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Effective: July 01, 2025

Summary of Benefits

Northern California Pipe Trades H&W Trust Fund Non-Medicare Retiree PPO Plan

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Summary of Benefits

Northern California Pipe Trades H&W Trust Fund
Effective July 1, 2025
PPO Plan

Custom PPO Non Medicare Retiree

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.

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. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$100
	Family coverage	$100: individual $200: 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	$750	$1,500
Family coverage	$750: individual $1,500: Family	$1,500: individual $3,000: 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.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
California Prenatal Screening Program	$0		$0	
Annual routine physical examination office visit	$10/visit		30%	✔
Colorectal cancer screening	$0		30%	✔
Osteoporosis screening	10%		30%	✔
Routine laboratory services	$10/visit		30%	✔
Vision and hearing screening	$10/visit		30%	✔
Medically necessary immunizations (according to age schedule)	$10/visit		30%	✔
Well Baby office visits	$10/visit		30%	✔
Well Baby routine laboratory services and immunizations	$10/visit		30%	✔
Well Baby vision and hearing screening	$10/visit		30%	✔
Physician services				
Primary care office visit	$20/visit		30%	✔
Specialist care office visit	$20/visit		30%	✔
Physician home visit	10%		30%	✔
Physician or surgeon services in an Outpatient Facility	$0	✔	30%	✔
Physician or surgeon services in an inpatient facility	$0	✔	30%	✔
Other professional services				
Other practitioner office visit	$20/visit		30%	✔
Includes nurse practitioners, physician assistants, therapists, and podiatrists.				
Acupuncture services	$10/visit	✔	$10/visit	✔
Up to 24 visits per Member, per Calendar Year.				
Chiropractic services	$10/visit	✔	30%	✔
Up to 24 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	$10/visit		Not covered	
• Injectable contraceptive	$25/injection		Not covered	
• Diaphragm fitting	10%	✔	Not covered	
• Intrauterine device (IUD)	50%	✔	Not covered	
• Insertion and/or removal of intrauterine device	10%	✔	Not covered	
• Implantable contraceptive	10%		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Tubal ligation	10%	✔	Not covered	
• Vasectomy	10%	✔	Not covered	
Medical nutrition therapy, not related to diabetes	$0	✔	30%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0	✔	30%	✔
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.*	$20/visit		$20/visit	
Emergency room Physician services	$100/visit	✔	$100/visit	✔
Urgent care center services	$20/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$50/transport	✔	$50/transport	✔
Outpatient Facility services				
Ambulatory Surgery Center	$35/surgery	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	$35/surgery	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	$150/admission	✔	Not covered	
• Physician inpatient services	$0	✔	Not covered	
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	$150/admission	✔	Not covered	
Outpatient Facility services	$35/surgery	✔	Not covered	
Physician services	$0	✔	Not covered	
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 *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	$20/visit	✔	30%	✔
• Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	$20/visit	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Other outpatient non-invasive diagnostic testing *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	✔	30%	✔
• Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0	✔	30%	✔
• Outpatient Department of a Hospital	$0	✔	30% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	$20/visit	✔	30%	✔
Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Speech Therapy services				
Office location	$20/visit	✔	$20/visit	✔
Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	Not covered		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔
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.*	10%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	10%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	10%	✔	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	10%	✔	10%	✔
Hospital-based SNF	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔
Hospice program services				
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	10%	✔	Not covered	
Short-term inpatient care for pain and symptom management	10%	✔	Not covered	
Inpatient respite care	$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	30%	✔
• Self-management training	$20/visit		30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Medical nutrition therapy	$20/visit		30%	✔
Dialysis services	10%	✔	30% Subject to a Benefit maximum of $300/day	✔
PKU product formulas and special food products	10%	✔	10%	✔
Allergy serum billed separately from an office visit	10%	✔	30%	✔

Mental Health Benefits	Your payment			
Mental Health Benefits are provided through Blue Shield's Mental Health Service 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	$10/visit		30%	✔
Teladoc mental health	$5/consult		Not covered	
Other outpatient services, including intensive outpatient care	$0		30%	✔
Behavioral health treatment in an office setting	$0	✔	30%	✔
Behavioral health treatment in home or other non-institutional facility	$0	✔	30%	✔
Partial Hospitalization Program	$0	✔	30% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔
Residential Care for mental health condition	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔

Substance Use Disorder Benefits	Your payment			
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	$10/visit		30%	✔
Teladoc mental health	$5/consult		Not covered	
Other outpatient services, including intensive outpatient care and office-based opioid treatment	$0		30%	✔
Behavioral health treatment in an office setting	$0	✔	30%	✔
Behavioral health treatment in home or other non-institutional facility	$0	✔	30%	✔
Partial Hospitalization Program	$0	✔	30% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	$0	✔	30% Subject to a Benefit maximum of $600/day	✔
Residential Care for substance use disorder condition	$0	✔	30% 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.

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

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

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

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.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a 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 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.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, a Copayment or Coinsurance may apply for the visit by a Participating Provider. 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.

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

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Outpatient Prescription Drug Rider

Northern California Pipe Trades H&W Trust Fund
Effective July 1, 2025
PPO

Custom PPO Non Medicare Retiree Plan

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* $0

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 Generic, Brand or Non-Formulary Copayment	
Formulary Generic Drugs	$10/prescription		25% plus $10/prescription	
Formulary Brand Drugs	$20/prescription		25% plus $20/prescription	
Non-Formulary Brand Drugs	$35/prescription		25% plus $35/prescription	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Formulary Generic Drugs	$20/prescription		Not covered	
Formulary Brand Drugs	$40/prescription		Not covered	
Non-Formulary Brand Drugs	$70/prescription		Not covered	
Network Specialty Pharmacy Drugs				
Per prescription, up to a 30-day supply.				
Specialty Drugs	30% up to $150/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.

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.

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 Formulary Generic Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

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

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

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Group Rider
Effective July 1, 2025
PPO

Hearing Aid Services Rider

Northern California Pipe Trades (Retiree) Additional Hearing Aid Summary of Benefits

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

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

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

Introduction

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

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

Benefits

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

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

Submitting a Claim Form

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

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

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

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

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

Exclusions

Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or

- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

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

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

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 Service 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 Servicio 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)**。