added to your EOC/Policy at anytime, as soon as his or her application is approved and dues/premiums are paid. You can call Member Services at **(800) 431-2809** to add a newborn child and/or spouse to your plan.

Please note: Vital Shield plans, Active Start plans, and Essential plans are for individual coverage only and do not provide maternity benefits. Shield Spectrum PPO Savings Plans 1800/3600 and 4000/8000, Vital Shield Plus plans and Balance plans do not provide maternity benefits. You are not able to enroll a new baby or spouse on these plans, and there is no 31-day grace period. Please see the plan's Policy for complete coverage details.

Pre-existing conditions

Benefits for pre-existing conditions will not be available until 6 months after Blue Shield receives your application. However, if you have "prior creditable coverage," and you apply for coverage within 63 days after termination of the prior creditable coverage, we will credit the length of time you were covered on your previous health plan toward the 6-month waiting period.

This exclusion does not apply to subscribers enrolled in the Shield Spectrum PPO Plan 1500 or 2000, or Blue Shield Life PPO Plans 1500 and 2000 under "guaranteed issue," or to newborn or adopted children who:

- Were enrolled under any creditable coverage within 31 days of the birth, adoption, or placement for adoption; and
- Applied for this plan within 63 days of termination of the creditable coverage.

Guaranteed issue coverage

Blue Shield's guaranteed issue coverage is provided as an alternative for people coming from group coverage who may not be eligible for underwritten plans because of a pre-existing condition. Please see the health plan application for details on who qualifies for guaranteed issue.

Blue Shield HMO plan specifics

The following information is specific to Access+ HMO and Access+ Value HMO.

Choice of physicians and providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Access+ HMO and Access+ Value HMO offer you a choice of physicians, hospitals and non-physician healthcare practitioners.

When you enroll in an HMO plan, you and each of your dependents must choose a Personal Physician servicing your area that's generally within 15 miles or a 30-minute drive* from where you live or work. You can search for your Personal Physician by going to the Find a Provider section of **blueshieldca.com** or you can call customer service to request a directory. To confirm your selection, you can call one of our Member Services representatives at **(800) 431-2809**. If you do not select a Personal Physician when you enroll, we will assign one to you. You can then choose a different Personal Physician at any time.

*Personal Physician Service Areas vary by contract. The 15 mile or 30 minute guideline is a general guideline only.

The *Find a Provider* section of our Web site, **blueshieldca.com**, and our *HMO Physician and Hospital Directory* list the locations and phone numbers of all Personal Physicians in your area, as well as the medical group or IPA with which they're affiliated. Each of your eligible family members may select a different Personal Physician, as long as each provider is located close enough to the member's home or work to ensure adequate access to care as determined by Blue Shield.

Obtaining specialty care

Option 1: Referral to specialty services and second opinions

There are conditions under which you may ask your Personal Physician to refer you to another physician for a second opinion. All second opinion consultations must be authorized by the plan. State law requires that health plans disclose to members, on request, the timelines for responding to a request for a second medical opinion. You can submit a request by calling **(800) 431-2809**.

Option 2: Use the Access+ *Specialist* feature

Access+ *Specialist*SM allows you to go to any participating specialist or Personal Physician in the same medical group or IPA as your Personal Physician without a referral, by paying a copayment. This benefit is subject to the limitations described in the EOC.

Accessing mental health and substance abuse services

The Access+ *Specialist* feature is also available for mental health and substance abuse services, as long as the provider is an MHSA participating provider. Refer to the *Blue Shield of California Behavioral Health Provider Directory*, or call the MHSA directly at **(877) 263-9952** to find an MHSA participating provider.

Non-emergency mental health services and substance abuse services received from a provider that is not in the MHSA participating provider network will not be covered, and all charges for these services will be the member's responsibility.

Waivered condition – pregnancy and maternity care

Pregnancy is a waivered condition, which means that benefits for pregnancy are not covered for a 6-month period beginning as of the effective date of coverage if you: received pregnancy-related medical advice, diagnosis, care or treatment, including prescription drugs, from a licensed health practitioner during the six months immediately preceding the effective date of coverage, with the exception of services required to treat involuntary complications of pregnancy. However, if you have prior creditable coverage, and you apply for coverage within 63 days after termination of the prior coverage, Blue Shield will credit the length of time you were covered on your previous health plan toward the 6-month period.

