



**MFOW WELFARE FUND  
240 2ND STREET  
SAN FRANCISCO CA 94105**

**August 15, 2023**

**TO: ALL PLAN PARTICIPANTS COVERED UNDER THE PHS REPLACEMENT PROGRAM HMO AND PPO MEDICAL AND PRESCRIPTION DRUG PLANS**

**RE: IMPORTANT NOTICE REGARDING YOUR HEALTH CARE COVERAGE ANNUAL SUMMARY OF BENEFITS COVERAGE FORM**

Attached is a copy of the most recent Summary of Benefits Coverage Form outlining the Medical and Prescription Drug Plan benefits in which you are currently enrolled through the MFOW Welfare Benefit Plan and notices prepared by various providers highlighting some of the benefit changes for the year.

The summary of changes outlined below, together with the enclosed Summary of Benefits Coverage Forms, constitute the “summary of material modifications” of the benefits provided under the medical plan options described in the Forms. Please keep this summary with your copy of the Summary Plan Description and your Evidence of Coverage.

If you wish to review the Summary of Benefits Coverage Forms for any of the other HMO/PPO plans and/or wish to make a change to one of the other HMO plans available to you, please contact the Welfare Fund Office (415) 986-1028 (240 Second Street, San Francisco, CA 94105). You have through September 30, 2023 to make any changes to your plan selection for an October 1, 2023 effective date.

If you wish to receive a hard copy of this notice, please contact the Welfare Fund Office. Summary of Benefits Coverage Forms for all HMO and PPO plans can be found at [www.mfoww.org](http://www.mfoww.org) under the “Downloads” tab.

The following is a summary of the major Plan clarifications or changes (note that all benefits are subject to the terms of the plan document and applicable group insurance policy and Evidence of Coverage):

**Kaiser Northern and Southern California Plans:** Effective October 1, 2023, there are no substantial benefit changes, except, the following two copayment changes will apply:

1. *Mental Health Services.* The copayment for Mental Health Outpatient Intensive ABA Program for Autism will change from \$20 per day to \$0 per day.
2. *Chemical Dependency Services.* The copayment for Chemical Dependency Outpatient Intensive Outpatient Program will change from \$5 per day to \$0 per day.

You should refer to your 2023 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

**Kaiser Hawaii Plan:** Effective October 1, 2023, there are no contract changes however the following

two clarifications apply:

1. *Home Phototherapy Equipment.* Clarify language that the home phototherapy equipment benefit applies to all members.
2. *Specialty Drugs.* Clarify language that specialty drugs available through mail order are covered at the usual Drug Rider copay for a 30-day supply.

For details on your coverage, please refer to your Kaiser Permanente Hawaii's Guide to Your Health Plan that can be obtained from the Fund Office or Kaiser.

**Kaiser Washington Plan:** Effective October 1, 2023, the following changes and/or clarifications apply. This list is not all-inclusive and you should refer to your 2023 Benefit Booklet for a complete list.

1. *Emergency Services* – If you need emergency services while traveling and are admitted to a non-network hospital, You or a family member must notify Kaiser with 24 hours (formerly 48 hours) or as soon as reasonably possible.
2. *Emergency ambulance service is covered only when:*
  - Transport is to the nearest facility that can treat your condition
  - Any other type of transport would put your health or safety at risk
  - The service is from a licensed ambulance.
  - The ambulance transports you to a location where you receive covered services.
3. *Ambulance Coverage Clarification:* Non-Emergency ground or air interfacility transfer to or from a Network Facility where you receive covered services when preauthorized by Kaiser Foundation Health Plan of Washington (KFHPWA) is covered. Contact Member Services for Preauthorization.
4. *New Benefit Advanced Care at Home* - is a patient centered program designed to provide hospital-level acute care and clinical services to Members with certain diagnoses at home under the direction of KFHPWA physicians. If a Member is admitted as an inpatient or to Advanced Care at Home directly from an emergency department, any emergency services copayment is waived. Coverage is subject to the hospital services Cost Share.
5. *Out-patient Prescription Drugs* - For outpatient prescription drugs and/or items that are covered under the Drugs –Outpatient Prescription section and obtained at a pharmacy owned and operated by KFHPWA, a Member may be able to use approved manufacturer coupons as payment for the Cost Sharing that a Member owes, as allowed under KFHPWA's coupon program. A Member will owe any additional amount if the coupon does not cover the entire amount of the Cost Sharing for the Member's prescription. When a Member uses an approved coupon for payment of their Cost Sharing, the coupon amount and any additional payment that they make will accumulate to their Out-of-Pocket Limit. More information is available regarding the Kaiser Permanente coupon program rules and limitations at [www.kp.org/rxcoupons](http://www.kp.org/rxcoupons).
6. *Eligibility, Enrollment and Termination – Continuation of Inpatient Services – Benefit Change* – Continuation of Inpatient services for a Member who is in the hospital on the date of termination of eligibility will no longer be covered under the contract. Therefore, you will be responsible for paying for any services provided on or after your termination date.

