Document ID: AETCSPS-073175	**Title:** National Clinical Services (NCS) 600 Transition/Continuity of Care Coverage – California Traditional Plans	
Parent Documents: Document ID of National policy		
Effective Date: See Document Information Page	**Last Review Date:** See Review and Revision History Section	**Business Process Owner (BPO):** Sr Mgr,Health Care Quality, CS NQM Quality Operation
Exhibit(s): Exhibit 1, California Traditional Transition Coverage Request Form		
Document Type: Tool		

Effective Date: 11/19/2024
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PURPOSE

This Amendment is written to meet regulatory and statutory requirements under the California Insurance Code 10133.56 that impacts NCS 600, Transition/Continuity of Care Coverage policy and procedure. This amendment will be used in conjunction with NCS 600 to comply with California requirements.

SCOPE

Applies to Department:	■ Care Management	■ Precertification (including NME, SCPU, Specialty Medical Precert)	■ NME Case Management
■ 24-Hour Nurse Line	■ DM	■ BH	■ Aetna Women's Health Program

Product:	☐ HMO	■ EPO	■ PPO	■ MC/POS	☐ TC	■ JV

Applies to California members in Traditional fully insured commercial plans (includes split funding arrangements).

POLICY

A. In order to provide for continuity of care for members and in accordance with California Insurance Code 10133.56, the plan shall provide the completion of covered services for conditions listed in Section B below. Completion of the covered services shall occur in the following circumstances:

- Terminated Provider – For an insured who at the time of the provider's contract termination, was receiving services from that provider for one of the conditions described below.
- Nonparticipating provider – For a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described below.

B. The medical, mental health or substance use conditions for which the plan will provide for the completion of covered services are:

1. An acute condition. An acute condition is a medical condition that involves the sudden onset of symptoms due to an illness, injury, or other medical, mental health or substance use problem that requires prompt medical attention and that has a limited duration. **Completion of covered services shall be provided for the duration of the acute condition.**

2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical, mental health or substance use problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the insured and the terminated provider and consistent with good professional practice. **Completion of covered services shall not exceed 12 months from the contract termination date.**

3. A pregnancy. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. **Completion of covered services shall be provided for the duration of the pregnancy.**

   Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

   An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider. **Completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.**

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. **Completion of covered services shall be provided for the duration of a terminal illness.**

5. The care of a newborn child between birth and age 36 months. **Completion of covered services shall not exceed 12 months from the contract termination.**

6. Performance of a surgery or other procedure that is authorized by the insurer as part of a documented course of treatment and has been recommended and documented by the provider to occur **within 180 days of the contract's termination or 180 days of the effective date of coverage for a newly covered enrollee.**

The policy shall not apply to an enrollee who is offered an out-of-network option.

C. Contractual Considerations

1. The amount of, and the requirement for payment of, co-payments, deductibles, or other cost-sharing components by the insured during the period of completion of covered services with a terminated provider shall be the same co-payments, deductibles and other cost-sharing components that would be paid by the insured when receiving care from a provider currently contracting with the plan.

2. The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, then the insurer is not required to continue the provider's services beyond the contract termination date.

3. The plan may require a **non-participating** provider whose services are continued for a newly covered insured to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently participating providers providing similar services who are practicing in the same or a new similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue to the provider services.

4. Unless otherwise agreed upon by the terminated or **nonparticipating** provider and the plan, the services rendered shall be compensated at rates and methods of payment similar to those used by the insurer for currently participating provider providing similar services who are practicing in the same or similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of the nonparticipating provider if the provider does not accept the payment rates. The provider who agrees to provide services shall accept the reimbursement as payment in full and shall not bill the plan for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles

D. The plan is not required to provide for the completion of covered services in the following instances:

1. For a provider whose contract with the insurer or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

2. For services or benefits that are not otherwise covered under the terms and conditions of the insurer contract.

3. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, then the insurer is not required to continue the provider's services beyond the contract termination date.

4. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

E. Additional Considerations and Requirements

1. The provisions contained in this policy are in addition to any other responsibilities of the plan to provide continuity of care. Nothing in this policy shall preclude the plan from providing continuity of care beyond the requirements of this section.

2. Decisions regarding Transition Coverage Requests are made within two (2) business days of obtaining all necessary information. Necessary information includes a completed Transition of Care form and information required by the form. The provider is notified telephonically within twenty-four (24) hours of the decision. The insured and the terminated provider are notified of the decision in writing within two (2) business days of the decision. If services were received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new plan level. The Medical Director considers delays incurred by the Plan which may have affected the insured's receipt of services prior to the approval of transition coverage.

3. As communicated in the Evidence of Coverage and Disclosure Notice, the plan provides all new insureds with notice of this policy as well as how to request a Transition of Care review. The insured must request a Transition Coverage Request Form by calling the Member Services telephone number listed on the ID card. The form must be completed by the insured. Request Forms may also be obtained from the insured's employer.

4. The plan shall provide a written copy of this policy to its insureds upon request. Members may request a copy of the information by calling the Member Services telephone number listed on the ID card and requesting a copy of the Transition of Care Coverage Policy.

5. If the plan delegates the responsibility of complying with these requirements to a provider group and/or its contracting entities, then the plan shall ensure that all requirements are met.

6. The plan is not required to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

7. The plan shall provide a written copy of this information to its contracting providers and provider groups.

STATE DEFINITIONS

- CA Insurance Code: "Terminated provider" means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.
- CA Insurance Code: "Provider" means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

EXHIBIT(S): Exhibit 1, California Traditional Transition Coverage Request Form

Transition/Continuity Coverage Request

ECHS

Category - TCRF

Personal and confidential

This form applies to fully insured commercial Traditional (non-HMO) members in California

Here's the form you requested for transition-of-care/continuity of care coverage from the health plan. If we approve your request, the health plan will cover ongoing care at the highest level of benefits from:

- An out-of-network doctor
- A doctor whose network status has changed
- Certain other health care providers who have treated you

Once we review your completed form, we'll send you a letter explaining our decision.

Some things you should know about transition-of-care/continuity of care coverage

You'll find answers to commonly asked questions about transition-of-care/continuity of care coverage on the other side of this form.

You should read them before filling out this form.

Transition-of-care/Continuity of care coverage does not apply if your provider is in the plan's network (participating) or is part of your plan's highest benefit tier. The online provider search directory is found on the health plan's webpage. It can tell you if your doctor is in the network or help you find a participating provider for your health plan. You can also call us at the phone number on your ID card.

How to complete the form and get it to us

Step 1: Fill out these sections:

1. Section 1 – Member, Group or employer Information.
2. Section 2 - Subscriber and patient information: Plan information is on the front of your ID card.
3. Section 3 - Authorization: Read the authorization, then sign and date the form.

Step 2: Give the form to the doctor/health care provider to complete Section 4 on page 4, including the diagnostic and treatment information requested on page 5.

Step 3: Fax or email the completed form to us for review. You should complete one form for each health care provider.

Fax medical requests to 1-859-455-8650. Send email requests to VFAXPrecert@aetna.com.
Fax mental health/substance abuse requests to 1-888-463-1309.

Be sure to complete all fields on page 5 before you submit this request form.
Your request will be answered faster that way.

Transition of care coverage questions and answers
California Commercial Traditional Fully Insured Products

Q. What is California transition-of-care/continuity of care (TOC/COC) coverage?

A. For new members:

TOC/COC coverage is temporary. You can get TOC/COC when you become a new member of a medical benefits plan or change your plan, and you are being treated for a medical, mental health or substance use condition by a doctor who:

- Is not in the plan's network
- Is not included in Narrow Network, or a plan sponsor specific network, and your benefits change to include one of these networks

TOC/COC coverage applies to the following types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to deliver or furnish health care services. Examples of individual practitioners include doctors, psychiatrists, licensed therapists and qualified autism service providers, professionals or paraprofessionals.

