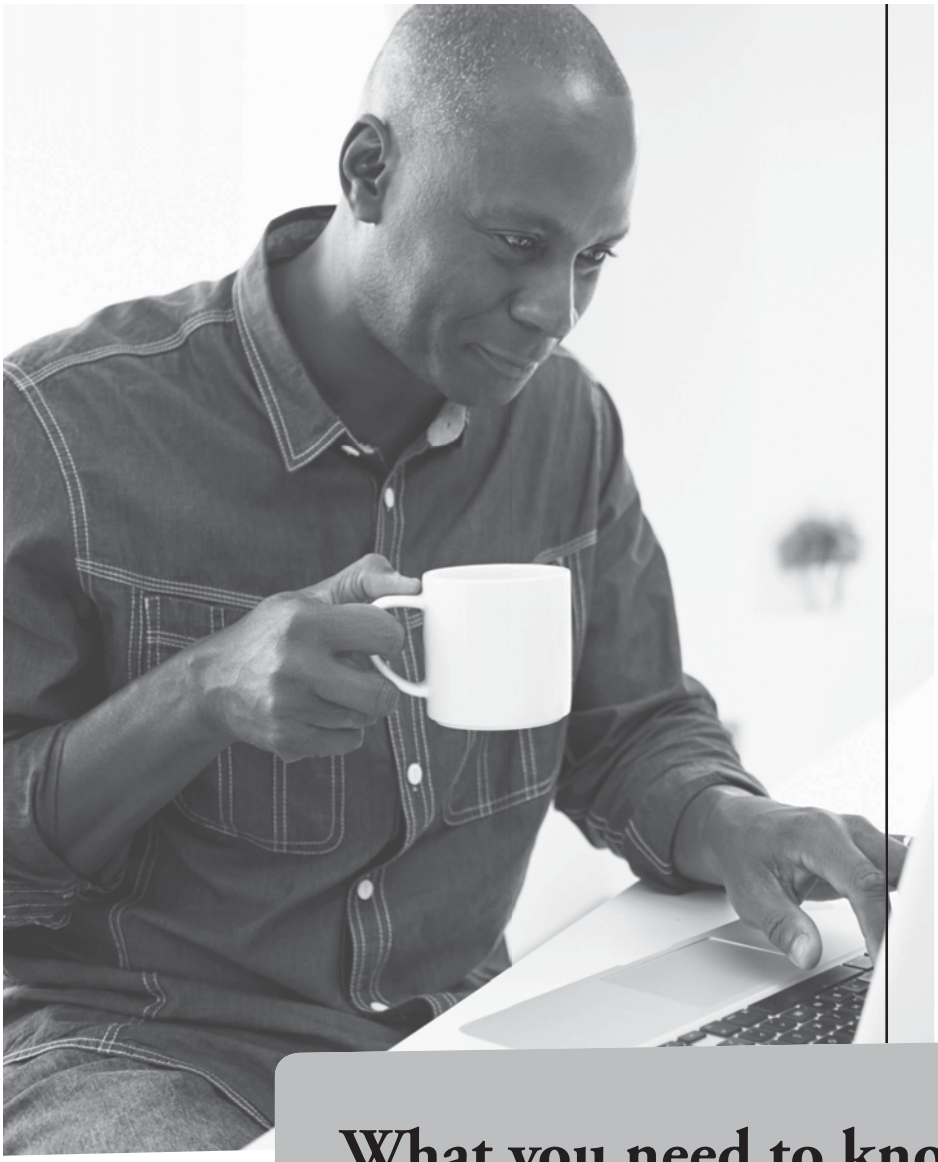

What you need to know

Important legal information about your health plan

Anthem BlueCross

52809CAMENABCFI-NP 03/16

Every year we send you important information about your rights, your benefits and more. Going paperless reduces clutter and it's easy to sign up to get these notices by email:

- Log in at **anthem.com/ca**.
- Pick **Profile**.
- Choose **Email Preferences**.
- Select **Primary Email Address**.
- Choose **Save/Update**.

Looking for information about your plan

Every year, we share details about your benefits and rights and responsibilities as a member so you can get the most from your health plan. This information is online, all in one place, and available anytime.
Visit **anthem.com/ca** to:

Learn about:

- Your rights and responsibilities
- Covered and non-covered services and benefits that have limitations
- Copayments and any costs you may have to pay
- Steps we take when evaluating new treatments to be considered as covered benefits

Learn how to:

- Access primary and specialty care, behavioral health and hospital services.
- Access care when you are out of the plan's service area.
- Get information about accessing emergency care and when to use 911 services.
- Search for doctors, specialists or hospitals in our network and learn about their qualifications.
- Find a new doctor if you are turning 18 and ready to move to adult care.
- File a claim for covered services.
- Access care after normal office hours.
- Voice a complaint or appeal a decision. This includes your right to independent external appeal.
- Get translation services in your preferred language and access TTY/TDD services.
- Share information about all the care you get with all your doctors.

