### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$2,500 per person / $5,000 per family 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 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, physician office visits, x-ray, imaging, emergency room, urgent care, home health visits, durable medical equipment, lab tests, hospice, outpatient rehabilitation &amp; habilitation, outpatient surgery, outpatient mental health &amp; substance use disorder services; and pediatric dental and vision 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. Preferred pharmacy deductible $200 per person / $400 per family per calendar year. Pharmacy deductible applies to tiers 1-4. 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>For preferred providers $7,550 per person / $15,100 per family. For out-of-network providers $25,000 per person / $50,000 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 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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billing charges, penalties for non-certification and healthcare 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/findadoctor">www.myhealthnetca.com/findadoctor</a> or call 1-888-926-4988.</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 provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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/eoc/ec/ppo/silver70iex](http://www.healthnet.com/2019/eoc/ec/ppo/silver70iex) 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/](https://www.healthcare.gov/sbc-glossary/) or [www.myhealthnetca.com](http://www.myhealthnetca.com) or you can call 1-888-926-4988 to request a copy. In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Services (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost sharing means copayments, including coinsurance and deductibles.
### Filling in the Chart

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Preferred Provider (You will pay the least): $40/visit deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Preferred Provider (You will pay the least): $80/visit deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 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-$35/visit deductible does not apply X-ray-$75/visit deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Preferred Provider (You will pay the least): $300/procedure deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 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>Preferred Provider (You will pay the least): $15/retail order $30/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic and preferred brand drugs (tier 2)</td>
<td>Preferred Provider (You will pay the least): $55/retail order $110/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (tier 3)</td>
<td>Preferred Provider (You will pay the least): $80/retail order $160/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (tier 4)</td>
<td>Specialty Provider (You will pay the least): 20% coinsurance up to $250 per prescription after pharmacy deductible has been met</td>
<td>Not covered</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

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SBC_SVR_70_IFP_EC_PPO_AI_AN_2019

FCF_NO_YPU_BGD
<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>20% coinsurance deductible does not apply</td>
<td>50% coinsurance after deductible has been met</td>
<td>Some outpatient surgical procedures require certification 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>Physician/surgeon fees</td>
<td>20% coinsurance deductible does not apply</td>
<td>50% coinsurance after deductible has been met</td>
<td>Some outpatient surgical procedures require certification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><em>Emergency room care</em></td>
<td>Facility fee-$350/visit deductible does not apply</td>
<td>Facility fee-$350/visit deductible does not apply</td>
<td>Copayment waived if admitted into the hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$250/transport</td>
<td>$250/transport</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40/visit deductible does not apply</td>
<td>50% coinsurance after deductible has been met</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% 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>20% coinsurance deductible may apply</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 – no charge</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>Facility: 20% coinsurance Physician: 20% coinsurance deductible may apply</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>20% coinsurance deductible may apply</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>20% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Coverage includes abortion services.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>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 need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$45/visit deductible does not apply</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 each calendar year). Certification is required for some services or a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40/visit deductible does not apply</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>$40/visit deductible does not apply</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>20% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>If certification is not obtained a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance deductible does not apply</td>
<td>Diabetic equipment (including footwear) and prosthesis only - 50% coinsurance after deductible has been met</td>
<td>Orthotics, corrective footwear and all other durable medical equipment are not covered out-of-network. If certification is not obtained a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>50% coinsurance after deductible has been met</td>
<td>If certification is not obtained a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</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>No charge</td>
<td>Not covered</td>
<td>Provider selected frames; 1 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to 1 check-up every 6 months.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

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

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Infertility services</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture (covered when medically necessary)</td>
</tr>
<tr>
<td>• Bariatric surgery (covered through the preferred provider network if medically necessary)</td>
</tr>
<tr>
<td>• Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)</td>
</tr>
</tbody>
</table>
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 (EBSA (3272) or www.dol.gov/ebsa/heathreform. 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): Dinek'ehgo shika a't'ohwol ninisingo, kwijjigo holne’ 1-888-926-4988.

