The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.healthnet.com/2019/eoc/ec/ppo/bronze60hdhipex or call 1-888-926-4988. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or www.myhealthnetca.com or you can call 1-888-926-4988 to request a copy. In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Services (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost sharing means copayments, including coinsurance and deductibles.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$6,000 per person / $12,000 per family through the preferred provider network; $12,000 per person / $24,000 per family for out-of-network providers per calendar year.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, prenatal office visits, pediatric vision and dental care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For preferred providers $6,650 per person / $13,300 per family. For out-of-network providers $25,000 per person / $50,000 per family per calendar year.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billing charges, penalties for non-certification and healthcare this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of preferred providers, see <a href="http://www.myhealthnetca.com/findadoctor">www.myhealthnetca.com/findadoctor</a> or call 1-888-926-4988.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
## Common Medical Event

### If you visit a health care provider's office or clinic

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Preferred Provider (You will pay the least): 40% coinsurance after deductible has been met</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>40% coinsurance after deductible has been met</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### If you have a test

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Preferred Provider (You will pay the least): 40% coinsurance after deductible has been met</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>40% coinsurance after deductible has been met</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

More information about prescription drug coverage is available at [www.myhealthnetca.com/druglist](http://www.myhealthnetca.com/druglist)

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred generic drugs (tier 1)</td>
<td>40% coinsurance up to a maximum of $500 per 30 day script after deductible has been met</td>
<td>Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care.</td>
</tr>
<tr>
<td>Non-preferred generic and preferred brand drugs (tier 2)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs (tier 3)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs (tier 4)</td>
<td>40% coinsurance up to a maximum of $500 per 30 day script after deductible has been met</td>
<td>Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>Facility fee-40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional services-No charge after deductible has been met</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office visit-40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>Preferred Provider (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>40% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge after deductible has been met</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
### Excluded Services & Other Covered Services:

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

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (covered when medically necessary)
- Bariatric surgery (covered through the preferred provider network if medically necessary)
- Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)

---

**Your Rights to Continue Coverage:**
Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit Fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-888-926-4988. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Health Net’s Customer Contact Center at 1-888-926-4988, submit a grievance form through [www.myhealthnetca.com](http://www.myhealthnetca.com), or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). If you have a grievance against Health Net, you can also contact the California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013 or at 1-800-927-HELP (4357), 1-800 482-483 TDD or at [www.insurance.ca.gov](http://www.insurance.ca.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Insurance at the contact information provided above.

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* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0088.


Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-522-0088.

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-522-0088.

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.com
About these Coverage Examples:

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

---

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $6,000
- Specialist coinsurance: 40%
- Hospital (facility) coinsurance: 40%
- Other coinsurance: 40%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$4,600</td>
</tr>
</tbody>
</table>

What isn't covered

| Limits or exclusions          | $50      |

The total Peg would pay is: $6,650

---

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $6,000
- Specialist coinsurance: 40%
- Hospital (facility) coinsurance: 40%
- Other coinsurance: 40%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$4,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,600</td>
</tr>
</tbody>
</table>

What isn't covered

| Limits or exclusions          | $50      |

The total Joe would pay is: $6,650

---

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible: $6,000
- Specialist coinsurance: 40%
- Hospital (facility) coinsurance: 40%
- Other coinsurance: 40%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $2,500

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

What isn't covered

| Limits or exclusions          | $50      |

The total Mia would pay is: $1,300

---

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

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Your Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with the Health Plan, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net’s Customer Contact Center at:

**Individual & Family Plan (IFP) Members On Exchange/Covered California** 1-888-926-4988 (TTY: 711)
**Individual & Family Plan (IFP) Members Off Exchange** 1-800-839-2172 (TTY: 711)
**Individual & Family Plan (IFP) Applicants** 1-877-609-8711 (TTY: 711)
**Group Plans through Health Net** 1-800-522-0088 (TTY: 711)

If you believe that Your Health Plan has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Your Health Plan and telling them you need help filing a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348
Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

English
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 the Customer Contact Center at the number on your ID card or call
Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace,
call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711).
For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية يمكنك أن تتوفر لك مترجم فوري. ويمكنك أن تقرأ لك النصوص باللغة العربية أو الإنجليزية باللغة العربية أو الإنجليزية عبر الرقم: 1-800-839-2172 (TTY: 711). يرجى الاتصال
مباشرًا بمركز خدمات العملاء عبر الرقم المذكور. بإمكانك أن تلقي النصوص باللغة العربية أو الإنجليزية من خلال الرقم: 1-888-926-4988 - Health Net