Learn about important programs, such as:

- Our Quality Improvement (QI) program and how we use this information to review and help improve the quality of our benefits and services
- Our Utilization Management (UM) process, rules for decision makers, how to contact UM staff toll-free, and our hours of operation
- Our Case Management program and how to sign up if you have a serious medical condition

To find your information, go to www.anthem.com/ca/aboutyourplan1614.
For a printed copy of this information, call Member Services at the number on your member ID card.

Protecting your privacy

Where to find our Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of our Notice of Privacy Practices on our website at anthem.com/ca or you may contact Member Services using the contact information on your identification card.

STATE NOTICE OF PRIVACY PRACTICES

As we indicate in our HIPAA Notice of Privacy Practices, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI is information that identifies a person and is often gathered in an insurance matter.

If we use or disclose PI for underwriting purposes, we are prohibited from using or disclosing PI that is genetic information of an individual for such purposes.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out of that activity, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Breast Reconstruction Surgery Benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy
- Surgery and reconstruction of the other breast to provide a symmetrical appearance
- Prostheses and coverage for physical complications during all stages of the covered mastectomy, including lymphedemas

All applicable benefit provisions will apply, including existing deductibles, copayments, and/or coinsurance. Contact your Plan administrator for more information.

For more information about the Women's Health and Cancer Rights Act, you can go to the federal Department of Labor website at **dol.gov/ebsa/publications/whcra.html**

How to file a grievance or appeal a decision

What to do if you're unhappy with your care or service

This process applies if you're covered by Anthem Blue Cross or Anthem Blue Cross Life & Health Insurance Company (Anthem). To find out, check your member ID card.

If you're unhappy with the care or service you received from Anthem or a network medical group or health care provider, you can file a complaint (we call this a "grievance"). If you disagree with a denial of treatment or claims payment, you can "appeal" the decision.

You have up to 180 calendar days from the date you get a denial notice or the date of an incident or dispute to file a grievance or appeal unless your plan documents say otherwise. If there's a good reason, we may give you more time to file a grievance or appeal.

How to submit a grievance or appeal:

- **Member Grievance form:** Complete a Member Grievance form and mail it to:

  Anthem Blue Cross
  Attn: Priority Member Grievances
  P.O. Box 60007
  Los Angeles, CA 90060-0007

  This form is available from your medical group, on our website, or by calling Member Services at the number on your member ID card.

- **Website:** Go to **anthem.com/ca,** and download the grievance or appeal form. You can find it under the heading *Customer Care*. You will see *I Need To*. Under that, choose **File an appeal or grievance.**
- **Member Services:** Call Member Services at the number on your member ID card to file a grievance or appeal.

For emergency complaints

For any emergency grievance or appeal, call Member Services right away at the number on your member ID card.

You can choose someone like an attorney or health care expert to file a grievance or appeal for you. You'll be asked to fill out and sign an authorization form so that person can represent you.

What to include with your appeal

- Your name and ID number
- The name of the provider or facility that provided care
- The date(s) of service
- The claim or reference number for the specific decision with which you disagree
- The reason(s) why you don't agree with the decision

You have the right to include written comments, documents or other key information with your appeal. We encourage you to do so.

What happens next?

- The proper administrative and/or clinical specialists will review all the information you or your representative submit with your appeal. Anthem reviewers cannot have been involved in the original decision. They also can't work for the person who made the initial decision.
- We may contact any providers who may have more information to support your appeal.
- We will send you a written decision within 30 calendar days of getting your grievance or appeal. If your condition is urgent, you can ask for an expedited review of your grievance or appeal. Anthem will then provide you with a written decision within 72 hours.
- If we deny your appeal, we'll give you other options, including external review, if available. You also can check your plan documents or call Member Services at the number on your member ID card to get more information about the appeal process.

Do you speak another language?

We can help you or any member who prefers to speak a language other than English and those with vision, speech or hearing loss by providing:

- Translation services for letters and written materials (through Member Services)
- An interpreter in a language other than English (through Member Services)
- Telephone relay systems
- Other devices to aid people with disabilities

For members enrolled in Anthem Blue Cross plans*

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-365-0609**, or at the TDD line **866-333-4823**, 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 number (**888-HMO-2219**) and a TDD line (**877-688-9891**) for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online. You may also contact the department by writing to the following address: 980 9th Street, Suite 500, Sacramento, CA 95814 or by e-mail at **helpline@dmhc.ca.gov**.

If you're enrolled in an Anthem Blue Cross Life & Health Insurance Company plan, you may contact*

California Department of Insurance
Consumer Affairs Bureau
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)

*To identify the company that provides your plan, check your member ID card.

What's an Independent Medical Review (IMR)?

As a member, you can apply to the California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) (whichever applies) for an Independent Medical Review (IMR) within six months of a qualifying event. You may request an IMR after filing an appeal with us and:

- The denial is upheld; or
- The appeal remains unresolved after 30 calendar days or after 72 hours for expedited reviews. After receiving an initial denial of investigational treatment, you don't have to go through the Anthem grievance and appeal process before you ask for an IMR.