Enrolling new dependents

Newborn infants and children placed with the subscriber for adoption will automatically be covered on your plan for a 31-day grace period starting at birth or the date you or your spouse gain the right to control the adopted child's health care. The child's services must be provided or authorized by his or her Personal Physician. For the month following birth or adoption, you must choose a Personal Physician from the same medical group or IPA as the mother's Personal Physician. (If the mother is not an Access+ HMO or Access+ Value HMO member, or if the child has been placed with the subscriber for adoption, you must select a Personal Physician in the same medical group or IPA as the subscriber's Personal Physician.) Please note that eligibility during the 31-day grace period includes treatment for injury or illness only, but does not include well-baby care benefits unless the child is enrolled. Well-baby care benefits are provided for enrolled children. You can call Member Services at **(800) 431-2809** to add a newborn to your plan.

What members pay

For most covered services, members pay a fixed-dollar copayment. Some services are covered at no charge to the member. The member will be responsible for payment for services that are not authorized by the Personal Physician, or those that are not emergencies, or covered out-of-area urgent service procedures.

If you require services that are available from the plan, we will not pay for services rendered by non-network providers unless your medical condition requires emergency or urgent care.

Reimbursement provisions

If a member receives and incurs expenses for emergency services other than medical transportation, the member must submit a complete claim along with the emergency service record for payment to the plan within 1 year after the first provision of the services for which he or she is requesting reimbursement. If the member receives covered medical transportation services in such an emergency situation, the HMO plan will pay the medical transportation provider directly.

If a member receives out-of-area urgent services from a provider who is not in the BlueCard network, the member must submit a complete claim along with the urgent service record for payment to the plan within 1 year after the first provision of urgent services for which he or she is requesting reimbursement.

Payment of providers

Blue Shield generally contracts with groups of physicians to provide services to members. A fixed, monthly fee is paid to the groups of physicians for each member whose Personal Physician is in the group. This payment system, known as capitation, includes incentives to the physicians to manage the services they provide to members in an appropriate manner consistent with the EOC/policy.

Blue Shield dental plan specifics

Conditions of coverage

Dental PPO and Dental HMO plan benefits are separate from the medical benefits of the Blue Shield health plans. General health plan provisions and exclusions apply with an exception for the following:

- Dental PPO and Dental HMO benefits are not subject to the health plan deductible requirements, and do not accumulate toward the maximum calendar-year copayment responsibility.
- The provisions of Access+ *Satisfaction*℠ do not apply to any dental services.
- Network benefits of the Blue Shield Dental PPO, the Blue Shield Dental HMO and Access+ Dentist services will be underwritten and administered by the dental plan administrator, Dental Benefit Providers Inc. Dental PPO out-of-network benefits will be underwritten by Blue Shield and administered by the dental plan administrator.
- If your dental coverage is cancelled for any reason by you or by Blue Shield, you may apply for reinstatement, but your coverage (if approved) will be subject to a waiting period of 12 months from the cancellation date.
- If you are signing up for the Blue Shield Dental HMO, you must choose a dentist from our directory of dental providers by going to **blueshieldca.com**, and clicking on the *Find a Provider* section. Or contact Member Services at **(800) 431-2809** for a list of dentists in your area.

General exclusions and limitations

For all Blue Shield health plans for individuals and families

Principal benefits and coverages

Please see *Choosing Your Health Plan* booklet for a summary of each plan's covered services and supplies. Also, refer to the EOC/Policy, which you will receive after you enroll. The EOC/Policy offers more detailed information on the benefits and coverage included in your health plan.

Principal exclusions and limitations on benefits

All services must be medically necessary. The fact that a physician, hospital, or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary, even if it is not specifically listed as a plan exclusion or limitation. Blue Shield may limit or exclude benefits for services that are not medically necessary.