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

SBC_SVR_70_IFP_EC_PPO_AI_AN_2019
**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.

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**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $2,500
- **Specialist copayment**: $80
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:  
- **Cost Sharing**
  - Deductibles: $2,500  
  - Copayments: $1,900  
  - Coinsurance: $1,800

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

The total Peg would pay is **$6,260**

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

---

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

- **The plan’s overall deductible**: $2,500
- **Specialist copayment**: $80
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
</table>

In this example, Joe would pay:  
- **Cost Sharing**
  - Deductibles: $200  
  - Copayments: $2,300  
  - Coinsurance: $300

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

The total Joe would pay is **$2,860**

---

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

- **The plan’s overall deductible**: $2,500
- **Specialist copayment**: $80
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

This EXAMPLE event includes services like:  
- Emergency room care (including medical supplies)  
- Diagnostic test (x-ray)  
- Durable medical equipment (crutches)  
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,500</th>
</tr>
</thead>
</table>

In this example, Mia would pay:  
- **Cost Sharing**
  - Deductibles: $300  
  - Copayments: $1,500  
  - Coinsurance: $20

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

The total Mia would pay is **$1,820**

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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
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call
Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace,
call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711).
For Group plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكنني أن نوفر لك مترجمًا مجانًا. ويمكننا أن نقرأ لك الوثائق باللغة العربية. للحصول على المساعدة اللازمة، برجي التواصل مع مركز خدمات اللغة عبر الرقم المبين على بطاقتك أو الاتصال بالرقم المحسب للخدمة الأتراك والعائلة: 1-800-839-2172 (TTY: 711).
(1-888-926-4988 (TTY: 711).)
للتواصل في كاليفورنيا، برجي الاتصال بالرقم المبين للخدمة الأتراك والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711).
(1-888-926-5133 (TTY: 711).)
(1-800-522-0088 (TTY: 711).)
(1-888-926-4988 (TTY: 711).)
Health Net

Armenian
Անաղավանք կարողանան հանրապետության տեղեկագրությունները բացառել են այլ լեզուներ։
Գաղտեկան համակարգերի սարքավորման հետ էելուստրացիան, միջնական և մեծ դրամաշնորհները
հատուկ համակարգերի շրջանակներով հետևում է օգտակար հանրանշանները
Individual & Family Plan (IFP) Off Exchange 1-800-839-2172 (TTY: 711):
1-888-926-4988 (TTY: 711) կամ Փարիս փոխադարձ համակարգեր
1-888-926-5133 (TTY: 711): Health Net-ի Մանկական ընդունումների համակարգ
1-800-522-0088 (TTY: 711).

Chinese
免费语言服务。您可使用口译员服务。您可请人将文件读给您听并请我们将其翻译成您所使用的语言带给您。如需协助，请拨打会员卡上的电话号码与客户服务中心联络或者拨打健康保险交易市场外的
Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，
請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
बिना शुल्क भाषा सेवाएँ। आप को एक दुसरी भाषा पर मान्यता कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पता लगाने सकते हैं। नीचे के लिए, अपने ऑटोमेटेड कार्ड में दिए गए नंबर पर गाइड सेवा केंड्र को कॉल करें या व्यक्तिगत और फैक्सिल हैल (एडवार्ड) ऑफ एस्सर्वेज: 1-800-839-2172 (TTY: 711) पर कॉल करें। केलिफोर्निया वासंके के लिए, ऑटोमेटेड ऑफ एस्सर्वेज 1-888-926-4988 (TTY: 711) या स्मार्टनब स्मार्टनब
1-888-926-5133 (TTY: 711) पर कॉल करें। हेलथ नेट के गाइडेंस से गुप्त हैल के लिए
1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsii Muaj Tus Ngi Pab Txbais Lus. Koj tuaj yeem tau txaes ib tus kws pab txbais hais. Koj tuaj yeem muaj ib
kus neeg nyesem cov ntaub ntawv rau koj ta koj hom hais. Txbawm rau pab, hoxvooj rau Neeg Qhua Lub
Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npaw ID lossis hau rau Tus Neeg thiab Tsev Neeg Qhov
Kev Npaj (IFP) Ntawm Kev Sib Hloow Pauv 1-800-839-2172 (TTY: 711). Rau California ghov chaw khab
khw, hau rau IFP Ntawm Qhov Sib Hloow Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luaa Me
1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hau rau
1-800-522-0088 (TTY: 711).
Japanese