When the DMHC or CDI decides your appeal qualifies for an IMR, Anthem provides the requested medical information within required time frames to an Independent Review Organization (IRO) picked by the DMHC or CDI. Anthem must follow the IRO's decision.

If services are approved, we notify you and your provider in writing within five business days. If services are denied, the DMHC or CDI notifies you in writing, explaining the reason for the denial. Check your Combined Evidence of Coverage and Disclosure for more about grievance procedures and the IMR process.

Are you an ERISA plan member?

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

Call Member Services

If you or a representative filed a grievance or appeal, you can call Member Services at the number on your member ID card with any questions or requests for information about your case.

What are utilization management, utilization review and medical necessity review?

Here's what it all means and how it works

To see if the health care or service your doctor or other health care provider wants to give you is a "medical necessity," Anthem looks at requests for authorization. Check your benefit plan to know what makes something a "medical necessity" and when care requires this review.

A "medical necessity review" may be called utilization review (UR), utilization management (UM), or medical management. It is a review process that helps decide if a certain outpatient care, inpatient hospital stay, technology or procedure is medically needed.

Reviews can happen at different times including:

- When a service, treatment or procedure is asked for or planned ahead. We call this prospective or pre-service review.
- During the course of care. We call this inpatient or outpatient ongoing care review.
- After care or services have been given. We call this retrospective or post-service review.

With so many different things to consider, it may help to get a clear picture of what to expect and how the process works.

Timing matters

We're committed to deciding cases quickly. Here are time frames you can expect:

Type of review	The maximum time allowed for a health plan to decide medical necessity once it gets the information needed to do so
Non-urgent pre-service (before care)	5 business days 72 hours for non-urgent prescription drug requests
Urgent pre-service (before care)	72 hours 24 hours for urgent prescription drug requests
Urgent inpatient or outpatient ongoing care (during care)	24 hours (in some cases) or no later than within 72 hours of getting a request
Retrospective/post-service (after care)	30 calendar days

What happens if there is a delay?

If we don't have the information we need to make a decision, we try to get it from the doctor or other health care provider who requests the service or care.

We'll write you and the requesting doctor or health care provider if there might be a delay because the information we need is not easy to get. This letter tells you what we need to make a decision. It also explains when to expect the decision once we get the information.

If we don't get the information we need, we will send a final letter explaining that we are unable to approve access to this benefit because we don't have enough information.

Professional reviewers decide

Qualified licensed health care professionals and doctors from Anthem Blue Cross and the medical group (or their peers) review requests and give an opinion specific to a medical condition, procedure and/or treatment under review. If the reviewer is unable to decide the medical necessity of a request, he or she may call the requesting doctor or other provider to discuss the case. In many cases, medical necessity can be determined after this call.

Decisions are based on what is right for each member for the type of care and service. Medically necessary review decisions made by Anthem Blue Cross are based on:

- Anthem's medical policy criteria and guidelines (reviewed at least once a year and updated as standards and technology change).
- Nationally recognized clinical guidelines approved by a committee including practicing doctors and health care professionals not employed by Anthem Blue Cross.
- Your health benefits.

Employees, consultants or other providers are not rewarded or offered money or other incentives for denying care or a service, or for supporting decisions that result in using fewer services. Also, Anthem doesn't make decisions about hiring, promoting or firing these individuals based on the idea or thought that they will deny benefits.

Medical necessity doesn't mean payment or coverage

If we find services are medically necessary, it doesn't mean the service is paid for or covered. Payment is based on the terms of your coverage at the time of service. There are some exclusions, limitations and other conditions that are part of your benefits. You will find them in your Evidence of Coverage.

Payment of benefits could be limited for a number of reasons, such as:

- Information included with the claim differs from that given at time of review.
- The service performed is not covered.
- You're not eligible for coverage when the service is given.

Decisions not to approve are put in writing

If we find the service is not a medical necessity, you and your doctor or health care provider requesting it will get written notice within two business days of the decision. This written notice has:

- A clear and simple explanation of the reason for the decision.
- The name of the criteria and/or guidelines used to make the decision and instructions for how to get a written copy.
- Information on how to appeal the decision and about your rights to an independent medical review.
- Specific parts of the contract that exclude coverage if the denial is based upon benefit coverage.

To see our guidelines

Anyone can see Anthem Blue Cross' medical-necessity guidelines for specific services.

- Go to **anthem.com/ca**.
- Choose **Customer Support** in the upper-right side of the screen.
- Under *Top FAQs*, select **Anthem-CA Medical Policies**.
- Choose **For detail around Anthem's Medical Policies**.
- Scroll down and pick **Continue**; you will see the *Medical Policies and Clinical UM Guidelines Overview* page.
- Select the **Medical Policies** or **UM Guidelines** option in the toolbar.
- Choose the link for the desired search option: **Recent Updates**, **By Category**, or **By Alpha**.
- Select the desired **Medical Policy** or **UM Guideline**.

