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 1-800-522-0088. 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 1-800-522-0088 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>$650 per member / $1,300 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. $50 per member / $100 per family per calendar year for non-preferred generics, preferred and non-preferred brand and specialty prescription drugs (waived for tier 1 generic and preferred brand). 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. $2,600 per member / $5,200 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 1-800-522-0088.</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><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>In network Provider (You will pay the least) $15/visit Deductible does not apply</td>
<td>Out of Network Provider (You will pay the most)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$25/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab - $15/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Requires referral.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100/procedure Deductible does not apply</td>
<td></td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.MyHealthNetCA.com">www.MyHealthNetCA.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier I drugs (most generic and low cost preferred brands)</td>
<td>$5/retail order $10/mail order Deductible does not apply</td>
<td>Not covered</td>
<td>Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. Deductible required for non-preferred generics, preferred and non-preferred brand drugs $50 per member / $100 per family (waived for tier 1 generic and preferred brand).</td>
</tr>
<tr>
<td>Tier II drugs (non-preferred generics and preferred brands)</td>
<td>$20/retail order $40/mail order</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier III drugs (non-preferred brands)</td>
<td>$35/retail order $70/mail order</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier IV drugs (Specialty drugs)</td>
<td>15% coinsurance up to $150 per prescription after prescription drug deductible</td>
<td>Not covered</td>
<td>Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30 day supply filled by specialty pharmacy. Deductible required $50 per member / $100 per family.</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>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% coinsurance  Deductible does not apply</td>
<td>Not covered  Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance  Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Facility - $100/visit  Deductible does not apply</td>
<td>Facility - $100/visit  Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$75/transport</td>
<td>$75/transport</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15/visit  Deductible does not apply</td>
<td>$15/visit  Deductible does not apply</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>15% coinsurance</td>
<td>Not covered  Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance  Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office - $15/visit  Deductible does not apply</td>
<td>Not covered  Prior authorization required except for office visits.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Facility: 15% coinsurance  Physician – 15% coinsurance  Deductible does not apply</td>
<td>Not covered  Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Prenatal - No charge  Postnatal - $15/visit  Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance  Deductible does not apply</td>
<td>Not covered  Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>Not covered  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
<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>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>$15/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Limited to 100 visits each calendar year. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$15/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$15/visit Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>15% coinsurance Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>15% coinsurance Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</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>————none———</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 1-800-522-0088. 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 1-800-522-0088, 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.

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 a’ohwol ninisingo, kwiijigo holne’ 1-800-522-0088.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* 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 prenatal care and a hospital delivery)

- **The plan’s overall deductible** $650
- **Specialist copayment** $25
- **Hospital (facility) coinsurance** 15%
- **Other copayment** $15

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$650</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $50

**The total Peg would pay is** $2,500

---

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

- **The plan’s overall deductible** $650
- **Specialist copayment** $25
- **Hospital (facility) coinsurance** 15%
- **Other copayment** $15

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$50</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

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

**The total Joe would pay is** $1,210

---

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

- **The plan’s overall deductible** $650
- **Specialist copayment** $25
- **Hospital (facility) coinsurance** 15%
- **Other copayment** $15

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$30</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is** $540

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 1-888-926-4998 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711).
For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكنك أن تتوفر لك مترجم في أي وقت. ونستطيع أن نقرأ لك النصوص بالأحرف المكعبة. للحصول على المساعدة اللازمة، يرجى الاتصال فالمركز للخدمة عبر الرقم المحمول أو الاتصال بغرفة المكالة عبر الرقم المحمول: 1-800-839-2172 (TTY: 711) أو 1-888-926-4998 (TTY: 711) أو 1-888-926-5133 (TTY: 711).

Armenian
Արդյունավետ էր թարգմանիչի ծառայությունները, սակայն զիջեց դիմելով պաշտպանի կողմից:
Փաստաթուղթը փորձում է համարվել, որ դարձի փաստաթուղթը թարգմանչի կողմից:
Անհրաժեշտ էր կապվել ի հայտ նշված էր հեռախոսը համարվում:
Phon numbers:
Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 հեռախոսահամարի համար (TTY: 711);
Individual & Family Plan (IFP) On Exchange: 1-888-926-4998 հեռախոսահամարի համար (TTY: 711) կամ Փաստաթուղթի համար
1-888-926-5133 հեռախոսահամարի համար (TTY: 711); Health Net-ի համար թարգմիչի ընտրությունը համար
1-800-522-0088 հեռախոսահամարի համար (TTY: 711);

Chinese
免费语言服务。您可以使用口译服务。请向我们致电并要求我们将某些文件翻译成您的语言
寄给您。如需协助，请拨打您会员卡上的电话号码与客户服务中心联系或者拨打健康保险交易市场外
的 Individual & Family Plan (IFP) 小组：1-800-839-2172（听障专线：711）。如为加州保险交易市场，
请拨打健康保险交易市场的 IFP 小组：1-888-926-4998（听障专线：711），小型企业则请拨打
1-888-926-5133（听障专线：711）。如为透过 Health Net 取得的回答，拨打
1-800-522-0088（听障专线：711）。

