



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/ca/aso>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 333-5730 to request a copy. For your Pharmacy benefits through Navitus go to [www.navitus.com/members](http://www.navitus.com/members) or call (855) 847-1035.

| Important Questions                                                       | Answers                                                                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$500/person or \$1,000/family for In- <u>Network Providers</u> .<br>\$500/person or \$1000/family for <u>Out-of-Network Providers</u> .                                                                                       | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                    |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . For more information see below.                                                                                                                          | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                            | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$3,500/person or \$7,000/family for In- <u>Network Providers</u> .<br>\$3,500/person or \$7,000/family <u>Out-of-Network Providers</u> .<br>Prescription: \$2,350/person or \$4,700 family for In- <u>Network Providers</u> . | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                          |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Pre-Authorization Penalties</u> , <u>Premiums</u> , <u>balance-billing charges</u> , and health care this <u>plan</u> doesn't cover.                                                                                        | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=JPU">www.anthem.com/find-care/?alphaprefix=JPU</a> or call (855) 333-5730 for a list of                                                                         | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your                                                                                                                                                                                     |

|                                                                  |                                                                                                      |                                                                                                                                                                                                                                |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                  | network providers. Benefits and costs may vary by site of service and how the <u>provider</u> bills. | <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | No.                                                                                                  | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                       |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                                 | Services You May Need                                           | What You Will Pay                                          |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                  |
|----------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                      |                                                                 | In-Network Provider<br>(You will pay the least)            | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                         |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness                | \$20/visit, <u>deductible</u> does not apply               | 40% <u>coinsurance</u>                                     | Virtual visits (Telehealth) benefits available.                                                                                                                         |
|                                                                      | <u>Specialist</u> visit                                         | \$20/visit, <u>deductible</u> does not apply               | 40% <u>coinsurance</u>                                     | Virtual visits (Telehealth) benefits available.                                                                                                                         |
|                                                                      | <u>Preventive care</u> / <u>screening</u> / <u>immunization</u> | No charge                                                  | 40% <u>coinsurance</u>                                     | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)                      | 20% <u>coinsurance</u>                                     | 40% <u>coinsurance</u>                                     | -----none-----                                                                                                                                                          |
|                                                                      | Imaging (CT/PET scans, MRIs)                                    | 20% <u>coinsurance</u>                                     | 40% <u>coinsurance</u>                                     | \$800 maximum/service for <u>Out-of-Network Providers</u> .                                                                                                             |
| <b>Pharmacy OOPM</b>                                                 | Out of Pocket Maximum (OOPM)                                    | \$2,350 per person / \$4,700 per family                    | Non-Participating Provider claims do not apply to the OOPM |                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b>          | Tier 1 – Typically Generic                                      | \$5 Copay (retail)<br>\$5 Copay (mail order)               | \$5 Copay (retail)<br>Not Covered for mail order scripts   | Your Prescription Drug Coverage is covered by Navitus Health Solutions. For more information, please call (855) 847-1035.                                               |
|                                                                      | Tier 2 – Typically Preferred/Brand                              | \$20 Copay (retail)<br>\$40 Copay (mail order)             | \$20 Copay (retail)<br>Not Covered for mail order scripts  |                                                                                                                                                                         |
|                                                                      | Tier 3 – Typically Non-Preferred/Specialty Drugs                | \$60 Copay (retail)<br>\$120 Copay (mail order)            | \$60 Copay (retail)<br>Not Covered for mail order scripts  |                                                                                                                                                                         |
|                                                                      | Specialty Drugs                                                 | 20% to \$150 max (retail)<br>20% to \$300 max (mail order) | Not Covered                                                |                                                                                                                                                                         |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                                                          |                                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                    |
|---------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | In-Network Provider<br>(You will pay the least)                                                            | Out-of-Network Provider<br>(You will pay the most)                                   |                                                                                                                                                                                                                                                           |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               | \$350 maximum/admission for <u>Out-of-Network Providers</u> .                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                                                                                                                                                                            |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$50/visit, then 20% <u>coinsurance</u>                                                                    | Covered as In- <u>Network</u>                                                        | <u>Copayment</u> waived if admitted. 20% <u>coinsurance</u> for Emergency Room Physician Fee.                                                                                                                                                             |
|                                                                           | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                                                                     | Covered as In- <u>Network</u>                                                        | -----none-----                                                                                                                                                                                                                                            |
|                                                                           | <u>Urgent care</u>                             | \$20/visit, <u>deductible</u> does not apply                                                               | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                                                                                                                                                                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               | \$500 penalty if <u>Out-of-Network preauthorization</u> is not obtained. \$600 maximum/day for Non-Emergency Admissions to <u>Out-of-Network Providers</u> .                                                                                              |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                                                                                                                                                                            |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office Visit<br>\$20/visit, <u>deductible</u> does not apply<br>Other Outpatient<br>20% <u>coinsurance</u> | Office Visit<br>40% <u>coinsurance</u><br>Other Outpatient<br>40% <u>coinsurance</u> | Office Visit<br>988 lifeline/mobile crisis team covered as In- <u>Network</u> . Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>-----none-----                                                                                     |
|                                                                           | Inpatient services                             | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               | \$600 maximum/day for Non-Emergency Admissions to <u>Out-of-Network Providers</u> . 20% <u>coinsurance</u> for Inpatient Physician Fee In- <u>Network</u> Providers. 40% <u>coinsurance</u> for Inpatient Physician Fee <u>Out-of-Network Providers</u> . |
| If you are pregnant                                                       | Office visits                                  | \$20/visit, <u>deductible</u> does not apply                                                               | 40% <u>coinsurance</u>                                                               | \$600 maximum/day for Non-Emergency Admissions to <u>Out-of-Network Providers</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                      |
|                                                                           | Childbirth/delivery professional services      | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               |                                                                                                                                                                                                                                                           |
|                                                                           | Childbirth/delivery facility services          | 20% <u>coinsurance</u>                                                                                     | 40% <u>coinsurance</u>                                                               |                                                                                                                                                                                                                                                           |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

