



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. Please read the FEHB Plan brochure RI-73-159 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at [www.healthnet.com/fehb](http://www.healthnet.com/fehb) and view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary). You can call 1-800-522-0088 to request a copy of either document.

| Important Questions                                                 | Answers                                                                                                                                                                                                                            | Why This Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0.                                                                                                                                                                                                                               | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Are there services covered before you meet your <u>deductible</u> ? | There is no <u>deductible</u> .                                                                                                                                                                                                    | There is no <u>deductible</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                                                                                                                | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Medical limit:<br>\$1,500/Self Only<br>\$3,000/Self Plus One<br>\$4,500/Self and Family per calendar year.<br>Separate pharmacy limit:<br>\$2,900/Self Only<br>\$5,800/Self Plus One<br>\$8,700/Self and Family per calendar year. | The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges and health care this plan doesn't cover.                                                                                                                                          | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.healthnet.com/fehb">www.healthnet.com/fehb</a> or call 1-800-522-0088 for a list of <u>network providers</u> .                                                                                        | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | Yes.                                                                                                                                                                                                                               | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> 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 Network Provider<br>(You will pay the least) | What You Will Pay Out-of-Network<br>(You will pay the most, plus you may be balance billed) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                   | Primary care visit to treat an injury or illness | \$20 copay/visit                                               | Not covered                                                                                 | If services are not provided by your PCP, nurse practitioner or physician's assistant, the specialist copay will apply.                                                                                                                                                                                                    |
|                                                                                                                                                                                                                 | <u>Specialist</u> visit                          | \$30 copay/visit                                               | Not covered                                                                                 | Requires prior authorization.                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                 | <u>Preventive care/screening/immunization</u>    | No charge                                                      | Not covered                                                                                 | 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.                                                                                                                                                                  |
| <b>If you have a test</b>                                                                                                                                                                                       | <u>Diagnostic test</u> (x-ray, blood work)       | No charge                                                      | Not covered                                                                                 | Requires referral.                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                 | Imaging (CT/PET scans, MRIs)                     | \$250 copay/procedure                                          | Not covered                                                                                 | Requires prior authorization.                                                                                                                                                                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition.</b><br><br><b>More information about prescription drug coverage is available at <a href="http://www.healthnet.com/fehb">www.healthnet.com/fehb</a></b> | Generic drugs (Tier 1)                           | \$10 copay/retail order<br>\$20 copay/mail order               | Not covered                                                                                 | 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. |
|                                                                                                                                                                                                                 | Preferred brand drugs (Tier 2)                   | \$35 copay/retail order<br>\$70 copay/mail order               | Not covered                                                                                 |                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                 | Non-preferred brand drugs (Tier 3)               | \$60 copay/retail order<br>\$120 copay/mail order              | Not covered                                                                                 |                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                 | <u>Specialty drugs</u>                           | 20% coinsurance up to \$200 max per prescription               | Not covered                                                                                 | 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. Refer to the recommended drug list for drugs considered specialty.                                                                                         |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay Network Provider<br>(You will pay the least)                                                              | What You Will Pay Out-of-Network<br>(You will pay the most, plus you may be balance billed) | Limitations, Exceptions & Other Important Information  |
|---------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------|
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | Hospital/ASC-\$200 copay/admission<br>Services other than surgery-No charge                                                 | Not covered                                                                                 | Requires prior authorization.                          |
|                                                                           | Physician/surgeon fees                         | No charge                                                                                                                   | Not covered                                                                                 | None                                                   |
| If you need immediate medical attention                                   | Emergency room care                            | \$100 copay/visit                                                                                                           | If you need immediate medical attention-\$100 copay/visit                                   | Copay waived if admitted into the hospital.            |
|                                                                           | <u>Emergency medical transportation</u>        | No charge                                                                                                                   | If you need immediate medical attention-No charge                                           | None                                                   |
|                                                                           | <u>Urgent care</u>                             | \$20 copay/visit                                                                                                            | If you need immediate medical attention-\$20 copay/visit                                    | None                                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | \$150 copay/day for a maximum of 5 days per admission                                                                       | Not covered                                                                                 | Requires prior authorization.                          |
|                                                                           | Physician/surgeon fees                         | No charge                                                                                                                   | Not covered                                                                                 | None                                                   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office-individual therapy session-\$20 copay/visit<br>group therapy session-\$10 copay/visit<br>Other than office-No charge | Not covered                                                                                 | Requires prior authorization except for office visits. |
|                                                                           | Inpatient services                             | \$150 copay/day for a maximum of 5 days per admission                                                                       | Not covered                                                                                 | Requires prior authorization.                          |
| If you are pregnant                                                       | Office visits                                  | \$20 copay for PCP/visit<br>\$30 copay for specialist/visit                                                                 | Not covered                                                                                 | Cost sharing does not apply to preventive services.    |
|                                                                           | Childbirth/delivery professional services      | No charge                                                                                                                   | Not covered                                                                                 | None                                                   |
|                                                                           | Childbirth/delivery facility services          | \$150 copay/day for a maximum of 5 days per admission                                                                       | Not covered                                                                                 | None                                                   |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay Network Provider<br>(You will pay the least) | What You Will Pay Out-of-Network<br>(You will pay the most, plus you may be balance billed) | Limitations, Exceptions & Other Important Information                                                                                                          |
|-----------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | Nothing for first 30 visits; \$10 per visit thereafter         | Not covered                                                                                 | Copay is required on and after the 31 <sup>st</sup> calendar day of the treatment plan. Limited to 100 visits per calendar year. Requires prior authorization. |
|                                                                       | <u>Rehabilitation services</u>   | No charge                                                      | Not covered                                                                                 | Requires prior authorization.                                                                                                                                  |
|                                                                       | <u>Habilitation services</u>     | No charge                                                      | Not covered                                                                                 | Requires prior authorization.                                                                                                                                  |
|                                                                       | <u>Skilled nursing care</u>      | No charge                                                      | Not covered                                                                                 | Limited to 100 combined days per calendar year. Requires prior authorization.                                                                                  |
|                                                                       | <u>Durable medical equipment</u> | No charge                                                      | Not covered                                                                                 | Corrective footwear is not covered. Requires prior authorization.                                                                                              |
|                                                                       | <u>Hospice services</u>          | No charge                                                      | Not covered                                                                                 | Requires prior authorization.                                                                                                                                  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | \$20 copay for PCP/visit<br>\$30 copay for specialist/visit    | Not covered                                                                                 | Covered only through age 17.                                                                                                                                   |
|                                                                       | Children's glasses               | Not covered                                                    | Not covered                                                                                 | None                                                                                                                                                           |
|                                                                       | Children's dental check-up       | Not covered                                                    | 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](#).)