You should refer to your 2023 Benefit Booklet for a complete list of your plan benefits and coverage

provisions.

**Kaiser Oregon Plan:** Effective October 1, 2023, there are no plan changes.

You should refer to your 2023 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

**Health Net HMO and PPO Plans:** The PPO Plans include some administrative and regulatory changes that Health Net is implementing effective October 1, 2023. There are no changes to the HMO Plan provisions effective October 1, 2023.

*(refer to attached Health Net notices for a list of all other changes and clarifications effective at renewal)*

You should refer to your 2023 Health Net Benefit Booklet for a complete list of your plan benefits and coverage provisions.

### Grandfathered Group Health Plans

The Welfare Fund's Board of Trustees has concluded that the HMO and PPO Plans are "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of certain lifetime limits on benefits.

Although it is a "grandfathered health plan", you should know that the Plan provides health coverage \benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage based on required work hours. Nor does the Plan discriminate in favor of certain members based on compensation, age, gender, or health status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (415) 986-1028. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## M.F.O.W. Welfare Fund

### PPO Plan Changes 10/1/23

Your plans include some **administrative and regulatory changes** that Health Net is implementing for the 2023 plan year that are reflected in your renewal package:

Chiropractic and Acupuncture Benefits	PPO/H'SA plans <u>will transition</u> to an rider-based approach for Chiropractic and Acupuncture benefits provided by the <b>American Specialty Health (ASH) network</b> .												
PPO													
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 35%;">In Network</th> <th style="width: 35%;">OON</th> </tr> </thead> <tbody> <tr> <td>Chiro</td> <td>\$10 copay</td> <td>30% after deductible</td> </tr> <tr> <td>Acupuncture</td> <td>\$10 copay</td> <td>30% after deductible</td> </tr> <tr> <td>Visit Limit</td> <td colspan="2" style="text-align: center;">20 visits chiro &amp; acu combined</td> </tr> </tbody> </table>		In Network	OON	Chiro	\$10 copay	30% after deductible	Acupuncture	\$10 copay	30% after deductible	Visit Limit	20 visits chiro & acu combined	
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Visit Limit	20 visits chiro & acu combined												
\$25 max payable on the chiro plan has been removed.													
ER Services	Professional Services and Room Services on OON tier the deductible will be waived.												
Ambulance	Ambulance ground and air on the OON tier is changed from 30% (deductible applies) to 10% (deductible waived).												
AB 245 Abortion Services	Per Assembly Bill 245, abortion services and abortion related services will be covered with no cost share for all non-HDHPs.  10% on the In-Network tier and 30% [deductible applies] will now be \$0 copay on both tiers.												
Female Sterilization	Female Sterilization will change from 10% on the In-network tier to zero cost-share.												
Infusion Therapy	Infusion Therapy administered at home will go from 10% coinsurance on the in-network tier to \$0 copay												
Bariatric Services	Bariatric Services will change from being covered on OON tier from 30% coinsurance to <u>not covered</u> .												
Mental Health ER Services	Use of emergency room will change from \$100 +10% to 10% on the in-network tier.												

