Health Net®

Small Business Application

for Group Enrollment and Change

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the "Health Net Entities"). Dental HMO plans, other than pediatric dental, are offered and administered by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans, other than pediatric dental, are underwritten by Unimerica Life Insurance Company and administered by Dental Benefit Administrative Services (together, the "DBP Entities"). Vision plans, other than pediatric vision, are provided by Fidelity Security Life Insurance Company and administered by EyeMed Vision Care, LLC (together, the "Fidelity Entities").

Pediatric dental HMO plans are provided by Health Net of California, Inc. Pediatric dental PPO and indemnity plans are provided by Health Net Life Insurance Company.

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans, other than pediatric dental or vision, are neither obligations of, nor guaranteed by, the Health Net Entities.

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.
2. Select the plan option(s) that is best for you and your covered family members.

   The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has essential coverage and is not subject to the ACA's individual shared responsibility payment provision. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information on the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the WholeCare HMO Network, SmartCare HMO Network, Salud HMO y Más Network, PureCare HSP Network, or Dental HMO (DHMO), you must select your provider, physician group, primary care physician (PCP), and dental provider. Be sure to fill in the names and numbers as they appear in Health Net's online ProviderSearch tool.

Note: If you do not select a physician group, primary care physician and/or a dental provider, one will be selected for you.

4. If you choose to enroll in a PPO or EPO insurance plan, you are not required to select a primary care physician or physician group to enroll.
5. Make a copy of the completed application for your records.

For administrative use only:	
Existing Business/Group PO Box 9103 Van Nuys, CA 91409-9103 www.healthnet.com	**New Business/Group** Please send all completed paperwork to your designated account executive or broker.

Health Net®

(For enrollment, sections 1, 3 and 8 are required. For waivers, only section 7 is required. All medical plans include pediatric dental and vision coverage.)

To be completed by employer	
Employer name:	
Requested effective date:	Employer group number *(medical)*:
Employee eligibility date *(new hire only)*: ☐ Same as hired date ☐ Other: _____	

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (Select coverage.)

WholeCare HMO[1]

Platinum	Gold
☐ 10 ☐ 25 ☐ Standard Copay	☐ 35 ☐ 45 ☐ Standard Copay

SmartCare HMO[2]

Platinum	Gold
☐ 10 ☐ 20 ☐ 30	☐ 40 ☐ 50

Salud HMO y Más[3]

Platinum	Gold
☐ 10 ☐ 20 ☐ 25	☐ 35 ☐ 45

PureCare One EPO[1]	PureCare HSP[1]
☐ Health Net Gold 80 EPO Alternate ☐ Health Net Silver 70 HSA EPO Alternate	☐ Silver Standard Coinsurance ☐ Bronze Standard Coinsurance

PPO

☐ Health Net Platinum 90 PPO	☐ Health Net Gold 80 PPO	☐ Health Net Silver 70 PPO	☐ Health Net Bronze 60 PPO

Dental (DHMO)	Dental (DPPO)	Vision (PPO)
☐ HN Plus 150 ☐ HN Plus 225	☐ Classic 5 ☐ Essential 2 ☐ Essential 6	☐ Preferred 1025-2 ☐ Preferred 1025-3 ☐ Preferred Value 10-2

2. Reason for change

Reason for change:	Reason for application:
☐ Plan change	☐ New hire Date of hire: ____/____/_____
☐ Change address/name	☐ Open Enrollment ☐ Loss of prior coverage date: ____/____/_____
☐ Delete dependent *(list names below)*	☐ COBRA[4] effective date: ____/____/_____ Qualifying event date: ____/____/_____
☐ Other: _____	☐ Add dependent: _____
	Qualifying event: _____ Qualifying event date: ____/____/_____

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:	City:	State:	ZIP:

Date of birth *(mm/dd/yyyy)*:	Social Security #/Matricular ID # (required for all applicants):	Job title:
Telephone #: ( )	Work phone #: ( )	Email address:
Date of hire: / /	Dept. #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner

If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No

Participating physician group/PPG #:	Health Net primary care physician/PCP #:	
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:

Employee name: ______________________________ Last 4 digits of Social Security #: __ __ __ __

4. *Family information, please list all eligible family members to be enrolled.*

(Attach additional sheets if necessary.)

