health net

Four Tips for Smarter Travel

NO MATTER WHERE YOU GO, HEALTH NET HAS YOU COVERED!

For Stanford Students

1 Healthy travel packing list

- **Health Net ID card.** Your ID card tells doctors, medical facilities and pharmacies that you have Health Net coverage.
- **Medications.** Be sure to pack the medications you take. If you need refills, you have access to Health Net-contracted pharmacies anywhere in the United States. If you need extra medication for a trip outside of the United States, contact the Walgreens at Vaden Health Center pharmacy for assistance before you leave campus.
- **List of local providers.** While planning your trip, locate the in-network providers, urgent care centers and pharmacies near your destination.

2 How to find providers and pharmacies

Go to **www.healthnet.com/cardinalcare**, and click *ProviderSearch Tips*.

- **To search for network doctors and facilities within California** but away from the Stanford campus, select *Stanford Student PPO* from the ProviderSearch drop-down menu.
- **To search for network doctors and facilities outside of California**, select *National PPO – First Health* from the drop-down menu. Follow the steps to search for local network providers.
- **To find a pharmacy anywhere in the United States, go to** www.healthnet.com/cardinalcare > *ProviderSearch Tips* > *Find a pharmacy*.

(continued)

Have questions?

Health Net
Member Services:
800-250-5226

Health Net International Member Services: **818-676-6767**

ISOS: **215-942-8226**
(collect calls accepted)

3 How to access care away from school

Within the U.S.

Students may access covered services under tier 2 of the plan. While in California, you must access the Health Net PPO network. When outside of California, you must access the First Health Network. If you don't have an emergency but need urgent care, you can go to the closest Health Net or First Health-contracted urgent care center.

Outside the U.S.

Students may access covered services under tier 2 of the plan from any licensed doctor or hospital anywhere in the world. You'll need to file a claim for reimbursement if you receive care outside the United States. Be sure to:

1. Make a copy of the itemized statement for the care you receive. Keep this for your records.
2. Include the original itemized statement and proof of payment (in U.S. dollars) with your claim form. "Proof of Payment" includes, but is not limited to, a copy of the credit card charge slip, a cruise ship statement or canceled checks. (Include the name of the country and currency used.)
3. Mail claim form to Health Net within 90 days of service date.

Travel note

Request documentation in English, if possible, or get forms translated to English before you send in your claim. Submit medical and pharmacy charges together only if both services are provided as part of an inpatient stay. Otherwise submit the claims separately.

4 International SOS (ISOS)

As a Cardinal Care member, you're entitled to ISOS emergency travel assistance when traveling abroad. Download an ISOS ID card from the ISOS website. Contact the numbers on the back of the card in the event of an emergency.

Services include:

- Emergency medical evacuation
- Medically necessary repatriation
- Help with medical, behavioral health, dental, pharmacy and hospital referrals.
- Help with prescription drug replacement

To print an ISOS member card, go to www.internationalsos.com.

NOTE:

In an emergency, call 911 or go to the nearest emergency room. Be sure to have the hospital staff or a family member inform Health Net within 48 hours. They can call the number on the back of your ID card.

Personalized ID card

Health Net offers several options for accessing an image, printing a copy or ordering a replacement of your ID card:

- Via smartphone with Health Net Mobile
- Online at www.healthnet.com/cardinalcare
- Call 1-800-250-5226

Forms

Needed forms can be found at the end of this PDF. You can also download them from www.healthnet.com/cardinalcare by clicking Travel Guide.

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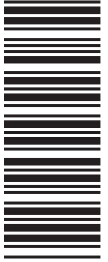
Member Reimbursement Form & Foreign Claim Questionnaire



Important: Complete a separate form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- Copy of itemized bill showing all services received. Must include name, address, phone number, tax ID number of doctor and/or facility, date of service and all diagnosis and procedure codes.
- Proof of payment for reimbursement requests over $200.[1]
- See the instructions in **Section 4** for Foreign Claim Questionnaire for services received outside of the U.S.

Mail all documents to: Health Net, LLC
Commercial Claims
PO Box 9040, Farmington, MO 63640-9040

Section 1: Member information – *Please complete a separate form for each person who received services.*

Last name:	First name:	MI:
Member ID #:	Date of birth (Mo./Day/Yr.): / /	
Phone #:	Email address:	
Address:		
City:	State:	ZIP:

Section 2: Other insurance – *Complete if it applies.*

Is the member also covered by other medical insurance at this time? ☐ Yes *(Complete information below.)* ☐ No

Name of other insurance company:	Policy #:
Subscriber/Member ID #:	Does this member have Medicare coverage? ☐ Yes ☐ No

Section 3: Services received – *If services were received outside the U.S., please skip to Section 4.*

Name of doctor and/or facility:	Phone number of doctor and/or facility:	
Address of doctor and/or facility:		
Medical description or nature of illness or injury:	Date of service:	Amount requested to be reimbursed:

Medical information authorization and release[2]

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to Health Net, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Health Net, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Health Net is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

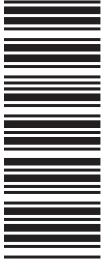
Name of person completing form (please print):	Signature:
Date:	Relationship – description of authority to act on behalf of the member, if applicable:

[1] "Proof of Payment" includes: a copy of the credit card charge slip or online statement, canceled checks, a bank account statement, cash withdrawal slips, or a cruise ship statement. **Note:** Invoices are not acceptable proof of payment.

[2] You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the plan, as referenced in the Notice of Privacy Practices.