PPO Rx

<p>OOPM max</p>	<p>Current RX plan does not have an OOPM; however, due to ACA regulations we are required to include an OOPM which will be combined with the medical.</p> <table border="1" data-bbox="626 407 1292 564"> <tr> <td>INN Individual OOPM:</td> <td>\$2,000</td> </tr> <tr> <td>INN Family OOPM:</td> <td>\$6,000</td> </tr> <tr> <td>OON Individual OOPM:</td> <td>\$6,000</td> </tr> <tr> <td>OON Family OOPM:</td> <td>\$18,000</td> </tr> </table>	INN Individual OOPM:	\$2,000	INN Family OOPM:	\$6,000	OON Individual OOPM:	\$6,000	OON Family OOPM:	\$18,000
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<p>Specialty Medications</p>	<p>Specialty medications will fall under Tier 4.</p> <p>Tier 4 (Specialty Pharmacy)          Applicable tier 1, 2, or 3 rx copay for Specialty drugs;  <b>Self Injectables will be 30% w/ \$250 max</b></p>								
<p>Oral Cancer Medications</p>	<p>OOPM will change from \$200 to \$250 for oral cancer medications.</p>								
<p>Blood Clotting Factors</p>	<p>Blood Clotting Factors will now be covered through pharmacy benefits.</p>								
<p><u>Current*</u>          When generic is available and Brand Name drug is dispensed: member is responsible for the Prescription Drug Deductible, The Generic (tier1) drug copayment, and the difference between the cost of the generic and the Brand Name. However, if the Prescription Drug Order states "do not substitute," "dispense as written," or words of similar meaning in the Physician's handwriting to indicate Medical Necessity, only the (Prescription Drug Deductible and the) Brand Name Drug Copayment will be applicable and the tier 2 drug copay for tier 2 drug, or tier 3 drug copay for tier 3 drug.</p> <p><u>New*</u>          If a Brand Name Drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the Generic and Brand Name Drug. [Generic Drugs will be dispensed when a Generic Drug equivalent is available.] However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.</p>									



Health Net of California, Inc.  
PO Box 9103  
Van Nuys, CA 91409-9103

**Commercial Large Group and  
Grandfathered Small Group Plans**  
*Notice of Changes to Coverage Terms for Groups*  
*Effective on and after January 1, 2023*

The Health Net of California, Inc. (Health Net) Group Hospital and Professional Service Agreements (GSAs) and Evidences of Coverage (EOCs) issued in 2023 will include the changes to coverage terms as described in this notice for compliance with new laws, regulatory requirements and/or to address our administrative changes. The following modifications apply to California Commercial Large Group and Grandfathered Small Group plans and will appear (where applicable) in GSAs/EOCs with the effective date on or after January 1, 2023.

Changes that appear on this notice are in addition to any other 2023 plan change materials that you may have received. This is only a summary of changes. Please refer to the EOC for more details on the terms of coverage. Additional changes, not confirmed at the time of this notice distribution, may be required. Please ensure that enrollees in your groups are informed of the changes described in this notice.

Unless specifically noted otherwise, the following changes apply to all commercial products, including HMO, PPO, SELECT (POS), ELECT Open Access, and Salud HMO.

**PPO**

- Regulator Change:** The PPO Policies and Certificates underwritten by Health Net Life Insurance Company and regulated by the California Department of Insurance has been discontinued and these PPO insurance plans will not be renewed in 2023. Health Net of California, Inc. will issue 2023 plans with a GSA and EOC regulated by the Department of Managed Health Care (DMHC). Although some terms have changed to comply with DMHC regulations and the documents' organization may be different, benefit and terms of coverage remain the same. (**Note:** Applies only to PPO)
- Health Net logo:** The Health Net logo has been updated to a new design. (**Note:** Applies only to PPO)

**Global Changes**

- Prior Authorization:** Throughout the document references to "Certification" have been changed to "Prior Authorization," but retains the same meaning. (**Note:** Applies only to PPO and SELECT)

**Legislative/Regulatory Changes**

- COVID-19 Consolidated Appropriations Act, 2021 - Stimulus and Omnibus Legislation (No Surprises Act, Section 104):** Federal law now prohibits balance billing to members for emergency services received from an out-of-network provider. Balance billing is the difference between out-of-network provider's billed charge and the maximum allowable amount. Due to the new regulation, the "Ambulance Services" provision under "Covered Services and Supplies" has been revised and a new footnote has been added to the Schedule of Benefits under "Ambulance Services." (**Note:** Applies only to PPO and SELECT)

