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. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MyHealthNetCA.com or by calling 1-800-522-0088. 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 1-800-522-0088 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>For participating providers $6,300 per member / $12,600 per family per calendar year. Does not apply to preventive care.</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 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, laboratory tests, rehabilitation and habilitation services, hospice, mental health and substance use disorder visits; first 3 non-preventive visits per year combined, including primary care, specialist, other practitioner, postnatal, urgent care; and pediatric vision and pediatric 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>Yes. $500 per member / $1,000 per family per calendar year for prescription drugs. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Yes. For participating providers $7,550 member / $15,100 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 family members in this plan, they have to meet their own out-of-pocket limits 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, penalties for non-certification and health care 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">www.MyHealthNetCA.com</a> or call 1-800-522-0088.</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**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Out of Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care &amp; postnatal non-preventive visits are combined.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$105/visit</td>
<td>Not covered</td>
<td>Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care &amp; postnatal non-preventive visits are combined.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray - 100% after deductible has been met Lab - $40 deductible waived</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier I drugs (most generic and low cost preferred brands)</td>
<td>100% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</td>
<td>Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior auth is required for select drugs. Deductible required for prescription drugs $500 per member / $1,000 per family per calendar year.</td>
</tr>
<tr>
<td>Tier II drugs (non-preferred generics and preferred brands)</td>
<td>100% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</td>
<td>Tier I, Tier II and Tier III will have a copay maximum of $500 per individual prescription of up to a 30-day supply or $1,500 for a 90-day supply.</td>
</tr>
<tr>
<td>Tier III drugs (non-preferred brands)</td>
<td>100% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</td>
<td>Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Prior authorization required for select drugs. Deductible required for prescription drugs $500 per member / $1,000 per family per calendar year. Tier IV drugs will have a copay maximum of $500 per individual prescription of up to a 30-day supply or $1,500 for a 90-day supply.</td>
</tr>
<tr>
<td>Tier IV drugs (Specialty drugs)</td>
<td>100% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</td>
<td></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).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<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>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility – 100% after deductible has been met</td>
<td>Facility – 100% after deductible has been met Copay applies then deductible applies. Copay waived if admitted as inpatient.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>100% after deductible has been met</td>
<td>100% after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75/visit</td>
<td>$75/visit Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care &amp; postnatal non-preventive visits are combined.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>100% after deductible has been met</td>
<td>Not covered If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>Office visit – $75/visit; Other than office visit – 100% up to $75 after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>100% after deductible has been met</td>
<td>Not covered If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal - No charge Postnatal - $75/visit</td>
<td>Not covered Deductible waived for 1st 3 postnatal visits combined with primary care &amp; urgent care visits.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>100% after deductible has been met</td>
<td>Not covered Coverage includes abortion services.</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)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Out of Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery facility services</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
<td>Limited to 100 visits year. If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>100% after deductible has been met</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to 1 visit per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>Not covered</td>
<td>Provider selected frames; 1 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
</tbody>
</table>

**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

* For more information about limitations and exceptions, see the plan or policy document at [www.MyHealthNetCA.com](http://www.MyHealthNetCA.com)
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 participating provider network if deemed 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 1-800-522-0088. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 1-800-522-0088, submit a grievance form through 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. If you have a grievance against Health Net, you can also contact the California Department of Managed Health Care, at 1-800-HMO-2219 or www.hmohelp.ca.gov. 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

* For more information about limitations and exceptions, see the plan or policy document at 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, kwijjigo holne’ 1-800-522-0088.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* 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 prenatal care and a hospital delivery)

- **The plan’s overall deductible**: $2,200
- **Specialist copayment**: $75
- **Hospital (facility) coinsurance**: 20%
- **Other copayment**: $30

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$6,300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $60

The total Peg would pay is **$7,160**

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

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $2,200
- **Specialist copayment**: $75
- **Hospital (facility) coinsurance**: 20%
- **Other copayment**: $30

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $60

The total Joe would pay is **$3,960**

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

- **The plan’s overall deductible**: $2,200
- **Specialist copayment**: $75
- **Hospital (facility) coinsurance**: 20%
- **Other copayment**: $30

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $60

The total Mia would pay is **$1,500**

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](http://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](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](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).


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FLY018690EP00 (6/18)
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. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق باللغة العربية. للحصول على المساعدة اللازمة، برخي التواصل مع مركز خدمات العملاء عبر الرقم المبين على البطاقة أو الاتصال بالرقم المقدم لخدمة الأفراد والعائلة: 1-800-839-2172 (TTY: 711).
(1-800-522-0088) (TTY: 711).

Armenian
Անօթագծային ծրագրեր. Հանդիսանում են էջիստական ծրագրերի տպագրությունները. Օգտագործեք համարծիռոցները փոխարեն են։ Պատրաստեք հեռախոս թվանորսները հեռախոս թվանորսության բնականության համար։ Օգտագործեք Individual & Family Plan (IFP) Off Exchange 1-800-839-2172 հեռախոսախոսական (TTY: 711): 1-888-926-4988 հեռախոսախոսական (TTY: 711) կամ Ֆիզիկական նախարարություն։
1-888-926-5133 հեռախոսախոսական (TTY: 711) և Health Net-ի նախարարություն։
1-800-522-0088 հեռախոսախոսական (TTY: 711):

Chinese
免费语言服务。您可使用口译员服务。您可请人将文件读给您听并请我们将某些文件翻阅成您的语言寄给您。如有需要，可拨打您会员卡上的电话号码与客户联络中心联络或者拨打健康保险交易市场外的 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），小型企業則請拨打 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 शुल्क भाषा सेवाएं। आप एक दुमास्विया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़ा सकते हैं। भाषा के लिए, अपने आईडी कार्ड में दिए गए नंबर पर गाथा सेवा केंद्र को कॉल करें या व्यक्तिगत और फैक्सिलिज्युन (आईपीएफ) ओफ एवर्चरज 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया वार्ज़ार्स के लिए, आईपीएफ ऑफ एवर्चरज 1-888-926-4988 (TTY: 711) या फुल्फिल मिनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेलेथ नेट के गारंटी से युप्त व्यवस्था के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Japanese


Khmer


Korean


Navajo


Persian (Farsi)

Panjabi (Punjabi)

Bilawal Jhangvi, Governor of Punjab, has signed the Punjab Health Act 2020. This law aims to provide health services to all residents of the province.

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, comuníquese 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

ไม่มีค่าบริการที่มีการค่าสินค้า คุณสามารถใช้สิ่งเหล่านี้ คุณสามารถให้คำแนะนำเพื่อให้เป็นการหยุดเนียร์ เทียบเท่ากับการจ่ายค่าสินค้าที่มีรายละเอียดเกี่ยวกับการจัดเก็บ หรือการจัดเก็บแบบบุคคลและครอบครัวขององค์การ (Individual & Family Plan (IFP), Off Exchange) ที่ 1-800-839-2172 (TTY: 711) สำหรับแผนแบบครอบครัวในประเทศ (Small Business) ที่ 1-888-926-5133 (TTY: 711) สำหรับแผนแบบกลุ่มผู้จ้างทาง Health Net โทร 1-800-522-0088 (TTY: 711)
Việtnamese

CA Commercial DMHC On and Off-Exchange Member Notice of Language Assistance

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