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.myhealthnetca.com](http://www.myhealthnetca.com) or call 1-800-839-2172. 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/](https://www.healthcare.gov/sbc-glossary/) or [www.myhealthnetca.com](http://www.myhealthnetca.com) or you can call 1-800-839-2172 to request a copy.

### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall **deductible**? | $0. | See the Common Medical Events chart below for costs for services this plan covers.

Are there services covered before you meet your **deductible**? | No. | You will have to meet the **deductible** before the plan pays for any services.

Are there other **deductibles** for specific services? | No. | 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.

What is the **out-of-pocket limit** for this **plan**? | $7,200 member / $14,400 family per calendar year. | 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.

What is not included in the **out-of-pocket limit**? | **Premiums** and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out–of–pocket limit**.

Will you pay less if you use a **network provider**? | Yes. For a list of preferred providers, see [www.myhealthnetca.com](http://www.myhealthnetca.com) or call 1-800-839-2172. | 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.

Do you need a **referral** to see a **specialist**? | Yes. Requires written prior authorization. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
**All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

<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><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>In network Provider (You will pay the least)</strong>: $30/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><strong>Out of Network Provider (You will pay the most)</strong>: Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab - $35/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRls)</td>
<td><strong>Out of Network Provider (You will pay the most)</strong>: $55/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier I drugs (most generic and low cost preferred brands)</td>
<td>$15/retail order</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.myhealthnetca.com">www.myhealthnetca.com</a></td>
<td>Tier II drugs (non-preferred generics and preferred brands)</td>
<td>$55/retail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier III drugs (non-preferred brands)</td>
<td>$75/retail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier IV drugs (Specialty drugs)</td>
<td>20% coinsurance up to $250 per 30 day script</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>Out of Network Provider (You will pay the most)</strong>: $300/procedure</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$40/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>Facility - $325/visit Physician – No charge</td>
<td>Facility - $325/visit Physician – No charge</td>
<td>Copays not required if admitted as an inpatient.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$250/transport</td>
<td>$250/transport</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$30/visit</td>
<td>$30/visit</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$600/day</td>
<td>Copay required up to 5 days max. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office visit: $30/visit Other than office visit: No charge</td>
<td>Prior authorization required except for office visits. Each group therapy session requires only one half of a private office visit copayment.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$600/day</td>
<td>Copay required up to 5 days max. Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Prenatal - No charge Postnatal - $30/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$600/day</td>
<td>Copay required up to 5 days max. Coverage includes abortion services.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$30/visit</td>
<td>Limited to 100 visits each calendar year. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$30/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$300/day</td>
<td>Copay required up to 5 days max. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Requires prior authorization.</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><strong>If your child needs medical or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Limited to 1 visit per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</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><em><strong><strong>none</strong></strong></em>__</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

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

- Acupuncture
- Bariatric surgery
- Routine eye care (Adult)

**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 1-800-839-2172. 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).

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
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 1-800-839-2172, 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

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 1-800-839-2172.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-839-2172.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-839-2172.
Navajo (Dine): Dinek’ehgo shika a’ohwol ninisingo, kwijigo holne’ 1-800-839-2172.

* 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in network prenatal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in network care of a well controlled condition)</th>
<th>Mia’s Simple Fracture (in network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible $0</td>
<td>The plan’s overall deductible $0</td>
<td>The plan’s overall deductible $0</td>
</tr>
<tr>
<td>Specialist copayment $55</td>
<td>Specialist copayment $55</td>
<td>Specialist copayment $55</td>
</tr>
<tr>
<td>Hospital (facility) copayment $600</td>
<td>Hospital (facility) copayment $600</td>
<td>Hospital (facility) copayment $600</td>
</tr>
<tr>
<td>Other copayment $30</td>
<td>Other copayment $30</td>
<td>Other copayment $30</td>
</tr>
</tbody>
</table>

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>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is $2,160

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>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Joe would pay is $2,460

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>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Mia would pay is $2,110

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-

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

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) On 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 مبتعث. ويمكنك أن تقرأ لك الوثائق بشكل مترجم. للحصول على المساعدة اللازمة، برحي التواصل مع مركز خدمات العملاء عبر الرقم الموحد على بطاقتك أو الاتصال بالرقم الموحد للخدمة الأدبية والعائلية: 1-800-839-2172 (TTY: 711).