☐ Spouse ☐ M ☐ Domestic partner ☐ F	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Matricular ID # (required for all applicants):		
Health Net primary care physician/PCP #:	Physician name *(first, last)*:		
Participating physician group/PPG #:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Matricular ID # (required for all applicants):		
Health Net primary care physician/PCP #:	Disabled: ☐ Yes ☐ No	Participating physician group/PPG #:	
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Matricular ID # (required for all applicants):		
Health Net primary care physician/PCP #:	Disabled: ☐ Yes ☐ No	Participating physician group/PPG #:	
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Matricular ID # (required for all applicants):		
Health Net primary care physician/PCP #:	Disabled: ☐ Yes ☐ No	Participating physician group/PPG #:	
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

[1] Available in all or parts of Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.

[2] Available in all or parts of Los Angeles, Orange, Riverside, San Diego, San Bernardino, Santa Clara, and Santa Cruz counties.

[3] Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

[4] Note: Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2–19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

Employee name: ____ Last 4 digits of Social Security #: __ __ __ __

5. *Do you or your dependents have other health care coverage?*

If "Yes," please complete this section including Medicare.

☐ Self	Name:	Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*		
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:	

☐ Spouse ☐ Domestic partner	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

6. *Group term life insurance, if applicable.* *(Attach separate sheet for additional or contingent beneficiaries.)*

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Life Insurance Company, and/or Fidelity Security Life Insurance Company's Group Policy and Certificate of Insurance.

Employee name: _____ Last 4 digits of Social Security #: __ __ __ __

7. Declination of coverage *(Complete this section if any coverage is being declined by you or your eligible dependents.)*

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Stop and read carefully.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).
By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage *(Signature required.)*

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. The Health Net Entities, the DBP Entities and/or the Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Evidence of Coverage or Certificate of Insurance for coverage underwritten by the Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Employee signature: _____ **Date:** _____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)

Please contact the Health Net Customer Contact Center at the toll-free numbers below if you need assistance in completing this form or if you have questions about your coverage:

English	1-800-361-3366
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

If you have questions about your life, dental or vision coverage, please call:

Life	1-800-865-6288
Dental	1-866-249-2382
Vision	1-866-392-6058

If you have questions about your physician or physician group, call your physician group directly, or contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

WholeCare HMO Network, SmartCare HMO Network, Salud HMO y Más Network, or Dental HMO (DHMO) enrollees:

Participating physician group (PPG), primary care physician (PCP) and dental provider selection.

Please note, if you do not select a participating physician group, primary care physician or dental provider for yourself and each of your eligible dependents, a participating physician group, primary care physician and/or dental provider will be selected for you.

Emergency and urgently needed care:

- If your situation is life-threatening or an emergency: Call 911 or go to the nearest hospital.
- If your situation is not so severe: If you cannot call your primary care physician or physician group, or you need medical care right away, go to the nearest hospital or medical center.
- If you are outside your physician group's service area: Go to the nearest hospital, medical center or call 911. In all cases, contact your primary care physician or participating physician group as soon as possible to inform them about your condition.

PPO insurance plan enrollees:

Emergency and urgently needed care.

- If your situation is life-threatening or an emergency:

  Call 911 or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

Precertification:

You, the member, are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring precertification.

For precertification, please call 1-800-977-7282.

Disabling conditions:

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer, and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled, (b) the maximum benefits of the prior insurer's coverage are paid, or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

Products/Entities:

Health Net of California, Inc. offers the following products: PureCare HSP Network, WholeCare HMO Network, SmartCare HMO Network, and Salud HMO y Más Network.

Health Net Life Insurance Company offers the following products: PureCare One EPO Network, PPO, Life and AD&D insurance.

Dental Benefit Providers of California, Inc. offers the following products: Dental HMO (DHMO).

Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of coverage:

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 60 days of the loss of coverage or acquisition of a new dependent.