| Common Medical Event                                           | Services You May Need            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                  |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                         |
|                                                                |                                  |                                                 |                                                    | *Coverage includes fertility preservation services, see Fertility Preservation section. |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | 100 visits/benefit period.                                                              |
|                                                                | <u>Rehabilitation services</u>   | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | *See Therapy Services section.                                                          |
|                                                                | <u>Habilitation services</u>     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                         |
|                                                                | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | 100 days/benefit period for skilled nursing services.                                   |
|                                                                | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | *See <u>Durable Medical Equipment</u> section.                                          |
|                                                                | <u>Hospice services</u>          | No charge                                       | 40% <u>coinsurance</u>                             | -----none-----                                                                          |
| If your child needs dental or eye care                         | Children's eye exam              | Not covered                                     | Not covered                                        | -----none-----                                                                          |
|                                                                | Children's glasses               | Not covered                                     | Not covered                                        |                                                                                         |
|                                                                | Children's dental check-up       | Not covered                                     | Not covered                                        | -----none-----                                                                          |

#### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |                                                                  |                        |                            |
|------------------------------------------------------------------|------------------------|----------------------------|
| • Children's dental check-up                                     | • Cosmetic surgery     | • Dental care (Adult)      |
| • Eye exams for a child                                          | • Glasses for a child  | • Hearing aids             |
| • Infertility treatment                                          | • Long-term care       | • Routine eye care (Adult) |
| • Routine foot care unless you have been diagnosed with diabetes | • Weight loss programs |                            |

#### Pharmacy Benefit Exclusions

- |                               |                                           |
|-------------------------------|-------------------------------------------|
| • Alcohol Swabs               | • Hair growth stimulants                  |
| • Insulin pumps/pump supplies | • Infertility Treatment                   |
| • Anti-wrinkle agents         | • Medical office administered medications |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                                                                                            |                                               |                                              |
|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| • Acupuncture 20 visits/benefit period                                                                                     | • Bariatric surgery (In- <u>Network</u> )     | • Chiropractic care 30 visits/benefit period |
| • Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a> | • Private-duty nursing in a Home Setting only |                                              |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

### Other Pharmacy Benefit Inclusions

- Sexual dysfunction agents
- Vaccines
- Acne/Skin disease (PA required for members age 35 or older)
- Smoking cessation

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357), Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, 300 South Spring Street, 14th Floor, Los Angeles, CA 90013, 800-927-4357, 800-482-4833 (TTY), <https://www.insurance.ca.gov>