You may also call **1-800-794-0838** to request a free paper copy of the guidelines used to determine your case. These guidelines are used by Anthem Blue Cross to authorize, change or deny benefits for people with similar illnesses or conditions. Specific care and treatment benefits vary based on individual need and covered benefits.

Questions about utilization management? Call us.

To learn more about a UM medical decision, preauthorization requests or the UR review process, or if you have questions or issues, call our toll-free number: **1-800-274-7767**, Monday through Friday (except holidays) from 7:30 a.m. to 5 p.m. PST.

If you call after hours or don't reach someone during business hours, leave a confidential voice mail message with your name and phone number. We'll return your call no later than the next business day, unless you request another time.

You also can call Member Services at the number on your ID card to ask for an interpreter in your preferred language. They can read UM information in another language or help explain it in your preferred language free of charge.

If you have a hearing or speech loss, dial **711** to use the National Relay Service or the number below for the California Relay Service. A special operator will contact Anthem to help with your needs.

- **1-800-855-7100** (English TTY/English voice)

Free Language Assistance Available

Language Assistance Program Reaches Out to Californians

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. You can also call us at the toll free number on the back of your ID card. To get an interpreter or to ask about written information in your language, first call your health plan's phone number at **888-254-2721**. Someone who speaks your language can assist you. You may also provide your preferred written and spoken language directly to your health plan and directly to your provider. If you provide your language preferences to your health plan, this information will be maintained by your health plan and will be shared with your provider when the provider calls to check eligibility or upon request. If your preferred written language is one of your health plan's threshold languages, you may receive some plan information in your preferred written language. You may update your preferred written and spoken languages and provide information on race and ethnicity to your health plan by calling **888-254-2721**. If you need more help, call the CA Dept. of Insurance at **800-927-4357**.

Arabic:

مهم: يمكنك الحصول على مترجم فوري للتحدث إلى طبيبك أو الخطة الصحية من دون أي تكلفة. كما يمكنك الاتصال بنا على الرقم المجاني الموجود بالجانب الخلفي لبطاقة هويتك. وللحصول على مترجم فوري أو السؤال عن معلومات مكتوبة بلغتك، اتصل أولاً برقم هاتف خطتك الصحية على **888-254-2721**. قد يتمكن شخص يتحدث لغتك من مساعدتك. ربما يمكنك أيضًا توفير لغة التحدث والكتابة المفضلة لديك مباشرة لخطتك الصحية ومقدم الخدمة لك. إذا قدمت اللغات المفضلة لخطتك الصحية، فسيتم حفظ هذه المعلومات من خلال خطتك الصحية ومشاركتها مع مقدم الخدمة لك عندما يطلب التحقق من الصلاحية أو عند الطلب. إذا كانت لغة الكتابة المفضلة لك إحدى لغات مستوى خطتك الصحية، فقد تستقبل معلومات الخطة بلغة الكتابة المفضلة لديك. بإمكانك تحديث اللغات المكتوبة والمنطوقة المفضلة لديك وتوفير معلومات عن العرق والإثنية إلى خطة صحتك بالإتصال على الرقم الرقم**2721**-254-888. إذا كنت في حاجة إلى مزيد من المساعدة، اتصل بإدارة كاليفورنيا للتأمين على الرقم**4357**-927-800.

Armenian:
ԿԱՐԵՎՈՐ Է. Դուք կարող եք անվճար օգտվել բանավոր թարգմանչի ծառայություններից ձեր բժշկի կամ առողջապահական ծրագրի հետ խոսելու համար: Կարող եք նաև զանգահարել մեզ ձեր ID քարտի հետևում գտնվող անվճար հեռախոսահամարով: Թարգմանիչ կամ ձեր լեզվով գրավոր տեղեկություններ խնդրելու համար սկզբից զանգահարեք ձեր առողջապահական ծրագրի հեռախոսահամարով՝ **888-254-2721:** Ձեր լեզվով խոսացող որևէ անձ կօգնի ձեզ: Դուք կարող եք նաև տեղեկացնել ձեր առողջապահական ծրագիրը կամ ուղղակիորեն ձեր մատակարարին ձեր նախընտրելի գրավոր և բանավոր լեզվի մասին: Եթե դուք ձեր առողջապահական ծրագրին հաղորդեք ձեր լեզվական նախընտրություններն, ապա առողջապահական ծրագիրը կպահպանի այդ տեղեկությունը և կփոխանցի այն ձեր մատակարարին, երբ մատակարարը զանգահարի իրավասությունը ստուգելու համար կամ խնդրի այդ տեղեկությունը: Եթե ձեր նախընտրելի գրավոր լեզուն ձեր առողջապահական ծրագրի շեմային լեզուներից մեկն է, հնարավոր է, որ դուք ստանաք ծրագրի որոշ տեղեկատվություն ձեր նախընտրելի գրավոր լեզվով: Կարող եք թարմացնել ձեր նախընտրելի գրավոր և բանավոր լեզուն ու տրամադրել ռասայական և ազգային պատկանելության վերաբերյալ տեղեկություններ՝ զանգահարելով ձեր առողջապահական ծրագիր՝ **888-254-2721** հեռախոսահամարով: Եթե լրացուցիչ օգնության կարիք ունեք, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ **800-927-4357** հեռախոսահամարով:

