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 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/ or www.myhealthnetca.com or you can call 1-800-839-2172 to request a copy.

<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>$2,500 per member / $5,000 per family per calendar year.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, preventive care, primary care, specialist visit, diagnostic test, imaging, outpatient surgery, emergency room, urgent care, outpatient mental health/substance abuse services, pre and postnatal office visits, home health care, rehabilitation and habilitation, durable medical equipment, hospice, pediatric vision &amp; 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. $200 per member / $400 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. $7,550 per member / $15,100 per family per calendar year.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have 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 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 1-800-839-2172.</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>Yes. Requires written prior authorization.</td>
<td>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.</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><strong>In network Provider (You will pay the least)</strong></td>
<td><strong>Out of Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
<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>$40/visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$80/visit Deductible does not apply</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>Lab - $35/visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$300/procedure Deductible does not apply</td>
<td>Not covered</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 $30/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier II drugs (non-preferred generics and preferred brands)</td>
<td>$55/retail order $110/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier III drugs (non-preferred brands)</td>
<td>$80/retail order $160/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier IV drugs (Specialty drugs)</td>
<td>20% coinsurance up to $250 per prescription after prescription drug deductible</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>20% coinsurance Deductible does not apply</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>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In network Provider (You will pay the least)</td>
<td>Out of Network Provider (You will pay the most)</td>
</tr>
</tbody>
</table>
| If you need immediate medical attention | Physician/surgeon fees       | 20% coinsurance  
Deductible does not apply                                                | Not covered                                           |                                                        |
|                                      | Emergency room care          | Facility - $350/visit  
Deductible does not apply  
Physician – No charge  
Deductible does not apply | Facility - $350/visit  
Deductible does not apply  
Physician – No charge  
Deductible does not apply | Copays not required if admitted as an inpatient. |
|                                      | Emergency medical transportation | $250/transport                                                                 | $250/transport                                         |                                                        |
|                                      | Urgent care                  | $40/visit  
Deductible does not apply                                               | $40/visit  
Deductible does not apply                                    |                                                        |
| If you have a hospital stay          | Facility fee (e.g., hospital room) | 20% coinsurance  
Deductible does not apply                                                | Not covered                                           | Requires prior authorization. |
|                                      | Physician/surgeon fees        | 20% coinsurance  
Deductible does not apply                                                | Not covered                                           |                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services          | Office visit: $40/visit  
Deductible does not apply  
Other than office visit: No charge | Not covered                                           | Prior authorization required except for office visits. Each group therapy session requires only one half of a private office visit copayment. |
|                                      | Inpatient services           | Facility: 20% coinsurance  
Physician: 20% coinsurance  
Deductible does not apply                                               | Not covered                                           | Requires prior authorization. |
| If you are pregnant                  | Office visits                | Prenatal - No charge  
Deductible does not apply  
Postnatal - $40/visit  
Deductible does not apply                                               | Not covered                                           |                                                        |
|                                      | Childbirth/delivery professional services | 20% coinsurance  
Deductible does not apply                                                | Not covered                                           | Coverage includes abortion services. |

* 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>In network 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>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Coverage includes abortion services.</td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>$45/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Limited to 100 visits each calendar year. Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$40/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$40/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
<td></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).

**Your Grievance and Appeals Rights:**

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
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 ninya 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): Dine'ehgo shika a't'ohwol ninisingo, kwiijigo 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</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 prenatal 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>
<tr>
<td>The <strong>plan’s overall deductible</strong> $2,500</td>
<td>The <strong>plan’s overall deductible</strong> $2,500</td>
<td>The <strong>plan’s overall deductible</strong> $2,500</td>
</tr>
<tr>
<td>Specialist copayment $80</td>
<td>Specialist copayment $80</td>
<td>Specialist copayment $80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
</tr>
<tr>
<td>Other copayment $40</td>
<td>Other copayment $40</td>
<td>Other copayment $40</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>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
<td>$200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
<td>$2,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,300</td>
<td>$300</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Peg would pay is **$5,660**

<table>
<thead>
<tr>
<th>The plan’s overall deductible $2,500</th>
<th>The plan’s overall deductible $2,500</th>
<th>The plan’s overall deductible $2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist copayment $80</td>
<td>Specialist copayment $80</td>
<td>Specialist copayment $80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
</tr>
<tr>
<td>Other copayment $40</td>
<td>Other copayment $40</td>
<td>Other copayment $40</td>
</tr>
</tbody>
</table>

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>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
<td>$20</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Joe would pay is **$2,760**

<table>
<thead>
<tr>
<th>The plan’s overall deductible $2,500</th>
<th>The plan’s overall deductible $2,500</th>
<th>The plan’s overall deductible $2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist copayment $80</td>
<td>Specialist copayment $80</td>
<td>Specialist copayment $80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
<td>Hospital (facility) coinsurance 20%</td>
</tr>
<tr>
<td>Other copayment $40</td>
<td>Other copayment $40</td>
<td>Other copayment $40</td>
</tr>
</tbody>
</table>

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>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
<td>$60</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$20</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Mia would pay is **$1,520**

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).

