The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myhealthnetca.com or call 1-800-839-2172. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or www.myhealthnetca.com or you can call 1-800-839-2172 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any 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>$0.</td>
<td>Not Applicable.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of preferred providers, see <a href="http://www.myhealthnetca.com">www.myhealthnetca.com</a> or call 1-800-839-2172.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes. Requires written prior authorization.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>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 visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>Not covered</td>
<td>———none———none———</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>———none———none———</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires referral.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier I drugs (most generic and low cost preferred brands)</td>
<td>No charge</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.</td>
</tr>
<tr>
<td></td>
<td>Tier II drugs (non-preferred generics and preferred brands)</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier III drugs (non-preferred brands)</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier IV drugs (Specialty drugs)</td>
<td>No charge</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.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>———none———none———</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>In-network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge</td>
<td>No charge</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Outpatient services</td>
<td>Office visit: No charge</td>
<td>Other than office visit: No charge</td>
<td>Prior authorization required except for office visits.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Office visits</td>
<td>Prenatal - No charge</td>
<td>Postnatal - No charge</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to 100 visits each calendar year. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</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>

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
Excluded Services & Other Covered Services:
Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Routine eye care (Adult)

Your Rights to Continue Coverage:
Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit Fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-800-839-2172. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, 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 1-800-839-2172, submit a grievance form through www.myhealthnetca.com, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444 (EBSA 3272) or www.dol.gov/ebsa/healthreform. If you have a grievance against Health Net, you can also contact the California Department of Managed Health Care, at 1-800-HMO-2219 or www.hmohelp.ca.gov. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444 (EBSA 3272) or www.dol.gov/ebsa/healthreform.

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.com
**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-839-2172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-839-2172.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-839-2172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne’ 1-800-839-2172.

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](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: $7,000
- Specialist copayment: $0
- Hospital (facility) copayment: $0
- Other copayment: $0

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>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Peg would pay is: $60

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: $7,000
- Specialist copayment: $0
- Hospital (facility) copayment: $0
- Other copayment: $0

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>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Joe would pay is: $60

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

- The plan’s overall deductible: $7,000
- Specialist copayment: $0
- Hospital (facility) copayment: $0
- Other copayment: $0

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>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Mia would pay is: $0
Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do 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 us, 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 Health Net 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 Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file 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).

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マ
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
សេវាភាសាសោយឥតគិតថ្លៃ។ សោកអ្នកអាចទទួលបានអ្នកបកប្បផ្ ទា ល់មាត់។ សោកអ្នកអាចសាដា ប់សគអានឯក
សារឱ្យសោកអ្នកជាភាសារបេ្មាប់ជំនួយ េូមសៅទូរេ័ពទាសៅកាន់មជ្ឈមណ ្ឌ លទំនាក់ទំនងអតិ
្ិជនតាមសលខបែលមានសៅសលើប័ណ ្ណេមាគា ល់ខលៃួនរបេ្មាប់ទីផ្សាររែ្ឋ California េូមសៅទូរេ័ពទាសៅកាន់កម្មវ ិធី Off Exchange
របេ្មាប់ទីផ្សាររែ្ឋ California េូមសៅទូរេ័ពទាសៅកាន់កម្មវ ិធី On Exchange របេ្មាប់ទីផ្សាររែ្ធិ
មាន្មាប់ទីផ្សាររែ្ធិមាន្មាប់ទីផ្សាររែ្ធិមាន្មាប់ទីផ្សាររែ្ធិ

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며
 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로
고객서비스 센터로 연락하시거나 Individual & Family Plan (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) 번으로 전화해 주십시오. 소규모 비즈니스의 경우 1-888-926-5133 (TTY: 711)번으로
전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088 (TTY: 711)번으로 전화해
주십시오.

Navajo
Doo bâgh ilînîgôo saad bee háká ada’îlyeed. Ata’ halne’i’gi da la’ ná háhîdîîot’gi. Naaltsoos da t’áá
shí shîzaaad k’e’hjí shîchí’ yîdooltah nînîzingô t’áá ná ákîdóolnitli. Ákôt’éego shîká a’dooowot nînîzingô
Customer Contact Center hoolyéhî ji’ hodîînih nînaltsoos nanitingô bee néého’dolzînîgî hodoonîhî’
Health Net를 통한 그룹 플랜의 경우 1-800-522-0088 (TTY: 711)번으로 전화해 주십시오.

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شافاهی بگیرید. می توانید درخواست کنید استاد به زبان شما برنامه شود. برای
دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی پی تر در فردی و خانوادگی (IFP) Off Exchange:
1-888-926-4988 (TTY: 711) تماس بگیرید. برای پزشک کالیفرنیا، با
1-888-926-5133 (TTY: 711) تماس بگیرید. برای طرح های گروهی از طریق
1-800-522-0088 (TTY: 711).
Panjabi (Punjabi)

ਕਿਸੋਂ ਕਿਸੋਂ ਸੰ ਤੇਕਰ ਹੋਣ ਦੌਰਾਨ ਸੰ ਥੇਕਾ। ਸੰ ਤੇਕਰ ਦੁਖਿਆਉਣਾ ਸੰ ਥੇਕਾ ਤਾਮਲ ਵਧ ਨਹੀਂ ਰਹਿੰਦੇ। ਗਰਤੇ ਹਨ। ਸੰ ਤੇਕਰ ਦੁਖਿਆਉ ਸੰ ਥੇਕਾ ਤਾਮਲ ਵਧ ਨਹੀਂ ਰਹਿੰਦੇ। ਸੰ ਤੇਕਰ ਦੁਖਿਆਉਣਾ ਸੰ ਥੇਕਾ ਤਾਮਲ ਵਧ ਨਹੀਂ ਰਹਿੰਦੇ। ਸੰ ਤੇਕਰ ਦੁਖਿਆਉਣਾ ਸੰ ਥੇਕਾ ਤਾਮਲ ਵਧ ਨਹੀਂ ਰਹਿੰਦੇ। 

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

ไม่มีค่าบริการให้คำปรึกษา คุณสามารถใช้ผ่านได้ คุณสามารถให้คำแนะนำได้ที่หน้าจอของคุณได้ หากต้องการความช่วยเหลือ โทรศูนย์สนับสนุนผู้ผลิตหรือที่ทำการบริการบัตรประกันสุขภาพหรือโทรศูนย์แผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรศัพท์ TTY: 711) ส่วนบริษัทสุขภาพหรือโทรศูนย์แผนบุคคลและครอบครัวของเอกชน (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรศัพท์ TTY: 711) หรือ สำนักงานของเอกชน (Small Business) ที่ 1-888-926-5133 (โทรศัพท์ TTY: 711) ส่วนบริษัทแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิแผนภูมิoplan Health Net โทรศัพท์ 1-800-522-0088 (โทรศัพท์ TTY: 711)
Việtnamese

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

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