### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall <strong>deductible</strong>?</td>
<td>$0 through the preferred provider network. $5,000 per person / $10,000 per family for out-of-network providers per calendar year.</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there services covered before you meet your <strong>deductible</strong>?</td>
<td>There is no <strong>deductible</strong> through the preferred provider network.</td>
<td>There is no <strong>deductible</strong> through the preferred provider network. You will however have to meet the out-of-network <strong>deductible</strong> before the <strong>plan</strong> pays for any out-of-network services (except for emergency services).</td>
</tr>
<tr>
<td>Are there other <strong>deductibles</strong> for specific services?</td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> 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 <strong>out-of-pocket limit</strong> for this <strong>plan</strong>?</td>
<td>For preferred providers $3,350 per person / $6,700 per family. For out-of-network providers $25,000 per person / $50,000 per family per calendar year.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limit</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td>What is not included in the <strong>out-of-pocket limit</strong>?</td>
<td><strong>Premiums</strong>, <strong>balance billing</strong> charges, penalties for non-certification and healthcare this <strong>plan</strong> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Will you pay less if you use a <strong>network provider</strong>?</td>
<td>Yes. For a list of <strong>preferred providers</strong>, see <a href="http://www.myhealthnetca.com/findadoctor">www.myhealthnetca.com/findadoctor</a> or call 1-888-926-4988.</td>
<td>This <strong>plan</strong> uses a <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the plan’s <strong>network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the provider’s charge and what your <strong>plan</strong> pays (<strong>balance billing</strong>). Be aware, your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> before you get services.</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>
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></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab-$15/visit X-ray-$30/visit</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs (tier 1)</td>
<td>$5/retail order $10/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic and preferred brand drugs (tier 2)</td>
<td>$15/retail order $30/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (tier 3)</td>
<td>$25/retail order $50/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (tier 4)</td>
<td>10% coinsurance up to $250 per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
</tbody>
</table>

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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)
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<tr>
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</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility fee-$150/visit Professional services-No charge</td>
<td>Facility fee-$150/visit deductible does not apply Professional services-No charge</td>
<td>Copayment waived if admitted into the hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$150/transport</td>
<td>$150/transport deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>If certification is not obtained in a non-emergency a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</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 - No charge Other than office visit-10% coinsurance up to $15</td>
<td>50% coinsurance after deductible has been met</td>
<td>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 through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>If certification is not obtained in a non-emergency a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>50% coinsurance after deductible has been met</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>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Coverage includes abortion services.</td>
</tr>
</tbody>
</table>

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<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>Diabetic equipment (including footwear) and prosthesis only-50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<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>Children’s glasses</td>
<td>No charge</td>
<td>Not covered</td>
<td>Provider selected frames; 1 per calendar year.</td>
</tr>
<tr>
<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 1-888-926-4988.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-926-4988.
Navajo (Dine): Dine'hoo shika at'ohwol ninisingo, kwiijige holne’ 1-888-926-4988.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
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</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan’s overall deductible** $0
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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

**What isn’t covered**
- Limits or exclusions $60

The total Peg would pay is $1,560

- **The plan’s overall deductible** $0
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$800</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60

The total Joe would pay is $1,060

- **The plan’s overall deductible** $0
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$600</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0

The total Mia would pay is $610

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
خدمات لغوية مجانية. يمكنك أن تتوفر لك مترجم مجانا. يمكنك أن تقرأ لك الوثائق باللغة، أو تسجيل الوثائق من خلال الهاتف. لا تحتاج إلى مزرعة للتمكين عبر الهاتف. للوصول إلى مكتب الاتصال بـ IFP أو IFP On Exchange 1-800-839-2172 (TTY: 711).

