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/2020/eoc/ec/ppoplatinum90iex 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

<table>
<thead>
<tr>
<th>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 $4,500 per person / $9,000 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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<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></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>50% coinsurance after deductible has been met</td>
<td></td>
</tr>
<tr>
<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 X-ray-$30/visit</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% 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><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs (tier 1)</td>
<td>$5/retail order $10/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred generic and preferred brand drugs (tier 2)</td>
<td>$15/retail order $30/mail order</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs (tier 3)</td>
<td>$25/retail order $50/mail order</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs (tier 4)</td>
<td>10% coinsurance up to $250 per 30 day prescription</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><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>
</tr>
<tr>
<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>
<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>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: Facility fee-$150/visit Professional services-No charge</td>
<td>Copayment waived if admitted into the hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Facility fee-$150/transport Professional services-No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$150/transport Facilities fee-$150/visit Professional services-No charge</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance Facilities fee-$150/visit Professional services-No charge</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 Facilities fee-$150/visit Professional services-No charge</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-$15/visit Other than office visit-10% coinsurance up to $15/visit</td>
<td>Certification is not required for outpatient services 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 Facilities fee-$150/visit Professional services-No charge</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 Facilities fee-$150/visit Professional services-No charge</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 Facilities fee-$150/visit Professional services-No charge</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance Facilities fee-$150/visit Professional services-No charge</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)

SBC_PLT_90_IFP_EC_PPO_2020
<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 need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>Preferred Provider (You will pay the least): 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 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><strong>Skilled nursing care</strong></td>
<td>10% coinsurance</td>
<td>50% coinsurance after deductible has been met</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></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><strong>Hospice services</strong></td>
<td>No charge</td>
<td>50% coinsurance after deductible has been met</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>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</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 (exclusion does not apply to preventive care behavioral interventions)

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

SBC_PLT_90_IFP_EC_PPO_2020
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 the preferred provider network if medically necessary)
- Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html.
- California Department of Insurance – 300 Capitol Mall Suite 1600 Sacramento CA 95814. Call toll free: (800) 927-4357 or visit http://insurance.ca.gov/consumers.

For more information on your rights to continue coverage, contact the plan at 1-888-926-4988. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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, 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/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. 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.

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.com
SBC_PLT_90_IFP_EC_PPO_2020
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, kwijigo 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

SBC_PLT_90_IFP_EC_PPO_2020
### 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.

---

<table>
<thead>
<tr>
<th>Example Event</th>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peg is Having a Baby</strong></td>
<td>Deductibles: $0, Copayments: $30, Coinsurance: 10%</td>
<td>$12,800</td>
</tr>
<tr>
<td><strong>Managing Joe’s type 2 Diabetes</strong></td>
<td>Deductibles: $0, Specialist Copayment: $30, Hospital (facility) Coinsurance: 10%, Other Coinsurance: 10%</td>
<td>$7,400</td>
</tr>
<tr>
<td><strong>Mia’s Simple Fracture</strong></td>
<td>Deductibles: $0, Specialist Copayment: $30, Hospital (facility) Coinsurance: 10%, Other Coinsurance: 10%</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

**In this example, Peg would pay:**
- Deductibles: $0
- Copayments: $300
- Coinsurance: $1,200
- What isn't covered: $60

**The total Peg would pay is** $1,560

**In this example, Joe would pay:**
- Deductibles: $0
- Copayments: $800
- Coinsurance: $200
- What isn't covered: $60

**The total Joe would pay is** $1,060

**In this example, Mia would pay:**
- Deductibles: $0
- Copayments: $600
- Coinsurance: $10
- What isn't covered: $0

**The total Mia would pay is** $610

---

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).

English

Arabic

Armenian

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您，可以將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 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，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईएफपी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैसलें लेने की तैयारी में आइए। आईएफपी ऑफ एक्सचेंज 1-800-839-2172 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से गुप्त प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Japanese

Khmer
លេខទូរសំនុខជាមួយអ្នកស្នូយស័ព្ទអំពីទំព័រនេះ។ អ្នកអាចទទួលបានអានប្រការដើម្បីអ្នក។ ំនុំត្រូវ៉ាយជាព័ត៌មានអំពីការរៀបការ។ អ្នកបានជាខ្លាតូល់ខ្លួនឯងតាមអំពីការរៀបការមុខងាររបស់អ្នក។ Khmer Customer Contact Center អំពីព័ត៌មានទំនិញមុខងារឬអំពីisdigitទូរសំនុកផ្ទៃក្រុង។ អ្នកបានជាដើម្បីការរៀបការការរៀបការ។ California ស្នូយស័ព្ទអំពីព័ត៌មានការរៀបការមុខងារឬអំពីថ្នាំឈឺរបស់អ្នក 1-888-926-4988 (TTY: 711)។ អ្នកបានជាដើម្បីការរៀបការការរៀបការមុខងារឬអំពីថ្នាំឈឺរបស់អ្នក 1-888-926-5133 (TTY: 711)។ អ្នកបានជាដើម្បីការរៀបការការរៀបការមុខងារឬអំពីថ្នាំឈឺរបស់អ្នក 1-800-522-0088 (TTY: 711)។

Korean

Navajo

Persian (Farsi)
خدمات زبان بدون هزینه. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید درخواست کنید استاد به زبان شما برایان خوانده شود. برای دریافت کمک با مرکز تامس مشتریان به شماره روزی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange: 1-800-839-2172 (TTY: 711), 1-888-926-4988 (TTY: 711) یا کسب و کار کافیرنیا، با تامس بگیرید. برای پلاک کنار کافیرنیا، با تامس بگیرید. برای طرح های گروهی از طریق Health Net (TT
Panjabi (Punjabi)

ਵਿਸ਼ਵੀਣ ਵਿੱਚ ਸਰਹਾ ਇੰਦੀਵਾਂ ਨਾਗਰ ਮੇਲਨਾਂ। ਉਸ਼ਾਦੀ ਤੇ ਸੁਨ ਲੜਿਆ ਦੀ ਮੇਲ ਰਾਮ ਵਿਚ ਵਿਚ ਦੇ ਹੋਣ। ਤੁਸੀਂ ਇੱਟੀ ਦੀ ਬਚਨ ਿੇ ਸੁਣਾਏ ਜਾ ਸਿਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਬਦਲੇ ਨੀਰ ਤੇ ਗਾਹਿ ਸੰਸ਼ਾਦ ਨੂ ਰੀ ਜਾਂ ਰਿਆਖ਼ਤੀਆਂ ਮੈਂ ਨੋਟਿਫਿਕਾਸ਼ਨ (IFP) ਨੋਟਿਫ਼ਲ ਦੀ ਜ਼ਰੂਰਤ, ਦੀ ਸਹਾਇਤਾ ਨੂ ਰੀ 1-888-926-4988 (TTY: 711) ਨੂ ਰੀ ਸਮੇਤ ਭਵੱਚ ਪ੍ਰਦਕਸ਼ਿਣੀ ਅਤੇ ਕਰਨ ਵਾਲੀਆਂ ਭਾਸਾ ਸੇਵਾ ਹਾਸਲ ਿਰ ਸਿਦੇ ਹੋ।

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