For complete details on any plan's exclusions and limitations, please read the EOC/Policy. Unless exceptions to the following exclusions are specifically made in the EOC/Policy for your plan, the following medical services or procedures are not included as benefits and/or services:

- For or incident to services and supplies for treatment of the teeth and gums (except for tumors) and associated periodontal structure including, but not limited to, diagnostic, preventive, orthodontic, and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extractions; dental implants; braces, crowns, dental orthoses, and prostheses; except as specifically provided in the EOC/Policy;
- For or incident to hospitalization or confinement in a pain management center to treat and cure chronic pain, except as may be provided through a participating hospice agency and except as medically necessary;
- For rehabilitation except as specifically provided in the EOC/Policy;
- Incident to hospitalization or confinement in a health facility primarily for rest, custodial, maintenance, domiciliary care, or residential care, except as provided under Hospice Program Services in the EOC/Policy (see the Hospice Program Services benefit for exception);
- Performed in a hospital by hospital officers, residents, interns and others in training;
- For routine eye refraction, surgery to correct refractive error (such as, but not limited to, radial keratotomy/refractive keratoplasty);
- For eye glasses and contact lenses except as specifically listed in the EOC/Policy, or hearing aids;
- For or incident to acupuncture or accupressure;
- For or incident to speech therapy, speech correction, or speech pathology, or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury, or illness except as specified in the EOC/Policy;
- For or incident to vocational, educational, recreational, art, dance, reading or music therapy; weight control programs or exercise programs; nutritional counseling except as specifically provided for under Diabetes Care benefits;
- For transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that are medically necessary;
- For callus, corn paring, or excision, toenail trimming, and treatment (other than surgery) of chronic conditions of the foot (except as may be provided through a participating hospice agency), e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., noncustom-made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthoses Benefits and Diabetes Care in the EOC/Policy; bunions, muscle trauma due to exertion; or any type of massage procedure on the foot;
- Which are experimental or investigational in nature, except for services for persons who have been accepted into an approved clinical trial for cancer;

- For learning disabilities, behavioral problems, or social skills training/therapy;
- For or incident to hospitalization primarily for radiological, laboratory, or any other diagnostic studies or medical observation;
- For convenience items such as telephones, TVs, guest trays, and personal hygiene items;
- For cosmetic surgery or any resulting complications; except medically necessary services to treat complications of cosmetic surgery (e.g., infections or hemorrhages) will be a benefit but only upon review and approval by a Blue Shield of California physician consultant. Without limiting the forgoing, no benefits will be provided for the following surgeries or procedures:
  - Lower eyelid blepharoplasty;
  - Spider veins
  - Services and procedures to smooth the skin (e.g., chemical peels, laser resurfacing or abrasive procedures);
  - Hair removal by electrolysis or other means; and
  - Re-implantation of breast implants originally provided for cosmetic augmentation;
- Incident to an organ transplant, except as specifically listed in the EOC/Policy;
- For or incident to the treatment of infertility, including the cause of infertility, or any form of assisted reproductive technology – including but not limited to the reversal of a vasectomy or tubal ligation, or any resulting complications, except for medically necessary treatment of medical complications;
- Any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;
- For routine health appraisals, well-baby care, vision and hearing tests, physical examinations, and immunizations, except as specifically listed under Preventive Care in the EOC/Policy, or for immunizations and vaccinations by any mode or administration (oral, injection, or otherwise) solely for the purpose of travel, or for physical exams required for licensure, employment, or insurance unless the examination is substituted for the annual physical examination;
- For or incident to sexual dysfunction, sexual inadequacies; except as provided for treatment of organically based conditions;
- For or incident to family planning, except as specifically listed in the EOC/Policy;
- For dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication except as specifically provided for in the EOC/Policy;
- Performed by a close relative or by a person who ordinarily resides in the subscriber's or dependent's home;
- Incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;
- In connection with private-duty nursing, except as specifically listed in the EOC/Policy;
- For substance abuse treatment or rehabilitation on an inpatient, partial hospitalization, or outpatient basis, except as specifically listed in the EOC/Policy;
- For penile implant devices and surgery, and any related services, except for any resulting complications and medically necessary services as provided for under Reconstructive Surgery Benefits in the EOC/Policy;
- For which the person is not legally obligated to pay or for services for which no charge is made to the person;
- For reconstructive surgery or procedures in situations: 1) where there is another more appropriate surgical procedure that is approved by a Blue Shield physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function

or in the appearance of the member (e.g., spider veins), or 3) as limited in the EOC/Policy;