Armenian
Անվճար լեզուային ծառայություններ։ Երկիրը թույլտվություն տրվում է աճախորդներին կանգնած մասնագիտական ծառայությունների։
Փոխանակիչները կարող են համարվել դրանց թվում։ Օգտվեք համար գրության համար համարական հսկայական ծառայությունների մեջ։ Այսուհատարանը կարող է օգտագործվել հետևյալ Հայաստանի թափանախություն The Health Net ընկերության համար գրության համար 1-800-839-2172 (TTY: 711)

Chinese
免费语言服务。您可使用口译员服务。您可请人将文件送到您处并请我们将其文件翻译成您的语言
寄给您。如需协助，请拨打您会员卡上的电话号码与客户服务中心联系或者拨打健康保险交易市场外的 Individual & Family Plan (IFP) 专线：1-800-839-2172（听障专线：711）。如为加州保险交易市场，
请拨打健康保险交易平台的 IFP 专线 1-888-926-4988（听障专线：711），小型企业则请拨打
1-888-926-5133（听障专线：711）。如为通过 Health Net 取得的保障计划，请拨打
1-800-522-0088（听障专线：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुकानदार ने अपनी भाषा में पढ़ाई कर सकते हैं। आप दस्तावेज को अपनी भाषा में पढ़ाई कर सकते हैं। बच्चे के लिए, अपने आईडी कार्ड में दिए गए नंबर पर शिक्षा सेवा केन्द्र को काले करें या व्यक्तिगत और फैक्सिलिटी लाज (आईएफपी) ऑफ एस्थेरिज़, 1-800-839-2172 (TTY: 711) पर कोल करें। केलिफोर्निया बायांकर्ने के लिए, आईएफपी ऑफ एस्थेरिज़ 1-888-926-4988 (TTY: 711) या स्कॉन विजन
1-888-926-5133 (TTY: 711) पर कोल करें। हेल्थ नेट के गर्मियां से गुप्त लाज के लिए
1-800-522-0088 (TTY: 711) पर कोल करें।

Hmong
1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau
1-800-522-0088 (TTY: 711).
Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP)（個人・家族向けプラン）
Off Exchange: 1-800-839-2172 (TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988 (TTY: 711) または Small Business
1-888-926-5133 (TTY: 711) までお電話ください。Health Netによるグループプランについては、
1-800-522-0088 (TTY: 711) までお電話ください。

Khemer
អំពីការកាត់ប្រែការព័ត៌មានអោនិស័យឬការស្វែងរកការជេក្តីការព័ត៌មានអោនិស័យឬការស្វែងរកការជេក្តីអំឡុងពេលទីបេះដូងអោនិស័យ On Exchange
ប្រព័ន្ធដោយអាយុសុខ (IFP) ការព័ត៌មានជំនួយ: 1-800-839-2172 (TTY: 711)។
អំពីការជេក្តីអំឡុងពេលទីបេះដូងអោនិស័យ On Exchange ប្រព័ន្ធដោយអាយុសុខ IFP ការព័ត៌មានជំនួយ: 1-888-926-4988 (TTY: 711) ប្រព័ន្ធញេលការព័ត៌មានអោនិស័យ មាន 1-888-926-5133 (TTY: 711)។
ប្រព័ន្ធញេលការព័ត៌មានអោនិស័យ Health Net មាន 1-800-522-0088 (TTY: 711)។

Korean
투료 연해 서비스입니다. 동록 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객 서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange:
1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우

Navajo
Doo bąąh illinggóó saad bee hááká ada'liyee. Ata' hainé'giilí da la' ná háádidóóotií. Naaltoosos da t'áa shi shizaad k'ehji shichíí yidooltah ninízingo t'áá ná ákóodooiní. Akót'éego shiká a'doowoi ninízingo Customer Contact Center hoolyéhjí' hodiilinh ninaaltoosos nanitingo bee néeho'dolziníi hodoohijí' bikáa' el doodago kojí' hóníe' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. در تولید بک متروج شفاهی بکری. در تولید درخواست نتیجه استفاده به زبان شما برای این خواندن شود. برای دریافت کمک، با مرکز نیازهای شرایط پیشرفت روی کارت هزینه با طرح فردی و خادمانی 1-888-926-4988 (TTY: 711) Off Exchange) با کارت کالج سامانی با طرح (TTY: 711) 1-800-839-2172
با کارت کالج سامانی با طرح Health Net (TTY: 711) 1-800-522-0088 (TTY: 711).
Panjabi (Punjabi)


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

ไม่มีคำวัดภาษาต่างประเทศ คุณสามารถใช้คำวัดได้ คุณสามารถให้ผู้แปลหรือไม่ให้ผู้แปลเป็นภาษาของคุณได้ หากคุณต้องการความช่วยเหลือ โปรดโทรเข้ามายังสำนักงานบริการลูกค้าของคุณ หรือโทรที่ 1-800-839-2172 (TTY: 711) สำหรับแผนการประกันพระชนชีพ (Individual & Family Plan, IFP) หรือ 1-888-926-4988 (TTY: 711) สำหรับแผนการประกันของผู้ประกอบการ (Small Business) 1-888-926-5133 (TTY: 711) สำหรับแผนการประกันแบบกลุ่มผ่าน Health Net โทร 1-888-926-4988 (TTY: 711).
Việtnamese

CA Commercial DMHC On and Off-Exchange Member Notice of Language Assistance
FLY017549EH00 (12/17)