**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Health Net of CA: Salud HMO ENS**

**Coverage Period:** 01/01/2019-12/31/2019

**Coverage for:** All Covered Members | **Plan Type:** HMO

---

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](http://www.healthnet.com) or call 1-800-722-5342. 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.healthnet.com](http://www.healthnet.com) or you can call 1-800-722-5342 to request a copy.

### Important Questions & Answers

<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>$0.</td>
<td>See the Common Medical Events charge below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>There is no deductible.</td>
<td>There is no deductible.</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.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$6,850 member/$13,700 family through Salud. $1,500 member/$4,500 family through SIMNSA per calendar year. Salud &amp; SIMNSA tiers cross accumulate.</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 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 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.healthnet.com/providersearch">www.healthnet.com/providersearch</a> or call 1-800-722-5342.</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>

---
**Common Medical Event** | **Services You May Need** | **SIMNSA Network** (Mexico members) | **Health Net Salud Network** (California members) | **SIMNSA Network** (Self-referral for California members) | **Limitations, Exceptions, & Other Important Information**
---|---|---|---|---|
### If you visit a health care provider’s office or clinic
- Primary care visit to treat an injury or illness
  - SIMNSA Network: $10/visit
  - Health Net Salud Network: $35/visit
  - SIMNSA Network (Self-referral): $10/visit
  - Requires prior authorization.
- Specialist visit
  - SIMNSA Network: $10/visit
  - Health Net Salud Network: $75/visit
  - SIMNSA Network (Self-referral): $10/visit
- Preventive care/screening/immunization
  - No charge
- **SIMNSA Network** (Self-referral for California members)

### If you have a test
- **Diagnostic test** (x-ray, blood work)
  - No charge
- Imaging (CT/PET scans, MRIs)
  - No charge

### If you need drugs to treat your illness or condition
More information about prescription drug coverage is available at [www.healthnet.com/ca_druglist](http://www.healthnet.com/ca_druglist)

<table>
<thead>
<tr>
<th>Tier I (Generic drugs)</th>
<th>Tier II (Preferred brand)</th>
<th>Tier III (Non-preferred brand drugs)</th>
<th>Specialty drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>$5 for drugs dispensed through SIMNSA/retail order</td>
<td>50% coinsurance w/ $250 max/retail order</td>
<td>$5 for drugs dispensed through SIMNSA/retail order</td>
</tr>
<tr>
<td>Not covered/mail order</td>
<td>$20/mail order</td>
<td>50% coinsurance w/ $750 max/mail order</td>
<td>Not covered/mail order</td>
</tr>
</tbody>
</table>
| $10/retail order | $100/mail order | Self injectables
  - No charge
  - Refer to the recommended drug list for other drugs considered specialty | Self injectables
  - No charge
  - Refer to the recommended drug list for other drugs considered specialty |
| $50/retail order | $5 for drugs dispensed through SIMNSA/retail order | $5 for drugs dispensed through SIMNSA/retail order |
| $750 max/mail order | Not covered/mail order | Not covered/mail order |

**Supply/order:** up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior Authorization is required for select drugs. If you buy a brand name drug that has a generic equivalent, you pay the difference in cost between the brand name and generic drug plus copay or coinsurance for the generic.

**Specialty drugs**

| Specialty drugs | Self injectables
  - No charge
  - Refer to the recommended drug list for other drugs considered specialty |
|---|---|
| $5 for drugs dispensed through SIMNSA/retail order | Self injectables
  - No charge
  - Refer to the recommended drug list for other drugs considered specialty |
| Not covered/mail order | Self injectables
  - No charge |
| | |