Armenian
Ազնվական բարեգրական ծառայությունները. Հանդիպման հրաժ有不同的 համար կարելի է հաշվել ձեռք բերել համակարգային
համակարգի համար։ Օգտվեք պատկանող մշակույթի ծառայությունով բնակեցատեղին և հայտնել ձեռք բերել համակարգի համար
Individual & Family Plan (IFP) Off Exchange 1-800-839-2172 համակարգի համար
1-888-926-4988 համակարգի համար (TTY: 711): համակարգի համար
1-888-926-5133 համակարգի համար (TTY: 711): Health Net-ի համար կարելի է հաշվել ձեռք
առանց համակարգի համար 1-800-522-0088 համակարգի համար (TTY: 711):

Chinese
免费语言服务。您可以使用口译服务。您可以聘请翻译将您读给我们将某些文件翻译成您的语言
寄给我们。如需协助，请拨打您会员卡上的电话号码或客户联络中心联络或者拨打健康保险贸易市场的
Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，
請拨打健康保險交易市場的IFP 專線 1-888-926-4988（聽障專線：711），小型企業請拨打
1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打
1-800-522-0088（聽障專線：711）。

Hindi
बिना खुलक भाषा सेवाएं। आप एक दुबारा या प्राप्त कर सकते हैं। आप अंग्रेज़ी को हिंदी भाषा में पहले
सकते हैं। भाषा के लिए, अपने आईडी कार्ड में दिए गए संख्या पर नाम सेवा केंद्र को कॉल करें या टेलिफोन
तंत्र (आईएफपी) और एक्स्चेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफ़ोर्निया
वाशिंगटन के लिए, आईएफपी और एक्स्चेंज 1-888-926-4988 (TTY: 711) या स्मार्ट वालिंग्टन
1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के कार्यालय से युपी कार्यालय के लिए
1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Ngj Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lys. Koj tuaj yeem muaj ib
tus neeg njeem cov ntaub ntawv rau koj na koj hom lys hais. Txhawm rau pab, huv xvooy rau Neeg Qhua Lub
Chaw Tiv Toj ntawm tus npawb nyob ntauw koj dain npab ID loossi hau rau Tus Neeg thiab Tsev Neeg Qhov
khiw, hau rau IFP Ntwm Qhov Sib Hloob Pauv 1-888-926-4988 (TTY: 711) loossi Lag Luan Me
1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hau rau
1-800-522-0088 (TTY: 711).
Japanese

Khmer
ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក Off Exchange ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក California ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក 1-888-926-4988 (TTY: 711) ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក California ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក 1-888-926-5133 (TTY: 711) ។ ប្រការដែលអាចអនុវត្តបានជាច្រើនតាមតម្រូវការរបស់អ្នក Health Net 1-800-522-0088 (TTY: 711) ។

Korean

Navajo

Persian (Farsi)
Panjabi (Punjabi)

विला दिने संचार व्यक्तियों कुछ सेवाएं। नयी विद्वेश हुआ दोहों दी में उम्मीद वसंत सब सक्रिय। उम्मीद दूल्हा दूल्हनी के संघ गुलाम वसंत सब सक्रिय। आपके अधिकांश व्यक्तियों देश दी दिनें तास के साथ भर्ती वेतनछ (IFP) वेद उच्चमत्रण दे चला वसंत हैं। चला वसंत हैं।
1-888-926-5133 (TTY: 711) दे चला वसंत हैं।
1-800-522-0088 (TTY: 711)

Russian


Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comunícalse con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog


Thai

ไม่มีค่าบริการสำหรับภาษา คุณสามารถใช้ข้อมูลได้ คุณสามารถขอได้แก่การให้ฟังเป็นภาษาของคุณได้ หากคุณต้องการสอบถามเพิ่มเติม โปรดติดต่อสำนักงานบริการข้อมูลของคุณ หรือฟังแผนภูมิและควบคุมการของบุคคล (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรทั่วไป TTY: 711) สำหรับแผนภูมิและควบคุมการของบุคคล (Small Business) ที่ 1-888-926-5133 (โทรทั่วไป TTY: 711) สำหรับแผนภูมิและควบคุมการของบุคคล (Small Business) ที่ 1-888-926-4988 (โทรทั่วไป TTY: 711) หรือ สอบถามข้อมูลกลุ่มเป็นทาง Health Net โทร 1-800-522-0088 (โทรทั่วไป TTY: 711)
Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiền dịch viên. Quý vị có thể yêu cầu được đọc cho

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