For existing members:

TOC/COC coverage can also apply when your doctor or facility leaves the plan's network or changes network status. Approved TOC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

TOC/COC coverage applies to the following types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to provide health care services. Examples of individual practitioners include doctors, psychiatrists, licensed therapists and qualified autism service providers, professionals or paraprofessionals.

TOC/COC coverage for new or existing members does not include durable medical equipment (DME) vendors or pharmaceutical items. If we approve TOC coverage, the doctor must use a DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Q. What is an active course of treatment?

A. An active course of treatment means you have been receiving services from your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course of treatment examples may include but are not limited to members who:

- Are pregnant and has begun a course of treatment (including prenatal care) for the pregnancy from the provider or facility. Pregnancy is the three trimesters of pregnancy and the immediate postpartum period.
    - Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
    - An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, **completion of covered services for the maternal mental health condition shall be provided 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.**
- Have an acute condition that involves the sudden onset of symptoms due to an illness, injury, acute, serious mental illness or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services will be provided for the duration of the acute condition.
- Are authorized to undergo a surgery or procedure from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery. The documentation must show that the provider recommends the treatment to occur within 180 days of the provider's contract termination date or within 180 days after the effective date of the newly covered enrollee.
- Have a terminal illness that is an incurable or irreversible condition and has a high probability of causing death within one year or less. Completion of covered services will be provided for the duration of the terminal illness.
- Have an on-going or disabling medical condition or serious or chronic mental illness due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services will be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan, in consultation with the member, the nonparticipating or terminated provider, and consistent with good professional practice. Coverage will not exceed 12 months from the contract termination date or 12 months from the effective date of a newly covered enrollee.

Continued on the next page.

- Are undergoing a course of treatment for a serious and complex condition from a provider or facility such as chemotherapy or radiation therapy
- Are receiving any services related to the care of a child ages 0-36 months up to 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
- May need or have an organ or bone marrow transplant

Q. Do I need to complete a form for each provider that I am requesting TOC/COC for?

A. Yes, a separate form is required for each provider.

Q. What other types of providers, besides doctors, can be considered for TOC/COC coverage?

A. TOC/COC coverage may also apply to physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services such as visiting nurses. TOC/COC is considered for participating hospitals when the facility is not designated for the highest benefit level for plans that include tiered networks or when a participating facility terminates from the network. Providers considered for transition coverage may vary by condition, as described above, in accordance with California law. California TOC/COC coverage does not apply to durable medical equipment (DME) vendors or pharmaceutical items.

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for California TOC coverage?

A. To be approved for TOC/COC, the procedure or service must be a covered benefit under the terms of your plan. **For providers that leave the network,** your doctor must accept the terms outlined on the TOC/COC request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you're currently receiving treatment (as described above), you may still be able to visit your PCP, even if your PCP leaves the network. If not, you may need to select a PCP in the health plan's network. Talk to your PCP for help you with your future health care needs.

Q. How do I sign up for TOC coverage?

A. Contact the Member Services number on your member ID Card. You must submit a TOC/COC request form to the health plan:

- Within 90 days of when you enroll or re-enroll
- Within 90 days of the date the health care provider left the plan's network or within 90 days from the date on the letter notifying you of the change
- Within 90 days of a doctor's network status change

You or your doctor can send in the request form

Q. Does TOC/COC coverage apply if my plan does not have a provider network?

A. No.

Q. What if I have a Narrow Network or plan sponsor specific network plan?

A. If we approve your TOC/COC coverage, you may still receive care at the highest benefits level for a certain time period. If you continue treatment with this doctor after the approved time period, your coverage would be limited to what your plan allows. This means you may have reduced benefits or no benefits.

Q. What if I have more questions about TOC/COC coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC/COC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health or behavioral health phone number.

Q. How will I know if my request for TOC/COC coverage is approved?

A. We will make a decision after we receive your request. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.

Transition/Continuity Coverage Request

ECHS

Category - TCRF

Personal and confidential

This form applies to fully insured commercial Traditional (non-HMO) members in California.

☐ **Medical** ☐ **Mental health/substance abuse**

Please indicate above whether this request is for medical treatment or mental health/substance abuse treatment.

