The Lincoln National Life Insurance Company

California Language Assistance Plan (CA LAP)

Policies & Procedures

California Language Assistance Program (CA LAP)

California passed regulations in 2004 that were finalized 10/19/2007, requiring all health care plans, including dental plans, to provide language assistance services to enrollees who are California residents and non- English speakers or Limited English Proficient (LEP) in order to alleviate the language and cultural barriers that such enrollees experience.

Regulations for CA LAP

Below is the high-level information for the California Language Assistance Program (CA LAP):

- Conduct a survey of all enrollees within the state of California to assess their language preference and linguistic needs;
- Translate vital documents into the identified threshold languages; this will be based on the results of the survey;
- Provide timely access to interpretation services at no charge to the insured persons;
- Put procedures in place on how we will notify insured persons that we offer the translated documents and interpretation services; and
- Educate staff with routine contact with non-English speakers and Limited English Proficient insured persons, to advise of our LAP requirements – this involves all of our dental contracting providers in the state of CA.
- Monitor our staff and dental providers' compliance for standards with our LAP plan, including:
    - The availability, quality and use of language assistance services;
    - Tracking grievances and complaints related to our LAP; and
    - Documenting actions taken to correct problems.

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Survey

Survey of the Limited English Proficient (LEP) insureds in CA	In 2020 the survey was completed through an email campaign to a sample of The Lincoln National Life Insurance Company insured population. In 2008, 2011 and 2014 The Lincoln National Life Insurance Company surveyed all Dental insureds whose policy is situsedin the State of California.
Who did we survey?	For Dental, 549 Employer's were sent e-mails requesting distribution of the survey to employee's that elected dental coverage. The dental insured's were asked to complete the survey for themselves and their dependents. • Insured persons were surveyed for the preferred spoken and written languages for themselves and any covered dependents. Race and ethnicity information, though optional, was required to be part of the survey.
Who responded?	A total of 400 insureds started the surveyed, we received 383 completed surveys. This is a return rate of 95.75%.

Survey, Continued

What were the results?

Of the 383 responses received the survey results were as follows:

99% (or 380) of the insured persons indicated English as their preferred language for spoken correspondence. 3 responses showed a preference for another language to be spoken.
97% (or 372) of the insured persons indicated English as their preferred language for written correspondence. 11 responses showed a preference for another language to be written.
96% of insured persons with spouse coverage (or 173 insured persons) indicated English as the preferred language for spoken correspondence for a covered spouse.
97% of insured persons with spouse coverage (or 162 insured persons) indicated English as the preferred language for written correspondence for a covered spouse.
97% of insured persons with other dependents (children) indicated English as the child's preferred language for both written and spoken correspondence.

For any of the above groupings <1% indicated Spanish, Cantonese, Mandarin, German, Russian, Ukrainian, Vietnamese, Korean.

Race and Ethnicity:
Of the respondents who chose to provide ethnicity and race information, our survey indicates:

- **Ethnicity**: 70.1% of insured persons were other than Hispanic or Latino. 17% were Hispanic or Latino.
- **Race:** 57.2% of our insured persons are Caucasian; 8.9% Asian; 8.1% other races (or two or more races); and 2.% black or African American.

Our website, www.Lincoln4Benefits.com, may be consulted for full survey results.

Translate Vital Documents

Translate Vital Documents	The CA Regulations state that we must translate written vital documents when the lesser of one of the following are met: • 3,000 or more; or • 5% of the insured population; Request a language other than English. Lincoln Financial Group did not meet either of the criteria.
Voluntary Translation	We will, upon group request, provide Benefit Summaries in a language other than English. Such language translation requests are typically fulfilled within 3-5 business days. We will also provide Spanish language enrollers upon group request.
***Lincoln DentalConnect* Website**	Our *LincolnDentalConnect* website is also offered in Spanish. This website is only available for insured persons with our dental plans. The insured will need to register on LincolnFinancial.com to access the website.

Interpretation Services

Provide Interpretation Services

We must provide timely access to interpretation services at no charge to the insured persons. Since 1996, we have offered these services to our insured persons. This is offered through a service called the Language Line.

- The Language Line is HIPAA, GLB and Sarbanes Oxley compliant. The Language Line continually screens, tests and monitors the performance of all of its interpreters.