Traditional Chinese:
重要事宜：您可以透過免費口譯員與您的醫師或健保計劃交流。您也可撥打您保險卡背面的免付費電話號碼與我們聯絡。如欲取得口譯員服務或要求以您的語言提供書面資訊，請首先聯絡您的健保計劃，電話號碼 **888-254-2721**。說您語言的人士能協助您。您也可以直接向您的健保計劃以及您的醫療服務提供者提供您的首選書面和口語語言。如果您向健保計劃提供了您的首選語言，這一資訊將由您的健保計劃保存，如果您的醫療服務提供者致電查詢資格情況或需要該資訊，則會將該資訊與其分享。如果您的首選書面語言是您健保計劃可提供的主要語言之一，您則可以收到以您首選書面語言提供的部分計劃資訊。您可以透過撥打 **888-254-2721**，向您的健保計劃更新您的首選書面或口語語言，並提供關於您的民族或種族資訊。如果您需要更多幫助，請撥打 **800-927-4357** 聯絡加州保險局 (CA Dept. of Insurance)。

Farsi:
نکته مهم: می توانید به صورت رایگان یک مترجم در اختیار داشته باشید تا با پزشک یا مسئول طرح سلامتتان صحبت کند. همچنین می توانید از طریق شماره تلفن رایگان که در پشت کارت شناساییتان درج شده است، با ما تماس بگیرید. برای دریافت مترجم شفاهی یا درخواست در مورد اطلاعات کتبی به زبان خود، ابتدا با برنامه درمانی خود به شماره تلفن **888-254-2721** تماس بگیرید. شخصی که به زبان شما صحبت می کند می تواند به شما کمک کند. همچنین می توانید مستقیماً درباره زبان گفتاری و شنیداری خودتان با مسئول طرح سلامت و ارائه دهنده تان صحبت کنید. اگر زبان مورد نظرتان را به اطلاع مسئول طرح سلامت برسانید، این اطلاعات توسط مسئول طرح سلامت حفظ می شود و هنگامی که ارائه دهنده تماس می گیرد تا شرایط را بررسی کند، یا به درخواست شما، با شما به اشتراک گذاشته خواهد شد. اگر زبان نوشتاری مورد نظرتان یکی از زبان های طرح سلامت باشد، به زبان کتبی خودتان بعضی از اطلاعات طرح را دریافت خواهید کرد. برای تغییر دادن زبان های کتبی و شفاهی ترجیحی خود و ارائه اطلاعات در مورد نژاد و قومیت خود می توانید با برنامه درمانی به شماره **888-254-2721** تماس بگیرید. اگر به راهنمایی نیاز داشتید، با بخش CA سازمان بیمه تان به شماره **800-927-4357** تماس بگیرید.

Hmong:
TSEEM CEEB HEEV: Koj siv tau ib tug neeg txhais lus dawb los pab koj tham nrog koj tus kws kho mob lossis koj qhov kev npaj pab them nqi kho mob. Koj muaj feem hu tuaj rau peb tau ntawm tus npawb xov tooj hu dawb nyob tom qab ntawm daim npav (ID card) Yog tias koj xav tau ib tug neeg txhais lus lossis xav tau tej yam ntaub ntawv sau ua koj hom lus, hu rau koj qhov kev npaj pab them nqi kho mob tus xovtooj ua ntej ntawm **888-254-2721**. Ib tug neeg uas txawj hais koj hom lus mam li pab koj. Koj muaj feem muab koj cov lus hais thiab cov ntawv koj sau tau rau hauv koj daim phiam hais txog kev noj qab haus huv thiab muab ncaj qha mus rau tus neeg ua nws pab koj. Yog tias koj muab koj cov lus hais rau hauv koj daim phiam hais txog kev noj qab haus huv, cov xwm txheej no yuav muab khaws cia hauv koj daim phiam thiab yuav muab qhia mus rau tus neeg ua nws pab koj tau paub tej thaum ua koj tau hu rau nws los mus saib txog kev muaj feem tau txais txiaj ntsig thiab koj ho noog lwm yam. Yog tias koj cov ntawv koj sau tau yog ib hom ua nyuam qhuav pib nyob hauv koj daim phiam kev noj qab haus huv, koj yuav tau txais ib cov xwm txheej qhia koj daim phiam uas sau koj cov ntawv ua koj sau tau. Koj hloov tau tias seb koj xum siv thiab hais hom lus thiab muab cov lus qhia txog haiv neeg thiab hom neeg thaum koj hu rau koj qhov kev npaj pab them nqi kho mob ntawm **888-254-2721**. Yog tias koj xav tau kev pab ntxiv, hu rau feem hauj lwm CA. Hais txog kev pov hwm **800-927-4357**.

