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/ecoc/pco/epo/mincoviex 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.

### Important Questions

<p>| What is the overall deductible? | For preferred providers $7,900 per person / $15,800 per family per calendar year. | 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. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, first 3 non-preventive visits per year combined (including non-preventive primary care, other practitioner, outpatient mental health &amp; substance use disorder and urgent care visits); and pediatric vision and dental care are covered before you meet your deductible. | 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>. |
| 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? | For preferred providers $7,900 per person / $15,800 per family per calendar year. | 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. |
| What is not included in the out-of-pocket limit? | Premiums, balance billing charges, penalties for non-certification and healthcare 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 <a href="http://www.myhealthnetca.com/findadoctor">www.myhealthnetca.com/findadoctor</a> or call 1-888-926-4988. | 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? | No. | You can see the specialist you choose without a referral. |</p>
<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></td>
<td></td>
<td>Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, other practitioner, urgent care and outpatient mental health &amp; substance use disorder visits).</td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0% coinsurance deductible waived for 1st 3 visits</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</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>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs (tier 1)</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic and preferred brand drugs (tier 2)</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (tier 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (tier 4)</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</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>Preferred 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 have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>Some outpatient surgical procedures require certification or a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>Some outpatient surgical procedures require certification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility - 0% coinsurance after deductible has been met&lt;br&gt;Professional services – no charge</td>
<td>Facility - 0% coinsurance after deductible has been met&lt;br&gt;Professional services – no charge</td>
<td>Cost sharing waived if admitted into the hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% coinsurance after deductible has been met</td>
<td>0% coinsurance after deductible has been met</td>
<td>Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, other practitioner, urgent care and outpatient mental health &amp; substance use disorder visits). Out of network urgent care is covered only under certain circumstances.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>0% coinsurance deductible waived for 1st 3 visits</td>
<td>0% coinsurance deductible waived for 1st 3 visits</td>
<td>Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, other practitioner, urgent care and outpatient mental health &amp; substance use disorder visits). Certification is required for some outpatient mental health, behavioral health, and substance abuse services (not including regular office visits) or a $250 penalty will apply.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained in a non-emergency a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>Certification is required for a hospital stay and some services received while admitted to the hospital.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office visit - 0% coinsurance deductible waived for 1st 3 visits&lt;br&gt;Other than office visit - 0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, other practitioner, urgent care and outpatient mental health &amp; substance use disorder visits). Certification is required for some outpatient mental health, behavioral health, and substance abuse services (not including regular office visits) or a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained in a non-emergency a $250 penalty will apply.</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>Preferred 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 are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>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>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>Limited to 100 visits per calendar year (rehabilitative and habilitative home health services are each limited to separate 100 visit limits per calendar year). Certification is required for some home health services or a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance after deductible has been met</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</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>
<td>Not covered</td>
<td>Limited to 1 visit per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>0% coinsurance after deductible has been met</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>Limited to 1 check-up every 6 months.</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 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, 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 1-888-926-4988, 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 1-866-444-3272 or 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), 1-800 482-4833 TDD or at 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.

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: $7,900
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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>Peg Would Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$7,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $60
- The total Peg would pay is: $7,860

---

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

- The plan's overall deductible: $7,350
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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>Joe Would Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$6,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Joe would pay is: $6,460

---

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

- The plan's overall deductible: $7,350
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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>Mia Would Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0
- The total Mia would pay is: $1,900

---

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

Arabic

Armenian

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 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，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 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
विना शुल्क भाषा सेवाएं। आप का एक दुसरे भाषा का पार सकते हैं। आप दस्तावेजों का अपना भाषा में पढ़ा सकते हैं। घर के लिए, अपने आईडी कार्ड में दिए गए नंबर पर गाइड सेवा केंद्र का कार्य करना या व्यक्तिगत और सामाजिक ज्ञान (आईएससी) ओफ एक्सचेंज 1-800-839-2172 (TTY: 711) पर कॉल करना। केलिफोर्निया बाजार के लिए, आईएससी ऑफ एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मार्ट वियोलेंस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के गाइड ज्ञान से युवा ज्ञान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Japanese

Khmer

Korean

Navajo

Persian (Farsi)
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

ไม่มีค่าบริการสำหรับการค้นหาเอกสาร คุณสามารถขอข้อมูลได้ คุณสามารถให้คำแนะนำได้ในสถานะการณ์เป็นกลางได้ หากคุณต้องการความช่วยเหลือ โทรฟรีสายด่วนสายที่ระบุข้อมูลบริการจำเป็นของคุณ หรือโทรไปที่แผนกบุคคลและครอบครัวของแยกทาง (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรศัพท์ TTY: 711) สำหรับแผนกบุคคลและครอบครัวของแยกทาง (IFP On Exchange) ที่ 1-888-926-4988 (โทรศัพท์ TTY: 711) หรือ สำหรับแผนกบุคคลและครอบครัวของแยกทาง (Small Business) ที่ 1-888-926-5133 (โทรศัพท์ TTY: 711) สำหรับแผนกบุคคลและครอบครัวของแยกทาง Health Net โทร 1-800-522-0088 (โทรศัพท์ TTY: 711)
Việtnamese

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