What is offered?

This service provides oral interpretation for our insureds. This may be used by the insured calling in to speak with us. Insureds may also utilize this service if they are in their dental provider's office and need an interpreter, to relay information to the dental provider and/or their staff.
In the event a Limited English Proficient (LEP) insured requires a translated document, we advise the insured or group that we will determine if we are able to translate that particular document and the timeframe in which it will be completed.
Please contact Client Services at 1-800-423-2765 for assistance. The translation of documents will be based on a case-by-case basis.

Hours

While the language line is open 24 hours a day, 7 days a week, 365 days a year, we are available to facilitate its use only during normal business hours.

Using family, friends and/or minors

We greatly discourage the use of family members, friends and/or minors to interpret on behalf of the insured. To comply with CA regulations, we prefer that you obtain an independent third-party interpreter on the phone by calling Client Services at 1-800-423-2765.

- If Language Line services are offered and refused, we document the refusal in the patient's file.

Interpretation Services, Continued

How to recognize Limited English Proficient (LEP) caller?

- Member is quiet or does not respond to questions.
- Member simply says yes or no or gives inappropriate or inconsistent answers to questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member self identifies as LEP by requesting language assistance.

If we identify any of these characteristics, we encourage using the “I Speak" Flashcard to determine the insured’s preferred spoken language. “I Speak" Flashcards are available by:

1. Visiting LincolnFinancial.com.
2. Scroll to the bottom of the page.
3. Under Employer Benefits, click **Find a Dentist**.
4. A separate tab will appear to click on the **Language Identification Flashcard**.

Information which insurers shall notify insureds and members of the public

Beginning in 2019, CA LAP requires additional notifications. These additional requirements include:

- Auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate format, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.
- That an insurer does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability; and
- How to file discrimination complaints.

These notifications must be included in the evidence of coverage, at least annually in newsletters or other materials routinely distributed by the insurer, and on the insurer’s internet website.

Lincoln’s stand-alone dental plan is a specialized health insurance policy, does not provide mental health or behavioral health benefits, and is not a “covered entity” subject to section 1557 of the Affordable Care Act. California’s insurance code empowers such entities to apply for a waiver of these new notification requirements. Lincoln submitted its application in 2019 and awaits California’s response.

Notification to the Limited English Proficient (LEP) insureds

By April 1, 2009, we will begin to notify our insureds and dental providers that we offer the Language Line at no charge to them. In addition, the notice will advise the insureds they are able to obtain limited written translations of our documentation.

Annual Notice to insureds for Dental

We will provide an annual notice to our insureds and to our dental providers. The dental notice to the insureds is as follows:

Lincoln Financial Group®

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 1-800-423-2765 . 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 1-800-423-2765 . Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-423-2765 . For more help call the CA Dept. of Insurance at 1-800-927-4357. English

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 1-800-423-2765 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 1-800-423-2765 . 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: 1-800-423-2765 번으로 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 1-800-423-2765 . Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

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 1-800-423-2765 للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

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 1-800-423-2765 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

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 1-800-423-2765 . Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

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 1-800-423-2765 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

ជំនួយភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-423-2765 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357. Khmer

خدمات هجانی 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 1-800-423-2765 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 ਵਿਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-423-2765 . 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

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 1-800-423-2765 . Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

CALIFORNIA INSURANCE CODE

Division 2 -- CLASSES OF INSURANCE...PART 2 -- LIFE AND DISABILITY INSURANCE...Chapter 1 -- THE CONTRACT...Article 2. Transfer

Ins s 10133.8 Commissioner's authority over translated materials

(a) The commissioner shall, on or before January 1, 2006, promulgate regulations applicable to all individual and group policies of health insurance establishing standards and requirements to provide insureds with appropriate access to translated materials and language assistance in obtaining covered benefits. A health insurer that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its population for purposes of subparagraph (A) of paragraph (3) of subdivision (b). An insurer that chooses to separate its Healthy Families Program enrollment from the remainder of its population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (3) of subdivision (b) is applicable and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (3) of subdivision (b).

(b) The regulations described in subdivision (a) shall include the following:

(1) A requirement to conduct an assessment of the needs of the insured group, pursuant to this subdivision.