Armenian
Անցանց լեզուային ծառայություններ: Շրջանակորեական լեզուային ծառայություն
Փառքաբերության կարգավորման համար կարելի է չդարձնել որպեսզի զարգացնեք ծառայությունը
Անցանց լեզուային ծառայություն համար կարելի է չդարձնել որպեսզի զարգացնեք ծառայությունը
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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将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或联系中心联系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 取得的護理計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुष्प्रभाव प्राप्त कर सकते हैं। आप अन्य भाषा में पढ़ा सकते हैं। हालांकि के लिए, अन्य आईडी कार्ड में दिए गए नंबर पर गाइड सेवा केंद्र को कल करें या व्यापारी और फैक्टरी प्लान (आईएफपी) ऑफ इफ्सरिज़न्स: 1-800-839-2172 (TTY: 711) पर कल करें। केरीफार्मिना बाजारों के लिए, आईएफपी ऑफ इफ्सरिज़न्स: 1-888-926-4988 (TTY: 711) या स्कॉल विलेज 1-888-926-5133 (TTY: 711) पर कल करें। हेल्थनेट के मामले से गुप्त प्लान के लिए 1-800-522-0088 (TTY: 711) पर कल करें।

Hmong
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)

Khmer
មានការជួយដាក់ស្នាដៃដូចគ្នាខក់ដំបូងពីរប៊ែកដូចគ្នាគ្រប់គ្រាន់។ ការជួយដាក់ស្នាដៃដូចគ្នា សម្រាប់អ្នកប្រឈម៖ Off Exchange 1-800-839-2172 (TTY: 711)
តើមានការជួយដាក់ស្នាដៃដូចគ្នាគ្រប់គ្រាន់ សម្រាប់អ្នកប្រឈម៖ California 1-888-926-4988 (TTY: 711)
ការជួយដាក់ស្នាដៃដូចគ្នាគ្រប់គ្រាន់ សម្រាប់អ្នកប្រឈម៖ Health Net 1-800-522-0088 (TTY: 711)

Korean

Navajo

Persian (Farsi)
خدمات زبان بدون هزینه. در توانایی یک مترود شفاهی گیباید. در توانایی درخواست کنید استعداد به زبان شما براپایان خودیه شوند. برای برایIFP (Off Exchange) دریافت کمک با مركز تخصصی مشتریان به شماره روی کارت شناسایی با طرح فردی و خانوادگی شماره 1-888-926-4988 (TTY: 711) (711) 1-800-879-2172 (TTY: 711) 1-888-926-5133 (TTY: 711) 711) 1-800-522-0088 (TTY: 711) Health Net
Panjabi (Punjabi)

निर्देश दिने सर्वांजलि धमस्त्रांणी सेवा संबंधीत आहेत. उपरोक्त निर्देश तुम्ही दुसऱ्याची की में उमेद वर्ते. हे निर्देश उपर्रतत्त्व तुम्ही बघून पडतात ते मुझे गुन्हे तत्साहित. सहमती, अथवा अधिक विवेचन ते हिंदू/तृणांत ते साधन विनियोजित केंद्र ते कसा वर्ते तात्त्विकतेनुसार अत्य निधित्वपूर्ण (IFP) घोषित ठेविसहून ते कसा वर्ते: 1-800-839-2172 (TTY: 711). वेतनसहितक्रिया भागभारतीय जनसंख्यानुसार ठेविसहून 1-888-926-5133 (TTY: 711) तसाच विनियोजित केंद्र ते कसा वर्ते. रेडियो टेलिफोन संपर्क पद्धतीच्या क्षेत्रात, 1-800-522-0088 (TTY: 711) ते कसा वर्ते.

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

ไม่ต้องการสัมภาษณ์คุณสามารถใช้ตัวเลข ที่คุณสามารถใช้ตัวเลขให้กับปัจจัยของคุณได้ หากต้องการติดต่อกับโทรศัพท์มือถือที่มีรายละเอียดที่มากกว่าคุณยังสามารถติดต่อกับแผนประกันการอุบัติการณ์ (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (หูฟัง TTY: 711) สำหรับแผนประกันทรัพย์สิน หรือแผนประกันการอุบัติการณ์ (Small Business) ที่ 1-888-926-5133 (หูฟัง TTY: 711) สำหรับแผนประกันภัยทาง Health Net โทร 1-800-522-0088 (หูฟัง TTY: 711)
Việtnamese
Các Dịch Vu Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu direkt đọc cho
nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung

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