Khmer
ព័ត៌នាគ្រប់គ្រងជីវិតស្ថាបនានីយ៍ ដែលអាចការពារប្រព័ះជាច្រើនជនជាតិប្រទេសប្រមូលឈ្មោះជាក្រុមប្រឹក្សាមកម្ពស់ គឺជាក្រុមប្រឹក្សាមកម្ពស់នូវការពារជាអ្នកឃើញតែប្រយោគយឺតផ្នែកហេតុអាជីវកម្ម ប្រព័ះជាច្រើនជនជាតិប្រទេស។ ព័ត៌នាគ្រប់គ្រងជីវិតស្ថាបនានីយ៍ ដែលអាចការពារប្រព័ះជាច្រើនជនជាតិប្រមូលឈ្មោះជាក្រុមប្រឹក្សាមកម្ពស់ Off Exchange ប្រព័ះជាច្រើនជនជាតិប្រមូលឈ្មោះជាក្រុមប្រឹក្សាមកម្ពស់ California ឬគ្រប់គ្រងជីវិតស្ថាបនានីយ៍ On Exchange ការសែនពីរដែល IPF ការសែនពីរ 1-888-926-4988 (TTY: 711) ្ណឹងស្តើងប្រព័ះជាច្រើនជនជាតិប្រមូលឈ្មោះជាក្រុម IPF ការសែនពីរ 1-888-926-5133 (TTY: 711) ្ណឹងស្តើងប្រព័ះជាច្រើនជនជាតិប្រមូលឈ្មោះជាក្រុម Health Net ឬគ្រប់គ្រងជីវិតស្ថាបនានីយ៍ជាក្រុម IPF ការសែនពីរ 1-800-522-0088 (TTY: 711)។

Korean

Navajo

Persian (Farsi)
Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей
(IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните
в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по
телéfono 1-888-926-4988 (TTY: 711) или в отдельные планы для малого бизнеса (Small Business)
по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через

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
Walang Bayad na Mga Serbisyo sa Wika. Makakakna kayo ng interpreter. Makakakna kayo ng mga
dokumento na babasahin sa inyo sa inyong wika. Para sa nilong, tumawag sa Customer Contact Center sa
numerong nasa ID card niyong o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pamamiliya

Thai
ไม่มีค่าบริการสำหรับภาษา คุณสามารถใช้สำหรับได้ คุณสามารถให้คำแนะนำได้แก่เป็นภาษาของคุณได้ หากต้องการความช่วย
เหลือ โปรดติดต่อผู้ให้บริการที่พักพิงที่เหมาะสม ซึ่งรูปแบบนี้มีอยู่ในแผนประกันการเงินส่วนบุคคล
และครอบครัวของคุณ (Individual & Family Plan, IFP) 1-800-839-2172 (TTY: 711) สำหรับแผนประกันทรัพย์สิน
ในรูปแบบของคุณและครอบครัวของคุณ (IFP On Exchange) ได้ที่ 1-888-926-4988 (TTY: 711) หรือ สำหรับแผนประกัน
สำหรับผู้ประกอบการของคุณ (Small Business) ได้ที่ 1-888-926-5133 (TTY: 711) สำหรับแผนแบบกลุ่มสำหรับ Health Net โทร
1-800-522-0088 (TTY: 711)
Việtnamese

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