



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 or call 1-800-522-0088. 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.healthnet.com or you can call 1-800-522-0088 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$0. | See the Common Medical Events charge below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | There is no deductible . | There is no deductible . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | Medical out-of-pocket limit: \$1,500 member/\$3,000 family through Salud or SIMNSA network per calendar year. Salud & SIMNSA networks cross accumulate. Prescription drug out-of-pocket limit: (applicable to prescription drugs from network pharmacies): \$750 individual/\$1,500/family per calendar year. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Medical out-of-pocket limit: Premiums , prescription drug costs, balance billing charges, healthcare this plan doesn't cover, and services indicated in the chart starting on page 3. Prescription drug out-of-pocket limit (in-network): premiums , balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. For a list of preferred providers , see www.healthnet.com/providersearch or call 1- 800-522-0088. | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | Yes. Requires written prior authorization. | 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 . |



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

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|---------------------------------|---|---|--|
| | | SIMNSA Network (Mexico members) | Health Net Salud Network (California members) | SIMNSA Network (Self-referral for California members) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$5/visit | \$5/visit | \$5/visit | -----none----- |
| | Specialist visit | \$5/visit | \$5/visit | \$5/visit | Requires prior authorization. |
| | Preventive care/screening/immunization | No charge for covered services | No charge for covered services | No charge for covered services | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | No charge | Requires referral. |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | No charge | Requires prior authorization. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com or by calling 1-800-451-6245 | Generic drugs | Not covered | \$3 copay / prescription (retail or mail order) | Not covered | You must use a pharmacy in Express Scripts' Prime Network (within the United States) to fill your prescription or no coverage. Each retail prescription limited to a 30-day supply. For maintenance medications, up to a 90-day supply is available using mail order. Some drugs require preauthorization . For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. Two retail fills are allowed before you must notify Express Scripts of your decision. If you use a brand name drug when a |

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|---|--|---------------------------------|--|---|---|
| | | SIMNSA Network (Mexico members) | Health Net Salud Network (California members) | SIMNSA Network (Self-referral for California members) | |
| | Brand and Specialty Drugs | Not covered | \$ 6 copay / prescription (retail); \$5 copay / prescription (mail order) | Not covered | generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable copay . Some drugs are not covered by the plan . Call 1-800-451-6245 for more information. |
| | Preventive Drugs | Not covered | No charge; deductible does not apply | Not covered | Certain preventive care drugs are covered at 100% with no copay; prescription required. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | No charge | Requires prior authorization. |
| | Physician/surgeon fees | No charge | No charge | No charge | -----none----- |
| If you need immediate medical attention | Emergency room care | \$10/visit | \$150/visit | \$10/visit | Copay waived if admitted as inpatient. |
| | Emergency medical transportation | No charge | \$50/transport | No charge | Air ambulance is not covered through SIMNSA Network. |
| | Urgent care | \$10/visit | \$5/visit | \$10/visit | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | No charge | Requires prior authorization. |
| | Physician/surgeon fees | No charge | No charge | No charge | -----none----- |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | SIMNSA Network (Mexico members) | Health Net Salud Network (California members) | SIMNSA Network (Self-referral for California members) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office-\$5/visit Other than office-No charge | Office-\$5/visit Other than office-No charge | Office-\$5/visit Other than office-No charge | Behavioral health services through the Health Net Salud Network is administered by Managed Health Network (MHN). Requires prior authorization except for office visits. |
| | Inpatient services | No charge | No charge | No charge | Behavioral health services through the Health Net Salud Network is administered by Managed Health Network (MHN). Requires prior authorization. |
| If you are pregnant | Office visits | No charge | No charge | No charge | Cost sharing does not apply for preventive services . |
| | Childbirth/delivery professional services | No charge | No charge | No charge | Coverage includes abortion services. |
| | Childbirth/delivery facility services | No charge | No charge | No charge | Coverage includes abortion services. |
| If you need help recovering or have other special health needs | Home health care | Not covered | No charge | Not covered | Requires prior authorization. |
| | Rehabilitation services | \$5/visit | \$5/visit | \$5/visit | Requires prior authorization. |
| | Habilitation services | Not covered | \$5/visit | Not covered | Requires prior authorization. |
| | Skilled nursing care | No charge | No charge | No charge | Limited to 100 days per calendar year through SIMNSA Network. Requires prior authorization. |
| | Durable medical equipment | No charge | 20% coinsurance | No charge | Corrective footwear is not covered. Requires prior authorization. |
| | Hospice services | No charge | No charge | No charge | Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires prior authorization. |
| If your child needs dental or eye care | Children's eye exam | \$5/visit | \$5/visit | \$5/visit | Covered through Health Net (not covered through Vision Service Plan). |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|---|---|---|--|
| | | SIMNSA Network (Mexico members) | Health Net Salud Network (California members) | SIMNSA Network (Self-referral for California members) | |
| | Children's glasses | Health Net: Not covered VSP: Not covered | Health Net: Not covered VSP: No charge for frames under \$120 allowance (80% of costs above \$120). No charge for most standard lenses. | Health Net: Not covered VSP: Not covered | For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Lenses and frames limited to once every 24 months. Charges apply for lens add-ons and premium progressive lenses. VSP provides limited benefits out-of-network. |
| | Children's dental check-up | Not covered | Not covered | Not covered | You may have other dental coverage not described here. |