(2) Requirements for surveying the language preferences and assessment of linguistic needs of insureds within one year of the effective date of the regulations that permits health insurers to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements every three years. However, the regulations may provide that the surveys and assessments by insurers of supplemental insurance products may be conducted less frequently than three years if the commissioner determines that the results are unlikely to affect the translation requirements.

(3) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

(i) A health insurer with an insured population of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment pursuant to paragraph (2) of subdivision (b) and any additional languages when 0.75 percent or 15,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

(ii) A health insurer with an insured population of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment pursuant to paragraph (2) of subdivision (b) and any additional languages when 1 percent or 6,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

(iii) A health insurer with an insured population of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

(B) Specification of vital documents produced by the insurer that are required to be translated. The specification of vital documents shall not exceed that of the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

(i) Applications.

(ii) Consent forms.

(iii) Letters containing important information regarding eligibility or participation criteria.

(iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, the right to file a complaint or appeal.

(v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to insureds.

(vi) Translated documents shall not include an insurer's explanation of benefits or similar claim processing information that is sent to insureds unless the document requires a response by the insured.

(C) For those documents described in subparagraph (B) that are not standardized but contain insured specific information, health insurers shall not be required to translate the documents into the threshold languages identified by the needs assessment pursuant to paragraph (2) of subdivision (b) but rather shall include with the document a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment pursuant to paragraph (2) of subdivision (b).

(i) Upon request, the insured shall receive a written translation of those documents. The health insurer shall have up to, but not to exceed, 21 days to comply with the insured's request for a written translation. If an enrollee requests a translated document, all timeframes and deadlines requirements related to the documents that apply to the health insurer and insureds under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health insurer's issuance of the translated document.

(ii) For appeals that require expedited review and response in accordance with the statutes and regulations of this chapter, the health insurer may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health insurers advise limited-English-proficient insureds of the availability of interpreter services.

(4) Standards to ensure the quality and accuracy of the written translation and that a translated document meets the same standards required for the English version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(5) Requirements for individual access to interpretation services.

(6) Standards to ensure the quality and timeliness of oral interpretation services provided by health insurers.

(c) In developing the regulations, standards, and requirements described in this section, the commissioner shall consider the following:

(1) Publications and standards issued by federal agencies, including the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) Policy Guidance 65 (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, including the Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health insurers that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health insurers.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists required pursuant to Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health insurers that contract for alternative rates of payment with providers, including existing practices.

(7) Information gathered from complaints to the commissioner and consumer assistance help lines regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in networks and method of service delivery. The commissioner shall allow for health insurer flexibility in determining compliance with the standards for oral and written interpretation services.

(d) In designing the regulations, the commissioner shall consider all other relevant guidelines in an effort to accomplish maximum accessibility within a cost-efficient system of indemnification. The commissioner shall seek public input from a wide range of interested parties.

(e) Services, verbal communications, and written materials provided by or developed by the health insurers that contract for alternative rates of payment with providers, shall comply with the standards developed under this section.

(f) Beginning on January 1, 2008, the department shall report biennially to the Legislature regarding health insurer compliance with the standards established by this section, including results of compliance audits made in conjunction with other audits and reviews. The department shall also utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The commissioner shall work to ensure that the biennial reports required by this section, and the data collected for the reports, do not require duplicative or conflicting data collection with other reports that may be required by government-sponsored programs. The commissioner may also delay or otherwise phase in implementation of the standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

(g) Nothing in this section shall prohibit government purchasers from including in their contracts additional translation or interpretation requirements, to meet the linguistic and cultural needs, beyond those set forth pursuant to this section.

Ins s 10133.9 Cultural and linguistic appropriateness

Within a year after the health insurer's assessment pursuant to paragraph (2) of subdivision (b) of Section 10133.8, health insurers shall report to the Department of Insurance on internal policies and procedures related to cultural appropriateness, in a format specified by the department, in the following ways:

(a) Collection of data regarding the insured population based on the needs assessment as required by paragraph (2) of subdivision (b) of Section 10133.8.

(b) Education of health insurer staff who have routine contact with insureds regarding the diverse needs of the insured population.

(c) Recruitment and retention efforts that encourage workforce diversity.