Please complete this form to the best of your ability. Your request for continued coverage will not be denied if sections are left blank or your treating provider does not fill out the form.

1. Group or employer information (Note: Please complete a separate form for each member and/or provider.)

Plan, Group or employer's name (please print)	Plan control number (s)	Plan effective date **(required)**

2. Subscriber and patient information

Subscriber's name (please print)	Subscriber's ID number	
Subscriber's address (please print)		
Patient's name (please print)	Birthdate *(MM/DD/YYYY)*	Telephone number
Patient's address (please print)	Plan type/product	
	Telephone number for patient/subscriber submitting request (Business hours, 9 a.m. – 5 p.m.)	
Request for Transition of Care due to: **New member:** ☐ Yes ☐ No **Provider termination:** ☐ Yes ☐ No **If provider termination,** please provide the date of the letter notifying you of the provider terminating from the network and include a copy of the letter with the completed form. *(MM/DD/YYYY)*		

3. Authorization

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with the health plan, or before the end of the provider's contract with the health plan's network, or before the provider's network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain limited period of time. I give permission for the health care provider to send any needed medical information and/or records to the health plan so a decision can be made.

Patient's signature (**required** if patient is 17 or older)	Date *(MM/DD/YYYY)*
Parent's signature (**required** if patient is 16 or younger)	Date *(MM/DD/YYYY)*

4. Provider information – (**Note:** Provide all specific information to avoid delay in the processing of this request.)

Name of treating doctor or other health care provider (please print)	Tax ID number
Service Address of treating doctor or other health care provider (please print)	
Contact name of office personnel to call with questions	Telephone number
Signature of treating doctor or other health care provider	Date *(MM/DD/YYYY)*

The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in the health plan's network. The patient has asked that we cover your care for a specific time period. This is because of a condition, such as pregnancy, that is considered an active course of treatment. An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation". Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If we approve this request, you agree:

- To provide the patient's treatment and follow-up
- Not seek more payment from this patient other than the patient responsibility under the patient's plan of benefits (for example, patient's copayment, deductibles or other out-of-pocket requirements)
- To share information on the patient's treatment with us

You also agree to use the health plan's network for any referrals, lab work or hospitalizations for services no part of the requested treatment.

Transition/Continuity Coverage Request

ECHS Category - TCRF

Personal and confidential

Patient's name (please print)	Birthdate *(MM/DD/YYYY)*

Please complete the diagnostic and treatment information below describing the active course of treatment and attach all clinical documentation to support this request.

ONCOLOGY

Are you in a current course of active treatment (Reconstruction Surgery, Radiation Therapy, Immunotherapy, Targeted Agents, **OR** Chemotherapy) for Cancer with treatment initiated in the last 90 days?

☐ Yes ☐ No Name of drug: _____ DX and description: _____

Expected length of treatment: _____ Visit and next Visit Dates: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

INTRAVENOUS THERAPY COURSE OF TREATMENT REQUEST

Is the member currently receiving intravenous therapy for Antibiotics, **OR** Hyperalimentation/Total Parenteral Nutrition?

☐ Yes ☐ No Treatment Start Date: (mm/dd/yyyy): _____ and Expected End Date: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

SURGICAL FOLLOW-UP REQUEST (POST-OP)

Is this a follow-up with a Surgeon's office and is the member within the 90 days post-operative period **OR** has the member started ~~a~~ series of surgical procedures to correct the same condition?

☐ Yes ☐ No Date of Surgery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OBSTETRICAL REQUEST

Is the member pregnant and has completed her first visit with an Obstetrician (OB) office?

☐ Yes ☐ No First OB Visit: (mm/dd/yyyy): _____ Expected Date of Delivery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OTHER REQUESTS

Is the member currently in an active course of treatment?

Type of treatment: _____

Treatment Start Date: (mm/dd/yyyy): _____ Last Date of Treatment: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

Misrepresentation: Attention California residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Aetna and its affiliates comply with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna and its affiliates provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD)**.

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DOI written notice of availability of language assistance

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 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

ដោយមិនគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមរលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad

TTY:711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน