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](http://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/](https://www.healthcare.gov/sbc-glossary/) or [www.myhealthnetca.com](http://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><strong>What is the overall deductible?</strong></td>
<td>For participating providers $6,300 per member / $12,600 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><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, laboratory tests, rehabilitation and habilitation services, hospice, mental health and substance use disorder visits; first 3 non-preventive visits per year combined (including primary care, specialist, other practitioner, postnatal, urgent care); and pediatric vision and 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><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes, preferred pharmacy deductible $500 per person / $1,000 per family per calendar year. Pharmacy deductible applies to tiers 1-4. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>For participating providers $7,800 member / $15,600 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><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, penalties for non-certification 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><strong>Will you pay less if you use a network provider?</strong></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><strong>Do you need a referral to see a specialist?</strong></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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<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>$65/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$95/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray - 40% coinsurance Lab - $40/visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>40% coinsurance</td>
<td>Not covered</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>$18/retail $36/mail order after prescription drug deductible has been met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier II drugs (non-preferred generics and preferred brands)</td>
<td>40% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier III drugs (non-preferred brands)</td>
<td>40% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier IV drugs (Specialty drugs)</td>
<td>40% after prescription drug deductible has been met/retail and mail order</td>
<td>Not covered</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>Participating Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility – 40% coinsurance Physician – No charge</td>
<td>Facility – 40% coinsurance Physician – No charge</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$65/visit</td>
<td>$65/visit</td>
<td>Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care &amp; postnatal non-preventive visits are combined.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>none</td>
</tr>
</tbody>
</table>
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit – $65/visit
Deductible does not apply;
Other than office visit – no charge | Not covered | none |
| | Inpatient services | 40% coinsurance | Not covered | If prior authorization is not obtained a $250 penalty will apply. |
| If you are pregnant | Office visits | Prenatal - No charge
Postnatal - $65/visit | Not covered | Deductible waived for 1st 3 non-preventive postnatal visits combined with primary care, specialist, other practitioner & urgent care. |
| | Childbirth/delivery professional services | 40% coinsurance | Not covered | Coverage includes abortion services. |
| | Childbirth/delivery facility services | 40% coinsurance | Not covered | Coverage includes abortion services. |

* 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>Participating Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>Limited to 100 visits year. If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$65/visit Deductible does not apply</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply. If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$65/visit Deductible does not apply</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>Not covered</td>
<td>If prior authorization is not obtained a $250 penalty will apply.</td>
</tr>
</tbody>
</table>

| **If your child needs dental or eye care** | **Children’s eye exam** | No charge                                     | Not covered                                   | Limited to 1 visit per year. |
|                                            | **Children’s glasses**     | No charge                                     | Not covered                                   | Provider selected frames; 1 per calendar year. |
|                                            | **Children’s dental check-up** | No charge                                 | Not covered                                   | ————none———|

**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

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Abortion services
- Acupuncture (covered when medically necessary)
- Bariatric surgery (covered through participating provider network if deemed 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 1-800-839-2172. 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.

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.

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.com
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, kwiijigo holne’ 1-800-839-2172.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### 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**: $6,300
- **Specialist copayment**: $95
- **Hospital (facility) coinsurance**: 40%
- **Other copayment**: $65

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>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$4,600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $7,760

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

- **The plan’s overall deductible**: $6,300
- **Specialist copayment**: $95
- **Hospital (facility) coinsurance**: 40%
- **Other copayment**: $65

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>$3,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $7,460

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

- **The plan’s overall deductible**: $6,300
- **Specialist copayment**: $95
- **Hospital (facility) coinsurance**: 40%
- **Other copayment**: $65

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>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $2,000