(d) Evaluation of the health insurer's programs and services with respect to the insurer's enrollee populations, using processes such as an analysis of complaints and satisfaction survey results.

(e) The periodic provision of information regarding the ethnic diversity of the insurer's insured population and any related strategies to insurers' providers. Insurers may use existing means of communication.

(f) The periodic provision of educational information to insureds on the insurer's services and programs. Insurers may use existing means of communication.

CA Code of Regulations

CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance Commissioner...Subchapter 3 -- INSURERS...Article 12.1. Health Care Language Assistance Program

T.10 s 2538.1 Authority and purpose

(a) These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of California Insurance Code sections 10133.8 and 10133.9 to establish standards and requirements to provide insureds, free of charge, with appropriate access to translated written materials and oral interpretation services in obtaining covered benefits. These regulations are applicable to all individual and group policies of health insurance and to all health insurers, as defined in section 106 of the California Insurance Code. Every health insurer shall comply with the requirements and standards established by Insurance Code sections 10133.8 and 10133.9 and these regulations.

(b) The purpose of these regulations is to accomplish maximum accessibility to language assistance services by limited English proficient insureds, including oral interpretation and written translation assistance and to set forth: a) the methods of surveying the language preferences and linguistic needs of insureds; b) the requirements, standards and quality assurance for translation of vital documents; c) the requirements, standards and quality assurance for individual access to oral interpretation services; and d) the reporting and data collection requirements for health insurers.

T.10 s 2538.2 Definitions

For the purposes of these regulations, the following definitions apply:

(a) " Demographic profile" means, at a minimum, primary/preferred spoken and written language of insureds, race and ethnicity.

(b) " Indicated/threshold language(s)" means the language(s) identified by a health insurer pursuant to California Insurance Code section 10133.8 and these regulations into which vital documents shall be translated.

(c) " Individual access to interpretation services "means an insured's ability to receive oral interpretation services in their primary/preferred language in the provision of their health care.

(d) " Interpreting " or " interpretation "means the process of listening, understanding and analyzing something spoken or reading something written in one language (source language) and orally re-expressing that message faithfully, accurately and objectively in another spoken language (target language), taking the cultural and social context into account.

(e) " Language assistance services" means oral interpreting and written translation services provided free of charge to insureds.

(f) " Language preferences and linguistic needs assessment "means assessing and determining the spoken and written language preferences of the insured population.

(g) " Limited English Proficiency (LEP)" means a limited ability or inability to speak, read, write, or understand the English language at a level that permits the insured to interact effectively with his or her health care providers or health insurers.

(h) " Point(s) of Contact" means an instance in which an insured access the services covered under a health insurer's policy or certificate, including administrative and clinical services, telephonic and in-person contacts.

(i) " Remote interpreting” means interpreting provided by an interpreter who is not in the presence of the speaker, e.g., interpreting via telephone or videoconferencing.

(j) " Translating " or " translation "means the conversion of a written text in one language into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

(k) " Vital Documents” includes but is not limited to the following documents when produced by the health insurer including when the production or distribution is delegated by the health insurer to a third party:

(1) Applications;

(2) Consent forms, including health insurer authorization forms;

(3) Letters containing important information regarding eligibility and participation criteria;

(4) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a complaint or appeal;

(5) Notices advising LEP persons of the availability of free language assistance and other outreach materials that are provided to insureds;

(6) An insurer's explanation of benefits or claims processing information that is sent to an insured if the document requires a response from the insured;

(7) A matrix of the categories of health insurance benefits outlined in the insurance contract including co-payments and coinsurance, exclusions and limitations in the following sequence: deductibles; lifetime maximums; professional services; outpatient services; hospitalization services; diagnostic and therapeutic radiological services; preventive health services; emergency health care coverage including ambulance services; prescription drug coverage; durable medical equipment; mental health services; chemical dependency services; home health services; other services.

T.10 s 2538.3 Language assistance program

(a) By April 1, 2009, every health insurer shall have established and implemented a Language Assistance Program (LAP) that complies with the requirements of Insurance Code sections 10133.8 and 10133.9 and this regulation. The Commissioner shall allow health insurers a reasonable degree of flexibility in the methods by which they achieve compliance.