- For or incident to out-of-country services; for medical equipment, drugs, and other substances obtained outside the United States except as provided in the EOC/Policy for covered emergency or urgent care;
- For home testing devices and monitoring equipment, except as specifically provided under Durable Medical Equipment in the EOC/Policy;
- For contraceptives and contraceptive devices, except as specifically included in the EOC/Policy; oral contraceptives and diaphragms are excluded, except as may be provided under the outpatient prescription drug benefit (outpatient prescription generic drug benefit for Essential plans only); no benefits are provided for contraceptive implants;
- For prescription and non-prescription food and nutritional supplements, except as provided for in the EOC/Policy;
- For drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); however, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions as set forth in state law have been met;
- For genetic testing except as specified in the EOC/Policy;
- For any type of communicator, voice enhancer, voice prosthesis, electronic voice-producing machine, or any other language-assistive devices, except as specifically listed in the EOC/Policy;
- For non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specified in the EOC/Policy, and disposable hypodermic needles and syringes except as specified in the EOC/Policy; or
- For services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein; or

Conditions for coverage

No person has the right to receive the benefits of any Blue Shield health plan for services provided following termination of coverage. Benefits of this plan are available only for services provided during the term the plan is in effect, and while the individual claiming benefits is actually covered by the plan EOC/Policy. Benefits may be modified during the term of the plan EOC/Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services provided on or after the effective date of the modification. There is no vested right to receive the benefits of any Blue Shield plan as outlined in the EOC/Policy.

- Not specifically listed as a benefit in the EOC/Policy.

Also excluded for Blue Shield PPO plans (Vital Shield plans, Vital Shield Plus plans, Active Start plans, Essential plans, Balance plans, Shield Spectrum PPO Plans, Shield Spectrum PPO Savings Plans)

Benefits and/or services:

- For rehabilitation or rehabilitative care except for those services for which benefits may be pre-approved in accordance with the Benefits Management Program, when services are the result of the conditions specified in EOC/Policy (excluding Vital Shield plans and Vital Shield Plus plans);
- For or incident to the reversal of surgical sterilization or any complications of this procedure;
- Incident to bariatric surgery services except as specifically provided for under the section entitled Bariatric Surgery Services;
- For Papanicolaou (Pap) tests or other FDA-approved cervical cancer screening tests, mammography, and colorectal cancer screening except as specifically listed in the EOC/Policy;
- For outpatient mental health and substance abuse services except as specifically listed in the Mental Health and Substance Abuse Services section of the EOC/Policy.

Also excluded for Vital Shield plans, Vital Shield Plus plans, Active Start plans, Essential plans, Balance plans, and Shield Spectrum PPO Savings plans 1800/3600 and 4000/8000

- Benefits and/or services for or incident to services and supplies related to pregnancy and maternity care.

Also excluded for Vital Shield and Vital Shield Plus plans

Benefits and/or services:

- For or incident to spinal manipulations and adjustments;
- For or incident to durable medical equipment and supplies needed to operate or maintain durable medical equipment;
- For or incident to orthotic appliances and devices and supplies needed to operate or maintain orthotic appliances and devices;
- For or incident to prostheses and supplies needed to operate or maintain prostheses except as provided in the section entitled Prosthetic Appliances;
- For or incident to professional charges for outpatient and office visits for mental health other than for severe mental illnesses or serious emotional disturbances of a child;
- For or incident to Internet consultations;
- For or incident to circumcision unless as a result of illness or injury;
- For or incident to rehabilitative services and therapy including, but not limited to, occupational, physical, and respiratory therapies;
- For or incident to speech therapy;
- For or incident to allergy testing and/or treatment;
- For or incident to physician visits except for those in a hospital setting or the physician's office;
- For or incident to skilled nursing facility services except for those provided in a hospital-based skilled nursing facility.

Also excluded for Access+ HMO and Access+ Value HMO plans

Benefits and/or services:

- Not provided, prescribed, referred, or authorized by a Personal Physician or Blue Shield except for Access+ *Specialist* visits, OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same medical group or IPA as your Personal Physician, emergency services or urgent services under the Emergency Services section in the EOC, or when specific authorization has been obtained in writing for such services from the plan;
- For spinal manipulation or adjustment;
- For rehabilitation services except as specified in the Outpatient Rehabilitation Services and Speech Therapy sections in the EOC;
- For orthopedic shoes, except as provided for under the Diabetes Care section in the EOC, home testing devices, environmental control equipment, generators, exercise equipment, self help/educational devices, or for types of communicator, voice enhancer, voice prosthesis, or any other language-assistance devices, except as provided under the Home Medical Care section in the EOC, vitamins, and comfort items;
- For transportation services other than the ambulance benefit specifically provided for in the EOC;
- For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as medically necessary;
- For or incident to reversal of a vasectomy or tubal ligation, repeat vasectomy, or tubal ligation;
- For unauthorized non-emergency services;
- For premarital blood tests;
- For testing for intelligence or learning disabilities.