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 us at the number listed on your ID card, or employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088. Individual & Family Plan (IFP) applicants please call 1-877-609-8711. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (por sus siglas en inglés, IFP) deben llamar al 1-877-609-8711. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) de California al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，雇主團體申請人請撥 Health Net 的商業聯絡中心，電話 1-800-522-0088。Individual and Family Plan (IFP) 申請人請撥 1-877-609-8711。如需其他協助：如果您投保的是 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發。

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị; người ghi danh theo nhóm của hãng sở xin gọi Trung tâm Liên lạc Thương mại của Health Net theo số 1-800-522-0088. Người ghi danh theo Chương trình bảo hiểm dành cho cá nhân và gia đình (Individual and Family Plan, IFP) xin gọi số 1-877-609-8711. Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 있는 안내번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 상업 (Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 1-877-609-8711번으로 전화해 주십시오. 더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의하십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID 카드상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Անվճար լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-877-609-8711 համարով: Լրացուցիչ օգնության համար՝ 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance), եթե գրանցվել եք PPO կամ EPO ապահովագրական ապահովագրի, որի կրողն է Health Net Life Insurance Company-ն: Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

無料の言語サービス。日本語の通訳が書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体プランへの加入をお申込みの方は、Health Netの民間コンタクト・センター、1-800-522-0088までお電話ください。個人・家族プラン（IFP）への加入をお申込みの方は、1-877-609-8711までお電話ください。さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、カリフォルニア州管理医療庁（DMHC）のヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدّمي الطلبات من الموظفين يُرجى الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدّمي طلبات خطة الفرد والأسرة (IFP)، يُرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تكتتبها شركة التأمين Health Net Life Insurance Company على الحياة، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفاً با مرکز تجارتی تماس Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

Farsi

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tawagan ang Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual & Family Plan (IFP), mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tawagan ang DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID, lossis cov tib neeg yuav thov kev pab tom chaw haujlwm thov hu rau Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej & Tsev Neeg (Individual and Family Plan; IFP) thov hu rau 1-877-609-8711. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh ‘Alínígóó Saad Bee ‘áka’anída’awo’ígíí. ‘Ata’ halne’í dóó naaltsoos bee ‘éédahozinígíí t’áá ni nizaad bee hadadilyaago nich’į’ yídóoltah. ‘Áka’a’eyeed biniiyégo, ninaaltsoos nitł‘izí bee nééhozinígíí bine’dęę’ béésh bee haneí biká’ígíí bee nich’į’ hodíilnih, doodago ninaalishí bił hada’dil’ínígíí t’áá shǫǫdí Health Net Commercial Hane’ ‘Íił‘įh Bił Haz’áníjį’ 1-800-522-0088 hodíilnih. Ła’ Jizíh dóó Hooghan Haz’ąągi Naaltsoos Hadadít’éhígíí (IFP) hada’dile’ígíí t’áá shǫǫdí kohjį’ 1-877-609-8711 hodíilnih. T’áá náásgóó ‘áka’a’eyeed biniiyégo: PPO doodago EPO béeso ‘ách’ąąh naa’nil bibee haz’áanii Health Net Life Insurance Company, bich’į’ haidiilaaígíí bił ha’dít’éhígíí bił ha’diléehgo, CA Dept. béeso ‘áchąąh naa’nil bił haz’ánígíí bich’į’ kohjį’ 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha’dít’éhígíí bił ha’diléehgo, DMHC ‘Áka’aná’awo’ Bił Haz’ánígíí kohjį’1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha’dít’éhígíí ninaaltsoos nitł‘izí bine’dęę’ bikáá’.

Navajo

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ក្រុមនិយោជកអ្នកដាក់ពាក្យសុំ សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088។ អ្នកដាក់ពាក្យសុំគំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 1-877-609-8711។ សំរាប់ព័ត៌មានបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងច្បាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc.។ ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в Коммерческий контактный центр компании Health Net (Commercial Contact Center) по телефону 1-800-522-0088. Участники планов индивидуального и семейного страхования (Individual and Family Plan, IFP), пожалуйста, звоните по номеру 1-877-609-8711. Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

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