|                                                                                                     |                                                                                                                                  |                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|

##### 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"> <li>• Acupuncture-\$10 copay/visit up to 20 visits per calendar year, combined with chiropractic care. Administered by American Specialty Health (ASH).</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care-\$10 copay/visit up to 20 visits per calendar year, combined with acupuncture. Administered by American Specialty Health (ASH).</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul> |
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## Your Rights to Continue Coverage:

You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-522-0088 or visit [www.opm.gov/insure/health](http://www.opm.gov/insure/health). Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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](http://www.HealthCare.gov) or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your plan’s FEHB brochure. If you need assistance, you can contact: Health Net’s Customer Contact Center at 1-800-522-0088. 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/fehb](http://www.healthnet.com/fehb), 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](http://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 or TDD line 1-877-688-9891 for the hearing and speech impaired or [www.dmhc.ca.gov](http://www.dmhc.ca.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at the contact information provided above.

## Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

## 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, 请拨打这个号码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 \$30
- Hospital (facility) copayment \$150
- Other copayment \$20

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$200        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$260</b> |

### 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 \$30
- Hospital (facility) copayment \$150
- Other copayment \$20

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$800        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$820</b> |

### Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$150
- Other copayment \$20

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$200        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$200</b> |

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. (Health Net) complies with applicable Federal nondiscrimination laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined medically necessary.

### **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:

**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. Appeals & Grievances

PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: [Member.Discrimination.Complaints@healthnet.com](mailto:Member.Discrimination.Complaints@healthnet.com) (Members) or

[Non-Member.Discrimination.Complaints@healthnet.com](mailto:Non-Member.Discrimination.Complaints@healthnet.com) (Applicants)

FEHB Program members must write to OPM within:

- 90 days after the date of our letter upholding Health Net's initial decision; or
- 120 days after you first wrote to health Net - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

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 مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: (TTY: 711) 1-800-839-2172. للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: (TTY: 711) 1-888-926-4988 أو المشروعات الصغيرة (TTY: 711) 1-888-926-5133. لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم (TTY: 711) 1-800-522-0088.

## Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Համախորհրդների 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 दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

## 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 ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu kovtooj 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

សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសាខ្មែរស្របតាមលោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 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 bąąh ilinígóó saad bee háká ada'ílyeed. Ata' halné'ígíí da la' ná hádííóót'íí. Naaltsos da t'áá shí shízaad k'ehjí shichí' yídooltah nínízingo t'áá ná ákódoolnii. Ákót'éego shiká a'doowot nínízingo Customer Contact Center hooyéhi' hodiilnih ninaaltsos nantingo bee néého'dolzinigii hodoonihj' bikáá' éi doodago koj' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhiigii koj' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éi doodago Small Business báhiigii koj' hólne' -888-926-5133 (TTY: 711). Group Plans through Health Net báhiigii éi koj' hólne' 1-800-522-0088 (TTY: 711).

## Persian (Farsi)

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

### **Panjabi (Punjabi)**

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਐਂਡ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐਂਡ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੈਲ ਬਿਜਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੇਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੇਨਾਂ 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 представленным 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 представленным 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**

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรมา TTY: 711) สำหรับเซตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมา TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมา TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมา 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 DMHC On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)