(b) The LAP shall be documented in a plan with comprehensive written policies and procedures that describe, at a minimum, the following elements: assessment of insureds; provision of language assistance services; staff training; and compliance monitoring. In addition, the policies and procedures shall include the following:

(1) How insureds will be informed of the availability of language assistance services at no charge to insureds and how to access those services;

(2) How contracting providers will be notified of the health insurer's LAP requirements for provision of language assistance services including the notice of the availability of language assistance services;

(3) How a survey of the language preferences and assessment of the linguistic needs of the insured population will be conducted including an explanation of the methodology for collection of relevant data;

(4) How vital documents will be translated into the indicated/threshold languages including standards to ensure the quality and accuracy of the written translation;

(5) How the insurer will provide individual access to interpretation services including an explanation of the standards to ensure the quality and timeliness of oral interpretation services;

(6) A training plan for the provision of adequate and ongoing training regarding the LAP for all health insurer staff who has contact with LEP persons. The training shall include instruction on, among other things, the health insurer's policies and procedures for accessing language assistance, working effectively

with LEP persons, working effectively with in-person and telephonic interpreters, and, cultural differences among and diversity of the health insurer's insured population; and,

(7) How the insurer will evaluate the LAP including an analysis of complaints and satisfactions surveys.

(c) Every health insurer shall develop a written notice that discloses the availability of language assistance services to insureds and explains how to access those services.

(1) A copy of this notice shall be included with all vital documents and all new and renewing insured welcome packets or similar correspondence from the health insurer confirming a new or renewed enrollment. The notice of availability of translated vital documents shall be translated into the threshold languages; however, nothing in this section shall prohibit an insurer from translating the notice into additional languages. A written notice shall also advise LEP insureds of the availability of interpreter services in his/her preferred spoken language at all points of contact.

(2) The Commissioner may develop the notice advising LEP insureds of the availability of language assistance services. Insurer specific information regarding how to access those services shall be provided by the health insurer. If the notice is developed by the Commissioner, it shall reflect that access to oral interpretation services requires informing insureds of the availability of interpreter services in his/her preferred spoken language and that availability of translated vital documents requires informing insured in the threshold languages that vital documents are available in specifically identified threshold languages. Health insurers shall provide the Commissioner's notice to their insureds as specified in these regulations.

(d) Health insurers shall require compliance with their language assistance program developed pursuant to these regulations by every contractor, health care provider, and any network that is contracted to provide health care to insureds. Health insurers who directly contract with health care providers or who lease networks of health care providers shall use these contracts to implement the specific provisions of the health insurer's LAP, seeking amendments to such contracts as needed within a reasonable time of the effective date of these regulations. Health insurers shall retain financial responsibility for the implementation of the LAP except to the extent that delegated financial responsibility has been negotiated separately and incorporated by reference into its contract.

(e) By December 1, 2008, every health insurer shall file their LAP plan with the Commissioner, in accordance with sections 10133.8 and 10133.9 of the Insurance Code.

(1) The plan shall include but is not limited to the written LAP policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Insurance Code sections 10133.8 and 10133.9 and these regulations. The filing shall include the section 10133.8(b) (3) (B) (v) notice to insureds regarding the availability of language assistance services and how to access those services. All material filed with the Commissioner that contains documents in non-English languages shall include the English version of each non-English document as well as an attestation by
the translator stating the qualifications of the translator and affirming that the non-English translation is an accurate translation of the English version.

(2) The Commissioner shall evaluate the totality of the health insurer's LAP to determine whether the program as a whole provides meaningful access for LEP insureds. This evaluation shall include a review of the information obtained from health insurer's biennial reporting to the Commissioner as required by these regulations and may consider relevant operational and demographic factors, including but not limited to:

(A) The nature of insureds points of contact;

(B) The frequency with which particular languages are encountered including specific challenges encountered in providing meaningful access and the process by which insurers address these challenges;

(C) The type of provider network or networks and methods of health care service delivery;

(D) The variations and character of a health insurer's service area;

(E) The availability of translation and interpretation services and professionals;

(F) The health insurer's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaboration with other health insurers to share a pool of interpreters, and other methods and technologies.

(3) The Commissioner shall periodically review health insurer compliance with the standards and requirements of section 10133.8 and 10133.9 of the Insurance Code and these regulations by methods that may include, but are not limited to, market conduct exams, reviews of consumer grievances and complaints and health provider complaints to the Department of Insurance. The Commissioner may also periodically request that health insurers submit information and data regarding insureds language needs and demographic profile.