(continued)

Section 4: Foreign claim questionnaire



If you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters, you'll need to complete this section. Be sure to answer every question so your claim can be processed quickly. Please provide any and all medical records given by the provider, such as a Face Sheet, Admission Sheet, Discharge paperwork, and all other paperwork provided, preferably in English.

What dates were you traveling out of the country?		
What was the nature of your emergency resulting in medical treatment?		
How long were you ill before you received medical attention?		
Were you admitted into the hospital? ☐ Yes ☐ No	If treated as an outpatient, how many times did you see the doctor?	
Name of the hospital, clinic or doctor's office where you received treatment:	Date(s) of admission/service:	
Address:		
Country:	Phone number:	
Name of treating physician:	Phone number:	
Medical description or nature of illness or injury:	Date of service:	Amount requested to be reimbursed:
Did you receive diagnostic tests? ☐ Yes ☐ No	If "Yes," what type?	
Were surgical procedures performed? ☐ Yes ☐ No	If "Yes," what type?	
Was your primary doctor in the U.S. notified? ☐ Yes ☐ No	If "Yes," when?	

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.

For your protection, California law requires the following statement to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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Health Net Life Insurance Company (Health Net)

Prescription Drug Claim Form

This claim form is to be used for reimbursement on covered medications provided by pharmacies. The filing of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information. If you have any questions regarding this form, or require additional forms, please contact Health Net at the telephone number listed on your member ID card, or visit **www.healthnet.com** (Group members) or **www.myhealthnetca.com** (Individual & Family Plan members).

Instructions

1. Complete the subscriber/enrollee information section below. You'll find your subscriber ID and group numbers on your Health Net ID card or on the copy of your application that serves as your temporary ID.
2. Please have your pharmacist complete the section on the back, and submit an itemized pharmacy receipt that includes the same information.
3. You must complete a separate claim form for each family member. You also need a separate form for each pharmacy you use.
4. This form must be completed in full, or it will be returned for completion. Please allow four weeks for completed claim forms to be processed.
5. Return the completed form to:

   Group members:
   Health Net Life Insurance Company
   C/O Caremark
   PO Box 52136
   Phoenix, AZ 85072-2136

Subscriber/Enrollee

Subscriber/Enrollee ID #:	Group #:	Contact phone #:

Subscriber/Enrollee last name:	First name:	MI:

Address:	City:	State:	ZIP:

Patient name:	Prescriptions were for (diagnosis):	Date of birth:

Is this medication for an on-the-job-injury? ☐ Yes ☐ No

Is this medication covered under any other group insurance plan? ☐ Yes ☐ No

If "Yes," give name of insurance company and other employer: ______________________________

Health Net PPO, Flex Net and Medicare Supplement are fully underwritten by Health Net Life Insurance Company.

I certify that the above information is correct and that the above-written person is eligible for benefits. I have received the medication described herein and authorize release of all information contained on this voucher to Health Net or its agent.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempting assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

X ______________________________ ______________________
Signature (insured person) Date

(continued)

Please ask your pharmacist to complete the remaining portion. We cannot process this form without this information.

Rx number:	Date filled:	Check one:	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
1.		☐ New ☐ Rx refill ☐ Compound				
Medication name and strength:				MD DEA number:	NDC number required:	
2.		☐ New ☐ Rx refill ☐ Compound				
Medication name and strength:				MD DEA number:	NDC number required:	
3.		☐ New ☐ Rx refill ☐ Compound				
Medication name and strength:				MD DEA number:	NDC number required:	

If compound – please fill out the information below.

Place pharmacy label here.

Pharmacy name:______________________________

Street address:______________________________

City:________________ State:______ ZIP:______

7-digit NABP number required: ____________________

(Please obtain this number from your pharmacy.)

Are you a Health Net participating pharmacy? ☐ Yes ☐ No

Pharmacist signature X ________________________

Note: Benefits are payable directly to the covered individual, and any assignment of these benefits is void.

Compound prescription information

- Include Rx number(s), drug name(s), strength(s), and date filled.
- Include all the NDC number(s) for the drug(s) dispensed.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.

Compound prescriptions

Rx number	NDC number	Drug name	Quantity	Cost	Date filled

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Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net Life Insurance Company and Health Net of California, Inc. (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

IFP On Exchange/Covered California 1-888-926-4988 (TTY: 711)
IFP Off Exchange 1-800-839-2172 (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, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online at: Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances, PO Box 10348, Van Nuys, CA 91410-0348, by fax: 1-877-831-6019, or online: healthnet.com (Group) or myhealthnetca.com (IFP).

If you are not satisfied with Health Net's decision or it has been more than 30 days since you filed the complaint, you may submit a complaint form to the Department of Managed Health Care (DMHC). The form is available at www.dmhc.ca.gov/FileaComplaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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) if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

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 Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի 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 xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese

無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP) (個人・家族向けプラン) Off Exchange: 1-800-839-2172 (TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988 (TTY: 711) または Small Business 1-888-926-5133 (TTY: 711) までお電話ください。Health Netによるグループプランについては、1-800-522-0088 (TTY: 711) までお電話ください。

Khmer

សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯក
សារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិ
ថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក 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
고객서비스 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 bááh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá
shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolnííł. Ákót'éego shíká a'doowoł nínízingo
Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee nééhó'dolzinígíí hodoonihjį'
bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711).
California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago
Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí
kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای
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 ਦੁਭਾਸ਼ੀਏ 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) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ
ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ
1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ,
1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

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

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog

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

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด 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 l òng 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).