Outpatient prescription drug exclusions for Vital Shield plans, Vital Shield Plus plans, Active Start plans, Essential plans, Balance plans, Shield Spectrum PPO Plans, Shield Spectrum PPO Savings Plans, Access+ HMO, and Access+ Value HMO plans

- Any drug provided or administered while the subscriber is an inpatient, or in a physician's office (see the Professional [Physician] Benefit and Hospital Benefits sections of your EOC/Policy);
- Take-home drugs received from a hospital, convalescent home, skilled nursing facility,

or similar facility, except as listed in the EOC/Policy;

- Drugs (except as specifically listed as covered in the EOC/Policy) that can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a non-prescription drug;
- Drugs for which the subscriber is not legally obligated to pay, or for which no charge is made;
- Drugs that are considered to be experimental or investigational;
- Medical devices or supplies, except as specifically listed as covered in the EOC/Policy;
- Blood or blood products except as specified in the Hospital Benefits section of the EOC/Policy;
- Drugs prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
- Dietary or nutritional products;
- Injectable drugs which are not self-administered in the home, including all injectable drugs for the treatment of infertility. Other injectable medications may be covered under the home health care, home hospice, family planning services, and home infusion care benefits of the health plan;
- Appetite suppressants or drugs for body weight reduction except when medically necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
- Contraceptive devices (except diaphragms), injections, and implants;
- Compounded medications if: 1) there is a medically appropriate formulary alternative, or 2) there are no FDA-approved indications. Compounded medications that do not include at least one (1) prescription drug, as defined, are not covered;
- Replacement of lost, stolen, or destroyed prescription drugs;
- Drugs obtained from a nonparticipating (non-network) pharmacy, except for emergency coverage (except generic drugs for emergency coverage for Essential plans only);
- Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;
- Non-formulary drugs, except with prior authorization from Blue Shield as described in the EOC (Access+ HMO and Access+ Value HMO only); brand-name drugs except for insulin and disposable insulin needles and syringes, pen delivery systems for the administration of insulin as determined by Blue Shield Life to be medically necessary diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); and diaphragms (Essential plans only).

Please note: The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency, and cost-effectiveness, and is reviewed and updated 4 times per year. Members should always present their Blue Shield ID card to obtain benefits at a participating (network) pharmacy. Except for covered emergencies, prescription drugs obtained from non-participating pharmacies are not covered. Call **(800) 351-2465** to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at **blueshieldca.com**.

General exclusions and limitations

For all Blue Shield dental plans for individuals and families

Following is a summary of services and supplies not covered by Blue Shield dental benefits. For a complete list of dental coverage exclusions and limitations, please refer to the plan's EOC/Policy supplements. The general exclusions and limitations include:

Dental PPO, Dental HMO, and Access+ *Dentist*

- Services not listed as covered in the member's Service Agreement Dental Supplement;
- Services to be paid by the member's Blue Shield health plan;
- Services begun prior to the patient's effective date of coverage;
- Temporary dental services;
- Services performed or supplies provided in a hospital or any place other than a dental office;
- Unnecessary, investigational, experimental, cosmetic or elective services; services for

which the prognosis is not favorable, as determined by the dental plan administrator;

- Services performed by a close relative or someone who lives in the member's home; services for which the member is not obligated to pay or services performed at no charge;
- Services paid for by any governmental agency;
- Implants;
- Crowns, inlays, onlays or other cast or laboratory-prepared materials if the tooth can be restored with a filling material; crowns or inlays installed as multiple abutments;
- Vestibuloplasy, orthognathic surgery, treatment of jaw fractures or TMJ (temporomandibular joint) syndrome;
- Treatment of congenital anomalies or developmental malformation;
- Treatment to correct malignancies, cysts, tumors and neoplasm;
- Myofunctional therapy, biofeedback procedures, athletic mouth guards, precision or semi-precision attachments, denture duplication;
- Orthodontic services rendered by a non-participating provider;
- Extraoral grafts;
- Procedures related to changing or maintaining vertical dimension or restoration of occlusion;
- Treatment of accidental or self-inflicted injuries, including setting of fractures and dislocation;
- General anesthesia, or intravenous or inhalation sedation, unless medically necessary;
- Prescription or non-prescription drugs or charges for local anesthetics;
- Prosthetic appliances related to periodontics;
- Replacement of appliances (dentures, space maintainers, crowns, etc.) lost or stolen within five years of installation;
- Charges for missed appointments;
- Removal of wisdom teeth unless of dental necessity; or
- Services of prosthodontists, and procedures requiring fixed prosthodontic restoration for complete oral rehabilitation or reconstruction.