Japanese:
重要：医師または保険プランとお話しになる際に、無料の通訳をご利用いただけます。また、IDカードの裏面に記載される無料通話番号をご利用の上お電話いただくこともできます。日本語での通訳または書面による情報をご希望の場合、保険プランの電話番号**888-254-2721**までお電話ください。日本語を話す担当者が対応いたします。お客様は、ご希望の文書および会話用言語を保険プランまたは医療プロバイダーまで直接提供することもできます。保険プランにご希望の言語を提供なさいますと、保険プランはこの情報を保持し、プロバイダーが保険の資格を確認するために連絡があった際に、または要請された時にプロバイダーに提供します。お客様の希望言語が保険プランが対応可能な標準言語の一つである場合、ご希望の文書用言語でプラン情報の一部をお受け取りいただけます。文書および会話用のご希望の言語を変更し、人種、民族に関する情報を提供するには、電話番号**888-254-2721**をご利用の上、保険プランまでご連絡ください。さらに支援が必要な場合には、カリフォルニア州保険局（電話番号**800-927-4357**）までご連絡ください。

Khmer:
ចំណាចសំខាន់ៗ អ្នកអាចទទួលសេវាអ្នកបកប្រែដោយឥតគិតថ្លៃ ដើម្បីនិយាយជាមួយគម្រោងសុខភាពឬគ្រូពេទ្យរបស់អ្នក។ អ្នកក៏អាចហៅទូរស័ព្ទមកកាន់យើងខ្ញុំតាមរយៈលេខទូរស័ព្ទឥតគិតថ្លៃដែលមាននៅខាងក្រោយនៃប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក។ ដើម្បីទទួលបានអ្នកបកប្រែឬដើម្បីស្នើសុំព័ត៌មានសរសេរជាភាសារបស់អ្នក ជាដំបូងសូមហៅទូរស័ព្ទទៅកាន់លេខគម្រោងសុខភាពរបស់អ្នក តាមរយៈលេខ **888-254-2721**។ អ្នកដែលចេះនិយាយភាសារបស់អ្នក អាចជួយអ្នកបាន។ អ្នកក៏អាចនឹងផ្តល់ភាសាសរសេរ ឬភាសានិយាយដែលអ្នកពេញចិត្តដោយផ្ទាល់ទៅកាន់គម្រោងសុខភាពរបស់អ្នក និងដោយផ្ទាល់ទៅកាន់អ្នកផ្តល់សេវាកម្មរបស់អ្នក។ ប្រសិនបើអ្នកផ្តល់ភាសាដែលអ្នកពេញចិត្តទៅកាន់គម្រោងសុខភាពរបស់អ្នក ព័ត៌មាននេះនឹងត្រូវរក្សាទុកគម្រោងសុខភាពរបស់អ្នក ហើយនឹងត្រូវចែករំលែកជាមួយអ្នកផ្តល់សេវាកម្មរបស់អ្នក នៅពេលអ្នកផ្តល់សេវាកម្មទូរស័ព្ទដើម្បីពិនិត្យមើលសិទ្ធិទទួលបានឬនៅពេលស្នើសុំ។ ប្រសិនបើអ្នកចង់បានជាភាសារសេរជាភាសាមួយនៃគម្រោងសុខភាពរបស់អ្នក អ្នកអាចទទួលបានព័ត៌មានអំពីគម្រោងមួយចំនួនជាភាសារសេរដែលអ្នកពេញចិត្ត។ អ្នកអាចនឹងធ្វើបច្ចុប្បន្នភាពផ្នែកភាសារសេរ និងនិយាយរបស់អ្នក និងផ្តល់ព័ត៌មានអំពីជាតិសាសន៍ និងជាតិព័ន្ធទៅកាន់គម្រោងសុខភាពរបស់អ្នក ដោយហៅទូរសព្ទទៅលេខ **888-254-2721**។ ប្រសិនបើត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅកាន់នាយកដ្ឋាន CA នៃផ្នែកធានារ៉ាប់រងតាមរយៈលេខ **800-927-4357**។