2. **Notice of Privacy Practices:** The Notice of Privacy Practices has been updated in accordance with AB 1184 and includes updates to the "Right to Request Confidential Communications" and new definitions for "Protected Individual" and "Sensitive Services."
3. **Deductible and Out-of-Pocket Maximum (OOPM) accumulations:** To comply with SB 368 Health Net will notify members of deductible and OOPM accumulations for each month in which benefits were used and when they have reached their deductible and OOPM amounts for the calendar year.
4. **Timely Access to Care:** To comply with current policy and SB 221, timely access waiting times have been updated.
5. **Termination of pregnancy:** To align with SB 245 the "Care for Conditions of Pregnancy" provision in the "Schedule of Benefits" and the "Pregnancy" provision under "Covered Services and Supplies" has been revised to include no cost coverage of termination of pregnancy and related services.
6. **Step Therapy:** A new "Step Therapy" provision has been added under the "Covered Services and Supplies" section that describes how the process works.
7. **Pilot Program:** *A pilot program as part of AB 315 that allowed up to a 90-day supply of maintenance drugs to be purchased at any retail pharmacy in Riverside and Sonoma counties has expired and has been removed from the EOCs.*

### Policy Changes

1. **Prior Authorization Requirements:** The list of services under "Outpatient procedures, services or equipment" that require prior authorization has been updated as follows:
  - *Cardiovascular procedures and Ear Nose and Throat (ENT) procedures have been added.*
  - Balloon sinuplasty and cochlear implants have been removed
  - "Genetic testing" has been changed to add that prior authorization for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer is not required.

(Note: Applies only to PPO and SELECT)

### Language Clarification

1. **Mobile Application:** The Health Net Mobile App will no longer be available. With new and improved mobile functionality, the new portal at [www.healthnet.com](http://www.healthnet.com) offers a great experience through whatever device you're using.
2. **Prescription Drugs:** In the "Definitions" section and "Schedule of Benefits," the descriptions for Tier 1, Tier 2, Tier 3, and Specialty Drugs have been changed to align with current Health Net pharmacy descriptions.

For more information regarding this Notice of Changes to Coverage Terms for 2023, please contact your Health Net sales representative.

Sincerely,

Health Net of California, Inc.

*HMO, EOA, POS, PPO and Salud con Health Net HMO plans are offered by Health Net of California, Inc. Health Net of California, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All rights reserved.*



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 1-800-522-0088. 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](http://www.healthnet.com) or you can call 1-800-522-0088 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <a href="#">deductible</a>?</b>	There is no <a href="#">deductible</a> through <a href="#">preferred providers</a> ; \$500 member/\$1,500 family through <a href="#">out-of-network providers</a> per calendar year.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	There is no <a href="#">deductible</a> through <a href="#">preferred providers</a> .	There is no deductible through <a href="#">preferred providers</a> . You will however, have to meet the <a href="#">out-of-network deductible</a> before the <a href="#">plan</a> pays for any <a href="#">out-of-network</a> services (except for <a href="#">prescription drugs</a> , <a href="#">emergency room care</a> & <a href="#">emergency medical transportation</a> ).
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$500/lifetime for infertility treatment. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<u>Combined medical/pharmacy limit</u> : \$2,000 member/\$6,000 family through <a href="#">preferred providers</a> ; \$6,000 member/\$18,000 family through <a href="#">out-of-network providers</a> per calendar year combined.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, non-authorization penalties and healthcare this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <b>preferred providers</b> , see <a href="http://www.healthnet.com/providersearch">www.healthnet.com/providersearch</a> or call 1-800-522-0088.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .





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 Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge for covered services	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
<b>If you need drugs to treat your illness or condition.</b>  <b>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthnet.com">www.healthnet.com</a></b>	Generic drugs	\$10 <a href="#">copay</a> /retail order \$20 <a href="#">copay</a> /mail order	\$10 <a href="#">copay</a> + 50% <a href="#">coinsurance</a> AWP/retail order	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior Authorization is required for select drugs and brands with a generic equivalent. Maintenance drugs may be filled by mail order or a CVS retail pharmacy for up to a 90 day supply.
	Preferred brand drugs	\$20 <a href="#">copay</a> /retail order \$40 <a href="#">copay</a> /mail order	\$20 <a href="#">copay</a> + 50% <a href="#">coinsurance</a> AWP/retail order	
	Non-preferred brand drugs	\$35 <a href="#">copay</a> /retail order \$70 <a href="#">copay</a> /mail order	\$35 <a href="#">copay</a> + 50% <a href="#">coinsurance</a> AWP/retail order	
	<a href="#">Specialty drugs</a>	Self injectables- 30% <a href="#">coinsurance</a> Refer to the recommended drug list for other drugs considered specialty	Not covered	Up to \$250 max copay per prescription. Supply/order up to a 30 day supply specialty pharmacy except where quantity limits apply. Prior authorization required for select drugs and brands with a generic equivalent. Specialty drugs not covered Out of network.

