

# Your summary of benefits



ACWA JPIA – C00361

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: 2025 Classic PPO Plan (1122) (Z0JZ)

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	\$15 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$200 person / \$600 family	\$200 person / \$600 family
Overall Out-of-Pocket Limit	\$2,000 person / \$4,000 family	\$2,000 person

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Out-of-Network deductibles are combined and accumulate toward each other; however In-Network and Out-of-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Maternity services</b> (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	\$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
<p><b>Manipulation Therapy (Chiropractic Services)</b> <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and manipulative treatment is limited to 30 visits combined per benefit period.</i></p>	20% coinsurance after deductible is met	20% coinsurance after deductible is met
<p><b>Acupuncture</b> <i>Coverage is limited to 12 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i></p> <p><b>Surgery</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	No charge	20% coinsurance after deductible is met
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	No charge	20% coinsurance after deductible is met
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p> <p>Outpatient Hospital <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Freestanding Radiology Center <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p> <p>Outpatient Hospital <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test</i></p> <p>Outpatient Hospital <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b> <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>\$15 copay per visit deductible does not apply</p> <p>\$50 copay per visit and then 20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p> <p>Ambulatory Surgical Center <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>  <i>Member is responsible for an additional 10% coinsurance if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to Out-of-Network Providers. Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to Out-of-Network Providers.</i></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>10% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical, occupational and manipulative treatment is limited to 30 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 100 days per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>10% coinsurance after deductible is met</p>	<p>10% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Hearing Aids</b> <i>Coverage is limited to 1 item per ear every 3 years.</i>	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	\$5,350 member / \$10,200 family	Not applicable
<p><b>Prescription Drug Coverage</b>  <b>Network: <i>Base Network</i></b>  <b>Drug List: <i>National</i></b> <i>Certain drugs require pre-authorization approval to obtain coverage and/or completion of step-therapy. Supply limits for certain drugs may be different.</i>  <b>Preferred Generics:</b> <i>If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed. This does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.</i></p>		
<p><b>Day Supply Limits:</b>  <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i>  <b>Home Delivery Pharmacy</b> <i>90-day supply (maximum cost shares noted below) of medications are available through CarelonRx Mail for 2 X the retail copay. You will need to call us on the number on your ID card to sign up when you first use the service. Please note that <b>maintenance</b> medications are subject to mandatory home delivery services through CarelonRx Mail after two retail fills have been dispensed at a retail pharmacy. Maintenance medications may also be filled at Walmart, Costco, Sam's Club, Albertsons, Vons, Pavilions, Safeway, and Ralphs at a 90-day supply for 2 X the retail copay.</i>  <b>Specialty Pharmacy</b> <i>30-day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</i></p>		
<p><b>Preventive Drugs</b> <i>No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.</i></p>		
<b>Tier 1 - Typically Generic</b>	\$5 copay per prescription (retail) and \$10 copay per prescription (home delivery)	\$5 copay + 50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the max allowed amount

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Tier 2 - Typically Preferred Brand</b>	\$20 copay per prescription (retail) and \$40 copay per prescription (home delivery)	\$20 copay + 50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the max allowed amount
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$50 copay per prescription (retail) and \$100 copay per prescription (home delivery)	\$50 copay + 50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the maximum allowed amount
<b>Tier 4 - Typically Specialty (brand and generic)</b>	\$5 copay per prescription (Generic Specialty) 20% coinsurance up to \$100 per prescription (Brand Specialty)	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

**Notes:**

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Outpatient Facility tests and treatments are limited to \$350 per admission for Out-of-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Hospital and Ambulatory Surgical Centers.

- Advanced Diagnostic Imaging is limited to \$800 per service for Out-of-Network Providers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- Additional family building and fertility benefits are available through Progyny. Call Progyny at 866-461-4990 to learn more.
- Certain surgeries, including knee replacement, hip replacement, lumbar fusion, cardiac bypass, and bariatric surgery, may be covered at no cost through Carrum Health. Call 1-888-855-7806 or visit [my.carrumhealth.com/acwajpia](http://my.carrumhealth.com/acwajpia) to learn more.
- Hinge Health is a virtual physical therapy benefit in addition to this plan's physical therapy benefits. To learn more, go to [www.hingehealth.com/acwajpia](http://www.hingehealth.com/acwajpia).
- When using a non-network pharmacy; members are responsible for the in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount up to \$250 per prescription, and costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Preferred Generics: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed. This does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
- Certain drugs require pre-authorization approval to obtain coverage.
- Supply limits for certain drugs may be different
- For additional information on this plan, please visit [www.acwajpia.com/member-agency-benefits](http://www.acwajpia.com/member-agency-benefits) to obtain a Summary of Benefit Coverage or Evidence of Coverage.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

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Questions: (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)



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# Get help in your language

## Notice of Language Assistance

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 alternate 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 tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

### Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمتترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

### Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

### Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。 (TTY/TDD: 711)

### Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمک‌های بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

### Hindi

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग को कॉल करें। (TTY/TDD: 711)

**Hmong**

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntauv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntauv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

**Japanese**

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

**Khmer**

សេវាកម្មភាសាខ្មែរឥតគិតថ្លៃ។ អ្នកអាចទទួលបានសេវាបកប្រែឬអ្នកបកប្រែប្រែប្រួល។ អ្នកអាចឱ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសាមរបស់អ្នក។ ដើម្បីទទួលបានជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើកាត់ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលបានជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

**Korean**

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

**Punjabi**

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਆਰੀਆ ਪਰਾਪਕ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜਿਜਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

**Russian**

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочесть документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

**Tagalog**

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

**Thai**

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

**Vietnamese**

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

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