Korean:
중요: 담당 의사 또는 건강 플랜과 대화하기 위한 통역사를 무료로 이용하실 수 있습니다. 또한 보험 ID 카드 뒷면에 인쇄된 무료통화 번호를 통해 당사로 전화하실 수도 있습니다. 통역사를 요청하거나 본인이 구사하는 언어로 된 서면 정보를 요청하려면 먼저 귀하 건강 플랜의 번호인 **888-254-2721**번으로 전화하십시오. 귀하 언어를 구사하는 분이 도와드릴 수 있습니다. 또한 귀하가 선호하는 구어, 문어가 무엇인지 직접 본인의 건강 플랜 및 담당 공급자에게 알릴 수도 있습니다. 본인의 건강 플랜에 어떤 언어를 선호하는지 알렸으면 이 정보는 귀하 건강 플랜에 의해 관리되고 공급자가 가입자격을 확인하기 위해 전화하거나 또는 요청 시 이 정보를 해당 공급자와 공유할 수 있습니다. 귀하가 선호하는 문어가 본인 건강 플랜에 준비된 언어 중 하나일 경우, 일부 플랜 정보를 귀하가 선호하는 문어로 받아볼 수 있습니다. **888-254-2721**번으로 전화하여 본인의 건강 플랜에 귀하가 어떤 문어, 구어를 선호하는지 업데이트 하고 인종 및 민족 정보를 제공하실 수 있습니다. 추가 도움이 필요하시면 캘리포니아 주(州) 보험국에 **800-927-4357**번으로 전화해 주십시오.

Punjabi (Gurmukhi):
ਮਹੱਤਵਪੂਰਣ: ਤੁਸੀਂ ਆਪਣੇ ਡਾਕਟਰ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਬਿਨਾਂ ਕਿਸੀ ਮੁੱਲ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਉੱਤੇ ਟੋਲ ਫ੍ਰੀ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਵੀ ਕਰ ਸਕਦੇ ਹੋ। ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਜਾਂ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿੱਖਤ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਪਹਿਲਾਂ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਨੂੰ **888-254-2721** ਤੇ ਫ਼ੋਨ ਕਰੋ। ਕੋਈ ਅਜਿਹਾ ਵਿਅਕਤੀ ਜੋ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਬੋਲਦਾ ਹੈ, ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਸਿੱਧਾ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਅਤੇ ਸਿੱਧਾ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨੂੰ ਆਪਣੀ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿੱਖਤ ਅਤੇ ਬੋਲਣ ਵਾਲੀ ਭਾਸ਼ਾ ਵੀ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦੇ ਹੋ। ਜੇ ਤੁਸੀਂ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਲਈ ਆਪਣੀਆਂ ਭਾਸ਼ਾ ਪਸੰਦਗੀਆਂ ਪ੍ਰਦਾਨ ਕਰਦੇ ਹੋ ਤਾਂ ਇਹ ਜਾਣਕਾਰੀ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਦੁਆਰਾ ਕਾਇਮ ਰੱਖੀ ਜਾਵੇਗੀ ਅਤੇ ਤੁਹਾਡੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਉਦੋਂ, ਜਦੋਂ ਪ੍ਰਦਾਤਾ ਪਾਤਰਤਾ ਦੀ ਜਾਂਚ ਕਰਨ ਲਈ ਫ਼ੋਨ ਕਰਦਾ ਹੈ ਜਾਂ ਬੇਨਤੀ ਕਰਨ ਉੱਤੇ ਸਾਂਝੀ ਕੀਤੀ ਜਾਵੇਗੀ। ਜੇ ਤੁਹਾਡੀ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿੱਖਤ ਭਾਸ਼ਾ ਤੁਹਾਡੇ ਹੈਲਥ ਪਾਲਨ ਦੀਆਂ ਥ੍ਰੈਸ਼ੋਲਡ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚੋਂ ਇੱਕ ਹੈ ਤਾਂ ਤੁਸੀਂ ਆਪਣੀ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿਖਤ ਭਾਸ਼ਾ ਵਿੱਚ ਕੁਝ ਪਲਾਨ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿੱਖਤ ਅਤੇ ਬੋਲਣ ਵਾਲੀ ਭਾਸ਼ਾ ਬਾਰੇ ਅਤੇ ਆਪਣੇ ਕੁਲ ਅਤੇ ਜਾਤੀ ਬਾਰੇ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਕੇ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਨੂੰ **888-254-2721** ਤੇ ਫ਼ੋਨ ਕਰਕੇ ਅਪਡੇਟ ਕਰ ਸਕਦੇ ਹੋ। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ CA ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ **800-927-4357** ਤੇ ਫ਼ੋਨ ਕਰੋ।

Russian:
ВАЖНО! Вы можете бесплатно получить помощь устного переводчика, если это нужно для общения с врачом или страховым планом. Вы можете позвонить нам телефону для бесплатных звонков, приведенному на обороте вашей идентификационной карточки. Если вам нужен устный переводчик или письменный перевод документа на ваш язык, позвоните в свой страховой план, телефон **888-254-2721**. Вам поможет сотрудник, который говорит на вашем языке. Кроме того, о языках, на которых вы предпочитаете говорить и читать, можно сообщить по телефону непосредственно в свой страховой план или своему врачу. План сохранит ваши языковые предпочтения и будет сообщать о них вашим врачам по их запросу и когда врачи будут звонить, для того чтобы узнать о вашей страховке. Если вы предпочитаете получать материалы плана на одном из основных наших языков, то некоторые документы плана мы можем присылать вам в переводе на этот язык. Для того чтобы поменять языки, на которых вы предпочитаете говорить или читать, или чтобы предоставить информацию о вашей расовой или этнической принадлежности, позвоните в свой страховой план, телефон **888-254-2721**. За дополнительной помощью обращайтесь в Департамент страхования штата Калифорния по телефону **800-927-4357**.