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), 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で
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）
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 ល់ខលៃួនរបេ្មាប់ឬសៅទូរេ័ពទាសៅកាន់កម្មវ ិធី Off Exchange
របេ្មាប់ទីផ្សាររែ្ឋ California េូមសៅទូរេ័ពទាសៅកាន់កម្មវ ិធី On Exchange របេ្មាប់គស្មាង IFP តាមរយៈសលខ 1-888-926-4988 (TTY: 711) ឬ្ករុមហ៊ុនអាជីវកម្មខ្្ន និតតូចតាមរយៈសលខ 1-888-926-5133 (TTY: 711)។

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 센터에 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) 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 bągh ilínígóo saad bee háká daa'įleed. Ata' halne'įgi da la’ ná hádíidóot'įį. Naaltsoos da t’áá
ší shizada k’ehjį shichį yidooltah nínizingo t’áá ná akódoolníi. Akót’ęego shiká a’doojot nínizingo
Customer Contact Center hoolyéhiįį’ hodiílnih ninaaltsoos nanitingo bee néeho’dolzingiį hodoonihįį’
California marketplace báhiįį kojį’ hólne’ IFP On Exchange 1-888-926-4988 (TTY: 711) 1-800-839-2172

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برای انتقال خواندن شود. برای
دروافت کمک، با مرکز تماس مشتریان به شماره روزی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange:
1-888-926-4988 (TTY: 711) 1-800-839-2172
(TTY: 711) 1-888-926-5133(TTY: 711) Health Net

(TTY: 711) 1-800-522-0088(TTY: 711)
Panjabi (Punjabi)

ਭਤੀ ਵਿਚੋਂ ਕੰਧਾਂ ਦੀ ਸਤਿਕ ਸ਼ਾਸਤਰੀਆਂ ਦੀ ਮੇਧਾ ਦੀ ਮੁਲਾਕਾਤ ਚਾਹੁੰਦੇ ਹਨ। ਤਸ਼ਤਵ ਦੀ ਮੁਖਜਦਾਤਨ ਦੇ ਪ੍ਰੇਮ ਦੇ ਪ੍ਰਤੀ ਮੁਕੇਸ਼ ਹੀ ਵਾਲਾ ਹੋਵੀ। ਹੀ ਹੋਵੀ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਿਆਈ ਦੀ ਸੇਵਾ ਹਾਸਲ ਹੋ ਸਕੀ ਹੋ। ਤੁਹਾਣੂੰ ਦੋਸਤ ਅਧਿਕਾਰ ਦੇ ਸੂਚਨ ਕੀਤੀਆਂ ਹੋਨਾ ਚਾਹੁੰਦਾ ਹੋਵੀ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਨੂੰ ਬੋਲਣ ਦੇ ਲਈ ਤਿੱਖੀਆਂ ਹੋ ਜਾਂ ਗਾਹਿ ਸੰਪਰਕ ਦੇ ਹੋਣ ਦੀ ਸੰਖਿਆ ਨੂੰ ਨਾਲ ਹਨ। IFP ਪੀਐਮਫੀਕਸ ਦੇਣ 'ਤੇ ਵਡੀ ਵਲੇ: 1-800-839-2172 (TTY: 711)। ਮੇਕਸੀਕਾਨਿਸ਼ਨ ਅਲਾਫਰਟਸ ਦੇਣ 'ਤੇ 1-888-926-4988 (TTY: 711) ਤੋਂ ਮੇਕਸੀਕਾਨਿਸ਼ਨ ਵਲੇ ਹੋਣ।

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

ไม่มีค่าบริการาการดําเนินงาน คุณสามารถใช้คํ่าถามได้ คุณสามารถให้เอกสารให้พัฒนาการพัฒนาได้ หากต้องการความช่วยเหลือ โทรหาศูนย์แล้วให้ทําแผนการพัฒนาได้ก่อนในบริการขั้นต้นของการดําเนินงาน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (หลังจาก TTY: 711) สำหรับแผนเบื้องต้น โทรหาแผนแผนบุคคลและครอบครัวของแผน (Small Business) ที่ 1-888-926-5133 (หลังจาก TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (หลังจาก TTY: 711).
Vietnamese

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

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