T.10 s 2538.4 Needs assessment of insured population

(a) Every health insurer shall survey the language preferences and assess the linguistic needs of insureds within one year of the effective date of these regulations. Health insurers may utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements of their insured population every three years.

(b) The LAP shall describe the health insurer's methods and timelines for surveying and assessing the language preferences and linguistic needs of the insured population, the calculations to be used to determine indicated/threshold languages, the method for collecting, summarizing and reporting the data to the Department, and how the health insurer shall advise limited English proficient insureds of the availability of translation and interpretation services.

T.10 s 2538.5 Written translations of vital documents

(a) Every health insurer shall translate vital documents, as defined above, into languages other than English hereinafter called "indicated/threshold languages" as follows:

(1) A health insurer with an insured population of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment and any additional languages when 0.75 percent or 15,000 of the insured population, whichever number is less, indicates in the needs assessment a preference for written materials in that language.

(2) A health insurer with an insured population of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment and any additional languages when 1 percent or 6,000 of the insured population, whichever number is less, indicates in the needs assessment a preference for written materials in that language.

(3) A health insurer with an insured population of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or five percent of the insured population, whichever number is less, indicates in the needs assessment a preference for written materials in that language.

(b) For those vital documents that contain insured-specific information, health insurers shall provide the English language document together with the written notice of the availability of interpretation services and translation services in the indicated/threshold languages identified by the needs assessment.

(1) Upon request, the insured shall receive a written translation of the documents. The health insurer shall have 21 (twenty-one) days after receipt of the request to provide the written translation to the insured.

(2) Whenever a requested document requires that an insured take action within a certain period of time, that period of time shall not begin to elapse until the health insurer issues to the insured a translation of that document in accordance with the provisions of this article. For appeals that require expedited review and response, the health insurer may satisfy this requirement by providing the notice of the availability and access to oral interpretation services.

(c) Health insurers may request a phase-in of the translation of vital documents by submitting a written request to the Commissioner at the time of submission of their LAP plan. The request shall detail the plan, timeframe, rationale and projected impact of the phase-in on the receipt of culturally and

linguistically competent health care by insureds. The translation of all vital documents shall be completed by the implementation date for the LAP as determined by these regulations.

(d) Every health insurer shall develop policies and procedures to ensure the quality and accuracy of written translations and that each translated document meets the same standards as are required for the English version of the document. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing translation services, including a documented and demonstrated proficiency in the source and target languages and knowledge of applicable specialized terminology in both the source and target languages.

(e) This section is not intended to prohibit or discourage a health insurer from providing translation of vital documents into a greater number of languages than the indicated/threshold languages.

T.10 s 2538.6 Individual access to oral interpretation services

(a) Every health insurer shall provide timely individual access to interpretation services at no cost to LEP insureds at all points of contact where language assistance is needed in accordance with these regulations. For purposes of this section, “timely " means in a manner appropriate for the situation in which language assistance is needed. Interpreter services are not timely if delay results in the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in important rights, benefits, or services to the LEP insured.

(b) Every health insurer shall develop policies and procedures that describe the health insurer's methods for providing timely interpretation services, including, but not limited to the following:

(1) The points of contact where the need for interpreting may be reasonably anticipated;

(2) The types of resources necessary in order to provide effective interpreting to the health insurer's insureds;

(3) The arrangements that the health insurer will make to inform insureds of oral interpretation services and to provide timely access to interpreting at all points of contact at no charge to insureds;

(4) The range of interpreting services that will be provided by trained and competent individuals to insureds as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(A) Bilingual health insurer or contractor/health care provider staff available for the duration of the need;

(B) Hiring staff interpreters;

(C) Contracting with outside interpreters;

(D) Making volunteer interpreters available; and

(E) Contracting for remote interpreting, as defined, for an LEP person.

(c) Every health insurer shall develop policies and procedures for the use of family, friends, and minors as interpreters. The intent of these regulations is to provide qualified interpreting for all LEP insureds, in their primary/preferred spoken language, at no cost to the LEP insureds at all points of contact where language assistance is needed. It is the intent of these regulations to discourage the use of family members and friends and strongly discourage the use of minors as interpreters; however, nothing in this section is intended to create a barrier to care for LEP insureds.