### Does this plan provide Minimum Essential Coverage? Yes/No.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes/No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                        |          | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                        |         | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                   |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                                                  | \$500    | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                               | \$500   | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                   | \$500   |
| ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                                                  | \$20     | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                               | \$20    | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                   | \$20    |
| ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                                                       | 20%      | ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                    | 20%     | ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                        | 20%     |
| ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                                                     | 20%      | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                  | 20%     | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                      | 20%     |
| This EXAMPLE event includes services like:<br><u>Specialist</u> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> )<br><u>Specialist</u> visit ( <i>anesthesia</i> ) |          | This EXAMPLE event includes services like:<br><u>Primary care physician</u> office visits ( <i>including disease education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose meter</i> ) |         | This EXAMPLE event includes services like:<br><u>Emergency room care</u> ( <i>including medical supplies</i> )<br><u>Diagnostic test</u> ( <i>x-ray</i> )<br><u>Durable medical equipment</u> ( <i>crutches</i> )<br><u>Rehabilitation services</u> ( <i>physical therapy</i> ) |         |
| Total Example Cost                                                                                                                                                                                                                                                                                             | \$12,700 | Total Example Cost                                                                                                                                                                                                                                                          | \$5,600 | Total Example Cost                                                                                                                                                                                                                                                              | \$2,800 |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                                |          | In this example, Joe would pay:                                                                                                                                                                                                                                             |         | In this example, Mia would pay:                                                                                                                                                                                                                                                 |         |
| <u>Cost Sharing</u>                                                                                                                                                                                                                                                                                            |          | <u>Cost Sharing</u>                                                                                                                                                                                                                                                         |         | <u>Cost Sharing</u>                                                                                                                                                                                                                                                             |         |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                                             | \$500    | <u>Deductibles</u>                                                                                                                                                                                                                                                          | \$100   | <u>Deductibles</u>                                                                                                                                                                                                                                                              | \$500   |
| <u>Copayments</u>                                                                                                                                                                                                                                                                                              | \$0      | <u>Copayments</u>                                                                                                                                                                                                                                                           | \$200   | <u>Copayments</u>                                                                                                                                                                                                                                                               | \$100   |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                                             | \$2,400  | <u>Coinsurance</u>                                                                                                                                                                                                                                                          | \$0     | <u>Coinsurance</u>                                                                                                                                                                                                                                                              | \$300   |
| <u>What isn't covered</u>                                                                                                                                                                                                                                                                                      |          | <u>What isn't covered</u>                                                                                                                                                                                                                                                   |         | <u>What isn't covered</u>                                                                                                                                                                                                                                                       |         |
| Limits or exclusions                                                                                                                                                                                                                                                                                           | \$70     | Limits or exclusions                                                                                                                                                                                                                                                        | \$4,300 | Limits or exclusions                                                                                                                                                                                                                                                            | \$10    |
| The total Peg would pay is                                                                                                                                                                                                                                                                                     | \$2,970  | The total Joe would pay is                                                                                                                                                                                                                                                  | \$4,600 | The total Mia would pay is                                                                                                                                                                                                                                                      | \$910   |

The plan would be responsible for the other costs of these EXAMPLE covered services.



## Get help in your language

### Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: 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 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357 (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card

#### Spanish

Servicios lingüísticos sin costo. Puede solicitar los servicios de un intérprete. También puede solicitar que le leamos y le enviemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

#### Arabic

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تُقرأ لك وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

#### Armenian

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար գանգահարեք մեզ ձեր ID քարտում նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացուցիչ օգնության համար գանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD: 711)

#### Chinese

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的 ID 卡所列的電話號碼，或致電 1-888-254-2721 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡

#### Farsi

خدمات زبان بدون هزینه. شما می‌توانید مترجم شفاهی درخواست کنید. می‌توانید بخوانید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود. برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 254-2721-888 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

#### Hindi

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ अपनी भाषा में पढ़वा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

#### Hmong

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

#### Japanese

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、IDカードに記載されている電話番号または 1-888-254-2721 までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357 (TTY/TDD: 711)

### **Khmer**

មិនគិតថ្លៃសេវាភាសាទេ។ អ្នកអាចទទួលបានអ្នក បកប្រែ។ អ្នកអាចទទួលបានឯកសារអានឱ្យអ្នក ស្តាប់ និងឯកសារខ្លះផ្សេងទៀតជាភាសាបស់អ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកយើងតាមលេខដែល មាននៅក្នុងកាត ID របស់អ្នក ឬ 1-888-254-2721។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅផ្នែកធានារ៉ាប់រង CA តាមរយៈលេខ 1-800-927-4357 (TTY/TDD: 711)

### **Korean**

무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 맥으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 1-888-254-2721 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)로 전화해 주십시오.

### **Punjabi**

ਬਿਨਾ ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-254-2721. ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

### **Russian**

Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711)

### **Tagalog**

Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

### **Thai**

บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถ รับล่ามเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบ มีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตาม หมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกรมการประกันภัยแห่ง แคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

### **Vietnamese**

Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên. Quý vị có thể yêu cầu họ đọc tài liệu hoặc gửi cho quý vị một số tài liệu bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ ID của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, hãy gọi cho Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711)



### **It's important we treat you fairly**

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>