English

Arabic

Armenian
Անվանը երիտասարդի ծանրամարտությունները պարագայում են հայրերի կողմից՝ թույլ տալով հայերի նկատմամբ հարցերի ուղարկումը. Բացի այդ, առաջին քայլով կուրսավորումը կարելի է ներկայացնել գլխավոր հայերի համար լուծելու համար. Ինչպես Individual & Family Plan (IFP) Off Exchange 1-800-839-2172 համար 1-888-926-4988 (TTY: 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件念給您朗請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您的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）。您可使用加州保險市場，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 एक दुसरे भाषाओं को अपनी भाषा में पढ़ता सकते हैं। आप दस्तावेज को अपनी भाषा में पढ़ता सकते हैं। ग्राहक के लिए, अपने आईडी कार्ड से दिये गए नंबर पर ग्राहक सेवा केन्द्र को कॉल करने या व्यक्तिगत और नामांकित व्यक्ति (आईडी कार्ड) ओफ एयरवेज: 1-800-839-2172 (TTY: 711) पर कॉल करें। केलिफोर्निया बाजार के लिए, एयरवेज़ ऑफ एयरवेज: 1-888-926-4988 (TTY: 711) या स्थानीय विनियम 1-888-926-5133 (TTY: 711) पर कॉल करें। हेलेन नेट के ग्राहक के लिए एयरवेज़ के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Japanese

Khem
نهائيความเสียหายภัยพิบัติ ถ้ามีระบบการรับประกันวุฒิการ์ภัยพิบัติ ถ้ามีระบบการรับประกันภัยพิบัติ On Exchange ปรากฏตามข้อมูล (IFP) กรณีแบบ: 1-800-839-2172 (TTY: 711)’

Korean

Navajo

Persian (Farsi)
**Panjabi (Punjabi)**

ہیں؟ دیاں ہیں ہدایات کی ضروریات بھی مدد کرتے ہیں۔ بچوں کی خصوصیات کی سمتی راہ جاتے ہیں۔ بچوں کی خصوصیات کی سمتی راہ جاتے ہیں۔ بچوں کی خصوصیات کی سمتی راہ جاتے ہیں۔ بچوں کی خصوصیات کی سمتی راہ جاتے ہیں۔ بچوں کی خصوصیات کی سمتی راہ جاتے ہیں۔ بچوں کی خصوصیات کی سمتی راہ جاتے ہیں。

**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**

ไม่มีค่าบริการสำหรับภาษา คุณสามารถใช้ตามได้ คุณสามารถให้ข้อมูลการให้ฟังในภาษาของคุณได้ หากคุณต้องการความช่วยเหลือ โปรดสำหรับภาษาฝรั่งเศสที่แผนที่สัมพันธ์ประจำองค์กร หรือสำหรับแผนบุคคลและครอบครัวขององค์กร (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (TTY: 711) สำหรับแผนกลุ่มของทรัพย์ สินวางแผนบุคคลและครอบครัวขององค์กร (IFP On Exchange) ที่ 1-888-926-4988 (TTY: 711) หรือ สำหรับแผนกลุ่มขององค์กร (Small Business) ที่ 1-888-926-5133 (TTY: 711) สำหรับแผนกลุ่มของทรัพย์ สินวางแผนบุคคลและครอบครัวขององค์กร (IFP On Exchange) ที่ 1-888-926-4988 (TTY: 711) หรือ สำหรับแผนกลุ่มขององค์กร (Small Business) ที่ 1-888-926-5133 (TTY: 711) สำหรับแผนกลุ่มของทรัพย์ สินวางแผนบุคคลและครอบครัวขององค์กร (IFP On Exchange) ที่ 1-888-926-4988 (TTY: 711) หรือ สำหรับแผนกลุ่มขององค์กร (Small Business) ที่ 1-888-926-5133 (TTY: 711)
Việtnamese

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