(1) In a non-emergency situation, an insured may request the use of a family member or friend as the interpreter. Once the insured has requested the use of a family member or friend as his or her interpreter, the insured shall be fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the family member or friend as the interpreter shall be documented in the medical record file.

(2) In an emergency situation, a minor maybe used as an interpreter if the following conditions are met:

(A) The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation; and,

(B) The insured is fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the minor as the interpreter shall be documented in the medical record file.

(d) Every health insurer shall develop policies and procedures to ensure the quality and timeliness of oral interpretation services provided to insureds. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing interpretation services, including a documented and demonstrated proficiency in the source and target languages, sensitivity to the LEP person's culture and a demonstrated ability to convey information accurately in both languages. A health insurer may develop and apply appropriate criteria for ensuring the proficiency of interpreter services. Criteria for interpreter ethics, conduct and qualifications adapted by the insurer from standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Health Care shall be accepted by the Commissioner**.**

T.10 s 2538.7 Health insurer monitoring, evaluation & reporting

(a) Every health insurer shall monitor the implementation and provision of its LAP and make modifications as necessary to ensure compliance with Insurance Code sections 10133.8 and 10133.9 and these regulations. The health insurer's policies and procedures shall include a description of the health insurer's method of (1) monitoring health insurer, contractor, health care provider, and network compliance with the health insurer's standards for the LAP Assistance Program, including the availability, quality and utilization of language assistance services, (2) tracking grievances and complaints related to its LAP Assistance Program, and (3) documenting actions taken to correct problems.

(b) Every health insurer shall evaluate the effectiveness of its LAP with regard to the following:

(1) Assessing indicated/threshold language(s) based on data collected;

(2) Assessing current language assistance needs of its insureds who are LEP persons;

(3) Documenting and responding to requests for translation and interpretation services;

(4) Whether the existing LAP Assistance Program meets the needs of its insureds that are LEP insureds;

(5) Whether health insurer staff knows the health insurer's policies and procedures and how to implement them;

(6) Whether the resources and arrangements for language assistance identified in the health insurer's policies and procedures are still current and available; and

(7) Responding to communications from insureds, including via surveys and complaints.

(c) Every health insurer shall report the information and data requested by the Department of Insurance in a timely manner. Health insurers who do not report in a timely manner shall be subject to fines and penalties as authorized by the Insurance Code.

(1) By December 1, 2007, every health insurer shall report to the Department of Insurance on the status of the implementation of its LAP Assistance Program;

(2) Within one year after the health insurers initial assessment but no later than December 1, 2009 and biennially by December 1st thereafter, every health insurer shall report to the Department of Insurance on its internal policies and procedures related to cultural appropriateness and any other information related to the health insurer's LAP as requested by the Commissioner, in a format specified by the department that shall include at least the following information:

(A) The data regarding the insured population based on the needs assessment as required by paragraph (2) of subdivision (b) of Insurance Code section 10133.8;

(B) The education of health insurer staff that have routine contact with insureds regarding the diverse needs of the insured population;

(C) The health insurer's recruitment and retention efforts that encourage workforce diversity;

(D) An evaluation of the health insurer's language assistance programs and services with respect to the health insurer's insured population, using processes such as an analysis of complaints and satisfaction survey results;

(E) The periodic provision of information regarding the ethnic diversity of the health insurer's insured population and any related strategies to health insurer's providers. Health insurers may use existing means of communication;

(F) The periodic provision of educational information to insureds on the health insurer's services and programs.

T.10 s 2538.8

Department of insurance reporting

Beginning on January 1, 2008, the Department shall report biennially to the Legislature regarding health insurer compliance with the standards established by Insurance Code section 10133.8 and these regulations including results of compliance audits made in conjunction with other audits and reviews. The Commissioner shall ensure that the reports required by this section as well as the data collected from health insurers for the reports do not require duplicative or conflicting data collection from health insurers. The Commissioner shall use the reported information from health insurers to make recommendations to health insurers for changes to their LAP, including the development of forms to notify insureds of their rights under these regulations and to further promote the purpose of these regulations.