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

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital-10% <a href="#">coinsurance</a> ASC-10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some outpatient surgical procedures require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some outpatient surgical procedures require <a href="#">prior authorization</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a> <a href="#">deductible</a> does not apply	<a href="#">Copay</a> waived if admitted into the hospital.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> <a href="#">deductible</a> does not apply	<a href="#">Prior authorization</a> is required in a non-emergency. If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
	<a href="#">Urgent care</a>	Medical-10% <a href="#">coinsurance</a> Mental health & substance use disorders-\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> services which meet the criteria for emergency care are payable at the <a href="#">preferred provider</a> level of coverage.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required in a non-emergency. If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required for a hospital stay and some services received while admitted to the hospital.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$10 <a href="#">copay</a> /visit Other than office-No charge	30% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained for services other than office visits, benefits will be reduced to 50% <a href="#">coinsurance</a> . Administered by Managed Health Network (MHN).
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required in a non-emergency. If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> . Administered by Managed Health Network (MHN).

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

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office visits	Prenatal-10% <a href="#">coinsurance</a> Postnatal-10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage includes abortion services.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage includes abortion services.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some services require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some services require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> . Limited to 20 visits through <a href="#">preferred providers</a> and <a href="#">out-of-network providers</a> combined for all therapies per calendar year.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing center</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some services require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. If <a href="#">prior authorization</a> is not obtained, benefits will be reduced to 50% <a href="#">coinsurance</a> .
If your child needs dental or eye care	Children's eye exam	PCP-\$10 <a href="#">copay</a> /visit Specialist-\$10 <a href="#">copay</a> /visit	Not covered	Covered only through age 16.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

## Excluded Services & Other Covered Services:

Services Your <b>Plan</b> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <b>excluded services</b> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><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 eye care (Adult)</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 <b>plan</b> document.)		
<ul style="list-style-type: none"><li>• Acupuncture-Administered by American Specialty Health (ASH). Acupuncture is covered with a cost share of \$10 copay/visit (PPO)/30% coinsurance (OON); up to 20 visits per calendar year.</li><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care-Administered by American Specialty Health (ASH). Chiropractic care is covered with a cost share of \$10 copay/visit (PPO)/30% coinsurance (OON); up to 20 visits per calendar year.</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment-limited to a lifetime limit of \$2,000.</li></ul>

## 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](http://www.dol.gov/ebsa/healthreform). Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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](http://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](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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

**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*)

### 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](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

**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*)

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

**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>\$12,700</b>
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<b>Total Example Cost</b>	<b>\$5,600</b>
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<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,390</b>

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$610</b>

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$270</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. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, 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](mailto:Member.Discrimination.Complaints@healthnet.com) (Members) or  
[Non-Member.Discrimination.Complaints@healthnet.com](mailto:Non-Member.Discrimination.Complaints@healthnet.com) (Applicants)

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](http://www.dmhc.ca.gov/FileaComplaint).

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: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر 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 Համախորհրդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Վարիֆորնիայի 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 Ինֆային 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**

សេវាកម្មភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសាស្រីលោកអ្នក។ 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 shizaad k'ehjí shichí' yídooltah nínízingo t'áá ná ákódoolnít. Ákót'éego shiká a'doowot nínízingo Customer Contact Center hoolyéhíjí' hodíílnih ninaaltsos nanítingo bee néého'dolznígíí hodoonhíjí' bikáá' éi doodago kojí' hólné' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojí' hólné' IFP On Exchange 1-888- 926-4988 (TTY: 711) éi doodago Small Business báhígíí kojí' hólné' -888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éi kojí' hólné' 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 ਦੁਬਾਰੀਏ 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 ਬਿਜਨੈਸ 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 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**

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)