Prior Authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30 days supply filled by specialty pharmacy.
<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 have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>SIMNSA Network (Mexico members)</td>
<td>Health Net Salud Network (California members)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>$1,000/procedure +25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$10/visit</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>$100/transport</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10/visit</td>
<td>$15/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>$1,000/stay +25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Physician – No charge</td>
</tr>
<tr>
<td>If you need mental health, behavioral</td>
<td>Outpatient services</td>
<td>Office-$10/visit</td>
<td>Office-$35/visit-individual therapy session</td>
</tr>
<tr>
<td>health, or substance abuse services</td>
<td></td>
<td>Other than office-</td>
<td>$17.50/visit-group therapy session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>Other than office-</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.healthnet.com](http://www.healthnet.com)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SIMNSA Network (Mexico members)</td>
<td>Health Net Salud Network (California members)</td>
<td>SIMNSA Network (Self-referral for California members)</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>No charge</td>
<td>$1,000/stay +25% coinsurance</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The $1,000 copay is combined with inpatient hospital, mental health, maternity, skilled nursing &amp; outpatient surgery and is required once per calendar year. The 25% coinsurance will continue to apply until the OOPM is reached. Requires prior authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>No charge</td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td></td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>$1,000/stay +25% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>The $1,000 copay is combined with inpatient hospital, mental health, maternity, skilled nursing &amp; outpatient surgery and is required once per calendar year. The 25% coinsurance will continue to apply until the OOPM is reached. Requires prior authorization. Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not covered</td>
<td>$35/visit</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$10/visit</td>
<td>$35/visit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>$1,000/stay +25% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>SIMNSA Network (Mexico members)</th>
<th>Health Net Salud Network (California members)</th>
<th>SIMNSA Network (Self-referral for California members)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Corrective footwear is not covered. Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires prior authorization.</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$10/visit</td>
<td>$35/visit</td>
<td>$10/visit</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</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.):**

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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 (covered as a specialist visit if deemed medically necessary)
- Bariatric surgery
- Chiropractic care-Your group has purchased a chiropractic benefit rider. When you use a practitioner in the American Specialty Health Plan network, chiropractic care is covered with a copayment of $15/visit up to 20 visits per calendar year. You may self-refer for the initial visit; subsequent visits require prior authorization.
- Infertility treatment
- Routine eye care (Adult)
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 1-800-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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0088.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-522-0088.
Navajo (Dine): DineKʼehgo shika aʼohwol ninisingo, kwiiji hołne’ 1-800-522-0088.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$75</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$1,000</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$35</td>
</tr>
</tbody>
</table>

- 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:
  - Deductibles $0
  - Copayments $1,100
  - Coinsurance $0
  - What isn't covered $60

  **The total Peg would pay is** $1,160

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$75</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$1,000</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$35</td>
</tr>
</tbody>
</table>

- 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:
  - Deductibles $0
  - Copayments $1,400
  - Coinsurance $0
  - What isn't covered $60

  **The total Joe would pay is** $1,460

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$75</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$1,000</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$35</td>
</tr>
</tbody>
</table>

- 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:
  - Deductibles $0
  - Copayments $700
  - Coinsurance $100
  - What isn't covered $0

  **The total Mia would pay is** $800

---

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

---

**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.
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

Hindi
बिना शुल्क भाषा सेवाएं। आप एक तुम्हारी प्राय जो गलत कर सकते हैं। आप दस्तावेंजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, आपने आईएफपी कार्ड में दिया गए नंबर पर यहां संयोजन को कॉल कर या व्यक्तिगत और फैसलें द्वारा, आईएफपी ऑफ स्क्वायर्ज 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजार के लिए, आईएफपी ऑफ स्क्वायर्ज 1-888-926-4988 (TTY: 711) या स्वीत्र विज्ञेस्न वर्नेंस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से युप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Japanese

Khmer
សេវាភាសាសោយឥតគិតថ្លៃ។ សោកអ្នកអាចទទួលបានអ្នកបកប្បផ្ ទា ល់មាត់។ សោកអ្នកអាចសាដា ប់សគអានឯកសារឱ្យសោកអ្នកជាភាសារបេ្មាប់ជំនួយ េូមសៅទូរេ័ពទាសៅកាន់មជ្ឈមណឌ្ឍជនតាមស្ថើស្ថាពីរដាននារីរបេ្មាប់គស្មាងជាលក្ខណៈបុគគាលនិ្ករុម្គរួសារ (IFP) តាមរយៈស្ថាពី 1-800-839-2172 (TTY: 711)។ េូមសៅទូរេ័ពទាសៅកាន់កម្មវ ិធី Off Exchange របេ្មាប់ទីផ្សាររែ្ឋ California េូមសៅទូរេ័ពទាសៅកាន់កម្មវ ិធី On Exchange របេ្មាប់គស្មាង IFP តាមរយៈស្ថាពី 1-888-926-4988 (TTY: 711) ឬ្ករុមហ៊ុនអាជីវកម្មខ្្ន តតូចតាមរយៈស្ថាពី 1-888-926-5133 (TTY: 711)។ េូមសៅទូរេ័ពទាសៅកាន់គស្មាងជា្ករ ុមតាមរយៈ Health Net េូមសៅទូរេ័ពទាសៅកាន់្មាប់គស្មាង (IFP) តាមរយៈស្ថាពី 1-800-522-0088 (TTY: 711)។

Korean

Navajo

Persian (Farsi)
Panjabi (Punjabi)

ਬਿਨਾਂ ਬਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਰਾ ਸੇਵਾ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦੀਆਂ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਨਾਂ ਤੇ ਗ੍ਰਾਹਕ ਜਾਨਕਾਰੀ (IFP) ਨੂੰ ਇਕ ਤੌਰ ਤੇ ਬਦਲ ਕੇ ਤੁਹਾਂ ਦੇ ਹਿਜ਼ੂਕਤੀਆਂ ਅਨੁਵਾਦ ਜਾਂ ਪਹਿਚਾਣ ਜਾਂਵਾਂ (IFP) ਨੂੰ ਇਕ ਤੌਰ ਤੇ ਬਦਲ ਕੇ ਇੱਕ ਤੌਰ ਤੇ ਗ੍ਰਾਹਕ ਜਾਨਕਾਰੀ (IFP) ਨੂੰ ਇਕ ਤੌਰ ਤੇ ਬਦਲ ਕੇ 1-800-839-2172 (TTY: 711) ਵੇਲੀਡੀਟੀਆਂ ਮੁਕਾਬਲਣ ਦੇਣਾ ਚਾਹੁੰਦੇ ਹਨ, IFP ਨੂੰ ਇਕ ਤੌਰ ਤੇ ਬਦਲ ਕੇ 1-888-926-4988 (TTY: 711) ਨੂੰ ਸੰਬੰਧ ਵੀਤਲੇਸ਼ਨ ਦੀ ਤਰਕਦੀ ਮਾਰਭਾਪਲੇਸ ਲਈ, IFP ਨੂੰ ਇਕ ਤੌਰ ਤੇ ਬਦਲ ਕੇ 1-888-926-5133 (TTY: 711) ਦੇ ਬਾਰੇ ਬਾਰੇ ਬਹਾਲ ਕਰਨਾ ਚਾਹੁੰਦੇ ਹਨ। 1-800-522-0088 (TTY: 711) 'ਤੇ ਹੈਲਥ ਨੈਟ ਦੀ ਸੇਵਾ ਪ੍ਰਾਪਤ ਕਰਨ ਦੀ ਤੱਕਨੀਕਾਂ ਲਈ।

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

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้ถ่ายเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ติ่งสัมพันธ์ที่อาจมีบนบัตรประชาชนประจำตัวของคุณ หรือโทรหาแผนเบี้ยประกันและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โปรด TTY: 711) สุทธิ ซี เซ็นทรัลเพล็กซ์ โทรหาแผนเบี้ยประกันและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โปรด TTY: 711) หรือ แผนแบบกลุ่มสำหรับการ Health Net (Small Business) ที่ 1-888-926-5133 (โปรด TTY: 711) สุทธิ ซี เซ็นทรัลเพล็กซ์ การ Treatment โทรหา Health Net โทร 1-800-522-0088 (โปรด TTY: 711)