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/po/gold80ix or call 1-888-926-4988. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or www.myhealthnetca.com or you can call 1-888-926-4988 to request a copy.

### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall **deductible**? | $0 through the preferred provider network. $5,000 per person / $10,000 per family for out-of-network providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your **deductible**? | There is no deductible through the preferred provider network. | There is no deductible through the preferred provider network. You will however have to meet the out-of-network deductible before the plan pays for any out-of-network services (except for emergency services).
Are there other **deductibles** for specific services? | No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the **out-of-pocket limit** for this plan? | For preferred providers $7,200 per person / $14,400 per family. For out-of-network providers $25,000 per person / $50,000 per family per calendar year. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the **out-of-pocket limit**? | Premiums, balance billing charges, penalties for non-certification and healthcare this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Will you pay less if you use a **network provider**? | Yes. For a list of preferred providers, see www.myhealthnetca.com/findadoctor or call 1-888-926-4988. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a **specialist**? | No. | You can see the specialist you choose without a referral.
<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) $30/visit</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$55/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></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab-$35/visit X-ray-$55/visit</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Preferred generic drugs (tier 1)</td>
<td>$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>$55/retail order $110/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (tier 3)</td>
<td>$75/retail order $150/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (tier 4)</td>
<td>20% coinsurance up to $250 per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

* 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 immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Facility-$325/visit Professional services-No charge</td>
<td>Facility-$325/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>$250/transport</td>
<td>$250/transport deductible does not apply</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></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</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><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office visit - No charge Other than office visit-20% coinsurance up to $30</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>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><strong>If you are pregnant</strong></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</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)
## Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Service</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>Home health care</td>
<td>20% coinsurance</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>Rehabilitation services</td>
<td>$30/visit</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$30/visit</td>
<td>Not covered</td>
<td>If certification is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<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>Durable medical equipment</td>
<td>20% coinsurance</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>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>
</tbody>
</table>

### If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Service</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>
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</thead>
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<tr>
<td>Home health care</td>
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<td>50% coinsurance after deductible has been met</td>
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<tr>
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<td>20% coinsurance</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>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>
</tbody>
</table>

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</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>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

**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](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:**
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](http://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](http://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](http://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 at’ohwol ninesisgo, kwiijigo holne’ 1-888-926-4988.

*For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com).*
### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

#### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan’s overall deductible** is **$0**
- **Specialist copayment** is **$55**
- **Hospital (facility) coinsurance** is **20%**
- **Other coinsurance** is **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)

**Total Example Cost** = **$12,800**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
<td>$1,800</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$60</td>
</tr>
</tbody>
</table>

The **total Peg would pay** is **$3,060**

#### Managing Joe’s type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan’s overall deductible** is **$0**
- **Specialist copayment** is **$55**
- **Hospital (facility) coinsurance** is **20%**
- **Other coinsurance** is **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)

**Total Example Cost** = **$7,400**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,100</td>
<td>$2,100</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$60</td>
</tr>
</tbody>
</table>

The **total Joe would pay** is **$2,460**

#### Mia’s Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan’s overall deductible** is **$0**
- **Specialist copayment** is **$55**
- **Hospital (facility) coinsurance** is **20%**
- **Other coinsurance** is **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)

**Total Example Cost** = **$2,500**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,300</td>
<td>$1,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$330</td>
<td>$330</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$60</td>
</tr>
</tbody>
</table>

The **total Mia would pay** is **$1,320**

---

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.jsp, 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

Armenian

Chinese
免费语言服务。您可使用口译员服务。您可请人将文件给您并请我们将其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联络中心联络或者拨打健康保险交易所外的 Individual & Family Plan (IFP) 專线：1-800-839-2172（聽障專線：711）。如為加州保險交易所，請拨打健康保险交易所的 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，請拨打 1-800-522-0088（聽障專線：711）。

Hindi
यह शुल्क मुफ्त सेवा है। आप एक दुसरे से आप को कह सकते हैं। आप दस्तावेज को अपनी भाषा में पढ़ा सकते हैं। रूप लिखके, आपने एडवर्ड कार्ड में दिया गया नंबर पर गाइड सेवा केंद्र को कॉल करें और वह आपकी फॉर्म में आरोपित और फॉलियो ला जाए। (यदि एडवर्ड कार्ड में) 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया गांवों के लिए, एडवर्ड कार्ड में एक संचालक 1-888-926-4988 (TTY: 711) या मुक्त विकल्प 1-888-926-5133 (TTY: 711) पर कॉल करें। हेलथ नेट के गांवों से मुफ्त द्वारा 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Japanese

Khmer
ការបង្ហាញយោងយោងជាមួយអ្នកអាហារឈ្មោះ។ អ្នកអាហារឈ្មោះអាកាសធាតុពីប្រទេសសហរដ្ឋអាមេរិក អាកាសធាតុពីប្រទេសការ៉ែលនើ េហ្គ៍អាកាសធាតុពីប្រទេសការ៉ែលនើ អាកាសធាតុពីប្រទេសសហរដ្ឋអាមេរិក អាកាសធាតុពីប្រទេសការ៉ែលនើ off exchange របៀបអាហារឈ្មោះប្រទេសការ៉ែលនើ (IFP) ទូរស័ព្ទ: 1-800-839-2172 (TTY: 711)។ California អាកាសធាតុពីប្រទេសសហរដ្ឋអាមេរិក on exchange របៀបអាហារឈ្មោះ IFP ទូរស័ព្ទ: 1-888-926-4988 (TTY: 711) អាហារឈ្មោះប្រទេសការ៉ែលនើ របៀបអាហារឈ្មោះ: Health Net អាហារឈ្មោះប្រទេសការ៉ែលនើ 1-800-522-0088 (TTY: 711)។

Korean

Navajo

Persian (Farsi)
Panjabi (Punjabi)

Вибачте, але ми відмовляється відповідати на цю запитання. Для того, щоб отримати поміч, будь ласка, зв'яжіться з нашим Центром, вказавши номер телефона, на який нам можна звернутися.

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

ไม่สามารถให้คำแนะนำได้ตามที่ความคิดเห็นของคุณให้คำแนะนำให้คุณเลือกตั้งข้อบังคับไม่เกี่ยวกับการเรียนรู้จากห้องสมุดหรือห้องเรียนไม่ได้ที่มากับบริการของคุณ หรือการให้คำแนะนำของคุณช่วยสร้างผลของเล็ก (Small Business) ที่ 1-888-926-5133 (TTY: 711) สำหรับแบบกลุ่มเล็กที่ Health Net โทร 1-800-522-0088 (TTY: 711)
Vietnamese

Các Dịch Vu Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu thông doc cho
giải từ liên 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

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

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