Dental HMO and Access+ Dentist

- Services not performed, prescribed, or authorized by the member's dental provider, unless authorized by the plan or when required in an emergency, as stated in the contract;
- Prophylaxis more often than once every 6 months;
- Precious metals;
- Unauthorized second opinions;
- Osseous or periodontal surgery more often than once every 36 months per quadrant;
- Any services the dental plan administrator determines not to be of dental necessity (if dental standards indicate that a condition can be treated by a less costly alternative than that proposed by the attending dentist, benefits will be paid based on the less costly service);
- Certain orthodontic services, including treatment for non-handicapping malocclusion, surgical orthodontics, myofunctional therapy, changes in treatment necessitated by an accident, treatment for TMJ, cosmetic orthodontic appliances, replacement of lost or stolen appliances, and treatment exceeding 24 months;
- See the Service Agreement Supplement for specific limitations on prosthodontics, dentures, restorative services, mouth rehabilitation, and pedodontics.

Access+ Dentist only

- All orthodontic services;
- Services performed by specialists.

Essential plans only

- Charges for services that are not listed in the Policy;
- Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if the Dental Plan Administrator or Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Dental Plan Administrator or Blue Shield Life for the treatment of such injury or disease;

- Charges for services performed by a close relative or by a person who ordinarily resides in the subscriber's home;
- Services or supplies provided in connection with a congenital anomaly (an abnormality present at birth) or developmental malformation (an abnormality which develops after birth). Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
- All prescription and non-prescription drugs or charges for local anesthetics;
- Services, procedures, or supplies which are not reasonably necessary for the care of the person's dental condition according to broadly accepted standards of professional care or which are experimental or investigational in nature or which do not have uniform professional endorsement;
- Appliances, restorations, or services including but not limited to equilibration required solely to change, maintain, or restore vertical dimension or occlusion or solely for the purpose of splinting (i.e., stabilizing loose teeth);
- Services, procedures, or supplies that are purely cosmetic or elective in nature;
- Myofunctional therapy; biofeedback procedures; athletic mouth guards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
- Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
- Any procedure not performed in a dental office setting;
- Dental services performed in a hospital, or any related hospital fee;
- Any service, procedure, or supply for which the prognosis for long-term success is not reasonably favorable as determined by the Dental Plan Administrator and its dental consultants;
- Services for which the member is not legally obligated to pay, or services for which no charge is made;
- Treatment as a result of accidental injury including setting of fractures or dislocation;
- Charges for dental appointments which are not kept, except as specified under the Schedule of Benefits;
- Charges for services incident to any intentionally self-inflicted injury; and
- Any service, procedure, or supply which is received or started prior to the patient's effective date of coverage.

Essential plans vision exclusions

Vision coverage general exclusions and limitations

Essential plans include vision benefits. Unless exceptions to the following general exclusions are specifically made elsewhere in this vision benefit, the Essential plan vision benefit does not provide coverage for:

- Any eye examination required by an employer as condition of employment;
- Services performed by a close relative or by an individual who ordinarily resides in the member's home;
- Services performed incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield Life for the treatment of the injury or disease;
- Services required by any government agency or program, federal, state, or subdivision thereof; and
- Services and materials for which the member is not legally obligated to pay, or services and materials for which no charge is made to the member.

blue of california

Notice on the Availability of Language Assistance Services to Accompany Vital Documents Issued in English

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 free help, 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 gratuita, 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)

An Independent Member of the Blue Shield Association A20275 (10/08) 00063348

Blue Shield of California
50 Beale Street, San Francisco, CA 94105 blueshieldca.com

Notice of the Availability of Language Assistance Services

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: 1-866-346-7198 번으로 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

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ 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 'ਤ ` ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على 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

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