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 .) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Prescription drugs | <ul style="list-style-type: none"> • 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.) | | |
| <ul style="list-style-type: none"> • Acupuncture (covered as a specialist visit if deemed medically necessary) • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care (covered as a specialist visit if deemed medically necessary) • Dental care (Adult) – available through separate standalone plan | <ul style="list-style-type: none"> • Infertility treatment • Routine eye care (Adult) – limited benefits for frames/lenses available through VSP plan |

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 www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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, 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 1-800-522-0088, submit a grievance form through www.healthnet.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 1-888-466-2219 (TDD line 1-877-688-9891 for the hearing and speech impaired) or www.dmhc.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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0088.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-0088.

Chinese (中文): 如果需要中文的帮助, 请打这个号码 1-800-522-0088.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-522-0088.

-----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 | \$0 |
| ■ Specialist copayment | \$5 |
| ■ Hospital (facility) copayment | \$0 |
| ■ Other copayment | \$5 |

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:

| Cost Sharing | |
|-----------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$107 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$167 |

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 | \$5 |
| ■ Hospital (facility) copayment | \$0 |
| ■ Other copayment | \$5 |

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:

| Cost Sharing | |
|-----------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$221 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$276 |

Mia's Simple Fracture

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

| | |
|---|-----|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$5 |
| ■ Hospital (facility) copayment | \$0 |
| ■ Other copayment | \$5 |

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 | \$1,900 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$185 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$185 |

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).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع
TTY: (.) مركز خدمة العملاء عبر الرقم المبدئي على بطاقتك أو الاتصال بالرقم الفرعي لخدمة الأفراد والاعزلة: 1-800-839-2172
(للتواصل ني كالبينورنيا، يرجى الاتصال بالرقم الفرعي لخدمة الأفراد والاعزلة عبر الرقم: 1-888-926-4988
لخطط المجموعة عبر TTY: (.) المشروعات الصغيرة 1-888-926-5133
Health Net، يرجى الاتصال بالرقم 1-800-522-0088 TTY: 711).

