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/ecoc/ppo/platinum90 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.

<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>$0 through the preferred provider network. $5,000 per person / $10,000 per family for out-of-network providers per calendar year.</td>
<td>Generally, you must pay all of the costs from 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>There is no deductible through the preferred provider network.</td>
<td>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).</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For preferred providers $3,350 per person / $6,700 per family. For out-of-network providers $25,000 per person / $50,000 per family per calendar year.</td>
<td>The 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 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>No.</td>
<td>You can see the specialist you choose without a referral.</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>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 visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td><em><strong><strong><strong>—none</strong></strong></strong></em>__</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td><em><strong><strong><strong>—none</strong></strong></strong></em>__</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</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><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab-$15/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td><em><strong><strong><strong>—none</strong></strong></strong></em>__</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>X-ray-$30/visit</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 you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs (tier 1)</td>
<td>$5/retail order</td>
<td>Not covered</td>
<td>Supply/order: up to 30 day (retail); 90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic and preferred brand drugs (tier 2)</td>
<td>$15/retail order</td>
<td>Not covered</td>
<td>Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (tier 3)</td>
<td>$25/retail order</td>
<td>Not covered</td>
<td>Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (tier 4)</td>
<td>10% coinsurance up to $250 per prescription</td>
<td>Not covered</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><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Some outpatient surgical procedures require certification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Some outpatient surgical procedures require certification.</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>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility fee-$150/visit Professional services- No charge</td>
<td>Facility fee-$150/visit deductible does not apply Professional services- No charge</td>
<td>Copayment waived if admitted into the hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$150/transport</td>
<td>$150/transport deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>If certification is not obtained in a non-emergency a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Certification is required for a hospital stay and some services received while admitted to the hospital.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office visit - No charge Other than office visit- 10% coinsurance up to $15</td>
<td>50% coinsurance after deductible has been met</td>
<td>Certification is not required for outpatient benefits for mental health and substance use disorder diagnoses except for reconstructive surgery. If certification is required but 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>Inpatient services</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>If certification is not obtained in a non-emergency a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>50% coinsurance after deductible has been met</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
<td>Coverage includes abortion services.</td>
</tr>
</tbody>
</table>

* 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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>Diabetic equipment (including footwear) and prosthesis only-50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

- Children’s eye exam | No charge | Not covered |
- Children’s glasses | No charge | Not covered |
- Children’s dental check-up | No charge | Not covered |

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 (exclusion does not apply to preventive care behavioral interventions)

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)

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.com
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/ebia, 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/ebia/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-HELPl (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 at’ohwol ninisingo, kwijijgo holne’ 1-888-926-4988.

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 pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$900</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td><strong>$1,560</strong></td>
</tr>
</tbody>
</table>

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

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

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td><strong>The total Joe would pay is</strong></td>
<td><strong>$1,060</strong></td>
</tr>
</tbody>
</table>

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

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

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

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td><strong>The total Mia would pay is</strong></td>
<td><strong>$610</strong></td>
</tr>
</tbody>
</table>

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

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Your Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

**Health Net:**

- Provides free aids and services to people with disabilities to communicate effectively with the Health Plan, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net’s Customer Contact Center at:

**Individual & Family Plan (IFP) Members On Exchange/Covered California** 1-888-926-4988 (TTY: 711)

**Individual & Family Plan (IFP) Members Off Exchange** 1-800-839-2172 (TTY: 711)

**Individual & Family Plan (IFP) Applicants** 1-877-609-8711 (TTY: 711)

**Group Plans through Health Net** 1-800-522-0088 (TTY: 711)

If you believe that Your Health Plan has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Your Health Plan and telling them you need help filing a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348
Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

English
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
(1-888-926-4988 (TTY: 711))
(1-888-926-5133 (TTY: 711))
(1-800-522-0088 (TTY: 711))