Spanish:
IMPORTANTE: Puede obtener un intérprete sin costo para hablar con su médico o plan de salud. También puede llamarnos al número de teléfono gratuito que figura al dorso de su tarjeta de identificación. Para obtener un intérprete o consultar por información escrita en su idioma, llame primero al número de teléfono de su plan de salud al **888-254-2721**. Lo asistirá una persona que hable su mismo idioma. También puede informarle directamente al plan de salud o a su proveedor qué idioma escrito y hablado prefiere. Si le informa a su plan de salud qué idioma prefiere, el plan de salud conservará la información y la compartirá con su proveedor cuando este llame para verificar la elegibilidad o si lo solicita. Si el idioma escrito que usted prefiere es uno de los idiomas ofrecidos por el plan de salud, podrá recibir información en ese idioma. Puede cambiar el idioma escrito y hablado que prefiere que use su plan de salud y brindar información sobre su raza y grupo étnico llamando al **888-254-2721**. Si necesita más ayuda, llame al Departamento de Seguros de California, al **800-927-4357**.

Tagalog:
MAHALAGA: Maaari kayong makakuha ng isang interpreter nang walang anumang gastos para sa inyo para kausapin ang inyong doktor o planong pangkalusugan. Maaari rin ninyong tawagan kami sa walang bayad na numero sa likod ng inyong ID card. Para makakuha ng isang interpreter o para humiling ng nakasulat na impormasyon sa inyong wika, tawagan muna ang numero ng telepono ng inyong planong pangkalusugan sa **888-254-2721**. Matutulungan kayo ng isang taong nagsasalita ng inyong wika. Maaari rin ninyong direktang ibigay ang inyong piniling nakasulat at sinasalitang wika sa inyong planong pangkalusugan at sa inyong tagabigay ng serbisyo. Kung ibibigay ninyo ang inyong mga kagustuhan sa wika sa inyong planong pangkalusugan, pananatilihin ng inyong planong pangkalusugan ang impormasyong ito at ibabahagi ito sa inyong tagabigay ng serbisyo kapag tatawag ito upang tingnan ang pagiging karapat-dapat o kapag hiniling. Kung ang inyong piniling nakasulat na wika ay isa sa mga pangunahing wika ng inyong planong pangkalusugan, maaari kayong makatanggap ng ilang impormasyon ng plano sa inyong piniling nakasulat na wika. Maaari ninyong i-update ang inyong piniling nakasulat at sinasalitang wika at maaari kayong magbigay ng impormasyon tungkol sa lahi at etnisidad sa inyong planong pangkalusugan sa pamamagitan ng pagtawag sa **888-254-2721**. Kung kailangan ninyo ng karagdagang tulong, tawagan ang CA Dept. of Insurance sa **800-927-4357**.

Vietnamese:
QUAN TRỌNG: Quý vị có thể yêu cầu một thông dịch viên miễn phí để nói chuyện với bác sĩ hay chương trình chăm sóc sức khỏe của quý vị. Quý vị cũng có thể gọi cho chúng tôi theo số miễn cước ở phía sau thẻ ID của quý vị. Để yêu cầu một thông dịch viên hay hỏi về thông tin viết bằng ngôn ngữ của quý vị, đầu tiên hãy gọi đến chương trình chăm sóc sức khỏe của quý vị theo số **888-254-2721**. Nhân viên nói ngôn ngữ của quý vị có thể trợ giúp quý vị. Quý vị cũng có thể cung cấp các ngôn ngữ nói và viết ưa thích của quý vị trực tiếp với chương trình chăm sóc sức khỏe và nhà cung cấp của quý vị. Nếu quý vị cung cấp ưu tiên ngôn ngữ cho chương trình chăm sóc sức khỏe của quý vị, thì thông tin này sẽ được duy trì bởi chương trình chăm sóc sức khỏe của quý vị và sẽ được chia sẻ với nhà cung cấp của quý vị khi nhà cung cấp gọi để kiểm tra tính đủ điều kiện hay theo yêu cầu. Nếu ngôn ngữ viết ưa thích của quý vị là một trong những ngôn ngữ tiêu chuẩn của chương trình chăm sóc sức khỏe, thì quý vị có thể nhận một số thông tin chương trình bằng ngôn ngữ viết ưa thích của quý vị. Quý vị có thể cập nhật các ngôn ngữ nói và viết ưa thích và cung cấp thông tin về chủng tộc và dân tộc của quý vị với chương trình chăm sóc sức khỏe của mình bằng cách gọi số **888-254-2721**. Nếu quý vị cần hỗ trợ thêm, hãy gọi cho Sở Bảo Hiểm CA theo số **800-927-4357**.

4361 Irwin Simpson Road
Mason, OH 45040

anthem.com/ca