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ:
Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների
սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք
Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711):
Կալիֆոռնիայի համար զանգահարեք IFP On Exchange՝
1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝
1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար
զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

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聽並請我們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 दभाषया प्राप् कर सकते हैं। आप दसतावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दए गए नंिर पर ग्राहक सेवा केें द्र को कॉि करेें या क्बतिगत और फै लमिी प्िान (आईएफपी) ऑफ एकसचेेंज: 1-800-839-2172 TTY: 711 पर कॉि करेें। कै लिफोलनया िाजारों के लिए, आईएफपी ऑन एकसचेेंज 1-888-926-4988 TTY: 711 या समॉि बिजनस 1-888-926-5133 TTY: 711 पर कॉि करेें। हेल्थ नेट के माधयम से गुप प्िान के लिए 1-800-522-0088 TTY: 711 पर कॉि करेें।

Hmong

Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntauv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

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) 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

សេវាភាសាខ្មែរឥតគិតថ្លៃ ព្រោះអ្នកអាចទទួលបានអ្នកបកប្រែ ឥតគិតថ្លៃ លំអិត។ ព្រោះអ្នកអាចសង្ខេប ឬគ្រាន់ឯកសារឱ្យព្រោះអ្នកជាភាសាខ្មែរ ឬចង់បានជំនួយ ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម លទ្ធភាពទំនងអតិថិជនតាមសលខ្សែលេខមានលេខប្រើប្រាស់ ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម Off Exchange របស់ ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម (IFP) តាមរយៈសលខ្សែ 1-800-839-2172 (TTY: 711)។ ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម California ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម On Exchange របស់ ឬចង់បានព័ត៌មានបន្ថែម IFP តាមរយៈសលខ្សែ 1-888-926-4988 (TTY: 711) ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម 1-888-926-5133 (TTY: 711)។ ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម Health Net ឬចង់បានព័ត៌មានបន្ថែម ឬចង់បានព័ត៌មានបន្ថែម 1-800-522-0088 (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 고객센터 센터에 연락하시거나 개인 및 가족 플랜(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 b33h 717n7g00 saad bee h1k1 ada'iiyeed. Ata' halne'7g77 da [a' n1 h1d7d0ot'88]. Naaltsoos da t'11 sh7 shizaadk'ehj7 shich9'y7dooltahn7n7zingot'11 n1 1k0dooln77[. !k0t'4egosh7k1 a'doowo[n7n7zingo Customer Contact Center hooly4h7j8' hod77lnih ninaaltsoos nanitingo bee n44ho'dolzin7g77 hodooni8' bik11' 47 doodago koj8' h0lne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace b1h7g77 koj8' h0lne' IFP On Exchange 1-888- 926-4988 (TTY: 711) 47 doodago Small Business b1h7g77 koj8' h0lne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net b1h7g77 47 koj8' h0lne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای به شماره: 1-800-839-2172 (TTY: 711) Off IFP (Exchange) دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (شماره 1-888-926-4988 Exchange On IFP تماس بگیرید. برای بازار کالیفرنیا، با (TTY: 711) 839-2172 (TTY: 711) برای طرح های گروهی از طریق (TTY: 711) (با کسب و کار کوچک 1-888-926-5133 Health Net، با 1-800-522-0088 (TTY: 711) تماس بگیرید.

Punjabi (Punjabi)

ਬਿਨਾਂ ਬਿੰਮੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਥੇ ਦੁਬਾਸੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਬਦਲ ਕੇ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਨੰਬਰ ਤੇ ਬਦਲੇ ਨੂੰ ਕਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਬਵਾਕੀਤੀਗਤ ਅਤੇ ਪਬਰਵਾਰਕੀ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕੀਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੱਲ ਬਿਜਨੇਸ ਨੂੰ

1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਬਹਿ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

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

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าใช้จ่ายด้านภาษา คุณสามารถใช้ได้ คุณสามารถให้อ่านเอกสารให้เป็นภาษาของคุณได้

หากต้องการความช่วยเหลือ

โทรหาศูนย์ หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน
ลูกค้าสมปन्नได

(Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทร TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหา
ฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้อีกที่ 1-888-926-4988 (โทร TTY: 711) หรือ
ฝ่ายธุรกิจขนาดเล็ก

(Small Business) ที่ 1-888-926-5133 (โทร TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net 1-
800-522-0088 (โทร TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

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

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