Armenian
Անվանական ծրագրերի պատմականություններն են սկսվում հնարավորություն խթանել նախատեսված պատմական ծրագրերի պատմականություններից են սկսվում հնարավորություն խթանել նախատեսված պատմական ծրագրերի պատմականություններից են սկսվում հնարավորություն խթանել նախատեսված պատմական ծրագրերի պատմականություններից են սկսվում հնարավորություն խթանել նախատեսված պատմական ծրագրերի պատմականություն
individual & family plan (IFP) off exchange: 1-800-839-2172 hmrnuhunuhuwnyn (TTY: 711)
1-888-926-4988 hmrnuhunuhuwnyn (TTY: 711)
1-888-926-5133 hmrnuhunuhuwnyn (TTY: 711)
Health Net-ի Մասնիկ զարգացման ծրագրերի պատմական հնարավորություն 1-800-522-0088 hmrnuhunuhuwnyn (TTY: 711)

Chinese
免费语言服务。您可使用口译员服务。您可请人将文件给您您和请我们将某些文件翻译成您的语言寄给您。如有合作，您可拨打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市场的Individual & Family Plan (IFP) 小线：1-800-839-2172（听障专线：711）。如为加州保险交易市场，您可拨打健康保险交易市场的 IFP 小线 1-888-926-4988（听障专线：711），小型企业则可拨打 1-888-926-5133（听障专线：711）。如为通过 Health Net 取得的保险计划，您可拨打 1-800-522-0088（听障专线：711）。

Hindi
बिना शुल्क भाषा सेवा। आपके एक दुसरे को अपनी भाषा में पढ़ावा सकते हैं। आप दस्तावेज को अपनी भाषा में पढ़ावा सकते हैं। बच्चों के लिए, अपने आईडी कार्ड में दिए गए नंबर पर गाइड सेवा केंड को कल करें या व्यक्तिगत और फैक्सिल तलाश (आईपीएन) ऑफ एस्पेनेज 1-800-839-2172 (TTY: 711) पर कल करें। नेटफोर्डिन वाणिज्य के लिए, आईपीएन ऑफ एस्पेनेज 1-888-926-4988 (TTY: 711) या नेटवर्क वाणिज्ञात 1-888-926-5133 (TTY: 711) पर कल करें। हेलेन नेट के प्रयोग से गुप्त तलाश के लिए 1-800-522-0088 (TTY: 711) पर कल करें।

Hmong
Japanese

Japanese

無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP) (個人・家族向けプラン)

Khmer

Khmer

ស្នេហានិងបង្ហាញព័ត៌មាននេះនិងបង្ហាញព័ត៌មានប្រកួតប្រជែងជាបញ្ហារបស់អ្នកបានស្តីបាន 
ក្នុងប្រកួតប្រជែងនេះអ្នកអាចប្រកួតប្រជែងជាពាក្យនេះបាន។ On Exchange 1-800-839-2172 (TTY: 711) ។ 
California On Exchange 1-888-926-4988 (TTY: 711) ។ Small Business 1-888-926-5133 (TTY: 711) ។ 
Health Net 1-800-522-0088 (TTY: 711) ។

Korean

Korean


Navajo

Navajo


Persian (Farsi)

Persian (Farsi)

Panjabi (Punjabi)

Բուհի են ենած երեզմ ընդհանուր է մեր ինչն սուր են են կամ ամուսն են հան ընկեղ. տուրքի երեզմ է մեր ինչն սուր են ամուսն են հան ընկեղ. տուրքի երեզմ է մեր ինչն սուր են ամուսն են հան ընկեղ.

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

ไม่มีการบริการด้านภาษา คุณสามารถใช้ด้านภาษาได้ คุณสามารถให้คำแนะนำให้พร้อมการขอคุณได้ที่咤ฉันฟังการมีสถานะ เช่น โรทฟ้าเรื้ออยู่ดีภาษาไทยได้ที่มาแล้วละงานประเภทของคน และหรือการนำแผนผังผู้เข้าร่วมระบบการขอคุณ (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทร TTY: 711) สำหรับของบุคคลพิพิธภัณฑ์ (Small Business) ที่ 1-888-926-5133 (โทร TTY: 711) สำหรับแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทร TTY: 711)
Vietnamese

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