Hindi
विना शुल्क भाषा सेवाएं। आप को एक दुसरे की प्रारंभी भाषा कर सकते हैं। आप दस्तावेज को अपनी भाषा में पहले से स्थल रखने के लिए, आपके आईडी कार्ड में दिया गया नंबर पर ग्राहक सेवा केंद्र को कॉल करने का यह व्यापक अनुमान और फैशनियॉन (आईएसपी) ओपन एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजार के लिए, आईएसपी ऑन एक्सचेंज: 1-888-926-4998 (TTY: 711) या स्कॉल विभाग
1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के ग्राहक के स्थल पर फ्लॉपले के लिए
1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Ngi Pab Tkhais Lus. Koj tuaj yeem tau txais ib tus kws pab tkhais hus. Koj tuaj yeem muaj ib
kus neeg nyes cov ntaub ntauw rau koj ua koj hom hus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub
Chaw Tiv Toj ntwmn tus npawb nyob ntauw koj daim npaw ID llossi hu rau Tus Neeg thiab Tsev Neeg Qhov
khuv, hu rau IFP Ntawm Qhov Sib Hlouo Pauv 1-888-926-4998 (TTY: 711) lossis Lag Luan Me
1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau
1-800-522-0088 (TTY: 711).
Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みされる場合
も可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP)（個人・家族向けプラン）
Off Exchange: 1-800-839-2172 (TTY: 711) までお電話ください。カリフォルニア州のマーケット
プレイスについては、IFP On Exchange 1-888-926-4988 (TTY: 711) または Small Business
1-888-926-5133 (TTY: 711) までお電話ください。Health Netによるグループプランについては、
1-800-522-0088 (TTY: 711) までお電話ください。

Khmer
ណេសគ្រូបាវបញ្ចូលខ្មែរបើប្រាប់ការអភិវឌ្ឍន៍ប្រការប្រការដែលបានប្រការប្រការហើយ
ផ្សេងៗក្នុងប្រជាជនរដ្ឋក្រុងបារាំង។ អ្នកអានឬអ្នកអាចប្រើប្រាស់ប្រព័ន្ធផ្សារព័ន្ធទូរសិរឱ្យ
ដោយជំរុញនូវអាសយដ្រូនីយ៍នៃពាន់ធានា Off Exchange
របស់អ្នកនៅរដ្ឋបាទក្នុងប្រការប្រការ (IFP) ការដាកឹង: 1-800-839-2172 (TTY: 711)។
អ្នកនៅរដ្ឋបាទក្នុងប្រការប្រការ California អ្នកអានឬអ្នកអាចប្រើប្រាស់ប្រព័ន្ធទូរសិរឱ្យ
របស់អ្នក Off Exchange 1-888-926-4988 (TTY: 711) អ្នកអានឬអ្នកអាចប្រើប្រាស់ប្រព័ន្ធទូរសិរឱ្យ
របស់អ្នក On Exchange 1-888-926-5133 (TTY: 711)។

Korean
루로 만드는 서비스입니다. 동력 서비스를 받으실 수 있습니다. 문서 납북 서비스를 받으실 수 있으며
일부 서비스는 귀하가 사용하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에서 수록된 번호로
고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange:
1-800-839-2172(TTY:711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우
IFP On Exchange 1-888-926-4988(TTY:711), 소규모 비즈니스의 경우 1-888-926-5133(TTY:711)번으로
전화해 주십시오. Health Net를 통한 그룹 플랜의 경우 1-800-522-0088(TTY:711)번으로 전화해
주십시오.

Navajo
Doo bągh illingdíí saad bee hákká ada’iiyéed. Ata’ hálíne’ií da la’ ná háádiído’ot’íí. Naaltsos da t’áá
shi shízaad k’éhjí shich’éí yidooltah nízíínigo t’áá ná áko’doolníí. Akót’éego shíká a’doowoi nízííngo
Customer Contact Center hoolyéhjíí hoolyéhjíí nízííngí naaltsos naa nízííngí bée néého’dozíígangi hodoonhíí’
California marketplace bághíí kojí’hóléne IFP On Exchange 1-888-926-4988 (TTY: 711) éí doodago
Small Business bághíí kojí’hóléne’-888-926-5133 (TTY: 711). Group Plans through Health Net bághíí éí
kojí’hóléne’-1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید که متخم شفاهی بگیرید. می توانید در خواست کنید اسناد به زبان سما برایتان خواهد شد. من برای
دریافت کمک، با مرکز خدمات مشتریان به شماره روز مکارت شناسی با طرح فردی و خدماتی شماره 1-888-926-4988 (TTY: 711)
(IFP) Off Exchange (TTM: 711) 1-800-839-2172 (TTY: 711) ماموریت کارکردنی نیست. برای طرح های گروهی از طریق
پلان ارائه (TTM: 711) 1-800-522-0088 (TTY: 711).

Health Net
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

Vietnamese

CA Commercial DMHC On and Off-Exchange Member Notice of Language Assistance
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