Small Business

Health Net Small Group HMO and PPO plans are pending completion of regulatory review

Application for Group Service Agreement/Group Policy

Medical plans are provided by Health Net of California, Inc. and Life/AD&D insurance plans are underwritten by Health Net Life Insurance Company (together, "Health Net"). Health Net Dental HMO and PPO plans, other than pediatric dental, are offered and serviced by Dental Benefit Providers of California, Inc. (DBP). Vision plans, other than pediatric vision, are underwritten by Health Net Life Insurance Company and serviced by EyeMed Vision Care, LLC ("EyeMed") and Envolve Vision, Inc.

Pediatric dental HMO and PPO plans are provided by Health Net of California, Inc. and administered by DBP.

Neither DBP nor EyeMed are affiliated with Health Net. Obligations under dental plans, other than pediatric dental, are not obligations of, and are not guaranteed by, Health Net.

Application is hereby made for a Group Service Agreement/Group Policy provided by Health Net and/or DBP, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring or requiring coverage hereunder. The following information regarding employee and/or dependent data is being submitted to allow Health Net and/or DBP to determine the eligibility of employees and/or dependents seeking enrollment.

Welcome to Health Net

Simple steps for completing the form:

1. Carefully review and select the plan option(s) that is/are best for your business.
2. Make a copy of the completed application for your records.
   If a correction is needed, cross out and initial each correction. Please do not use a white-out product.

Health Net Medical:
1-800-522-0088 *(English)*
1-800-331-1777 *(Spanish)*
1-877-891-9053 *(Mandarin)*

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

Pre-tax solutions (e.g., IRS code section 125 premium-only plans and Flex plans)

If you are interested in learning about the tax savings potential for your employees and company, please contact Total Administrative Services Corporation (TASC) at 1-800-422-4661.

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.

Small Business

Application for Group Service Agreement/Group Policy

Important: If adding Dental or Vision to your existing coverage, please complete sections 1 (ancillary options), 2, 3, 4, 5, 6, 7, and 8; for all other changes to existing coverage, please complete only sections 2, 3, 4, and 7.

1. Health plan information

Select a package, then select your plan(s):

☐ Enhanced Choice ☐ Other _____

Full HMO Network[1]

Platinum	Gold	Silver
☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55

SmartCare HMO Network[2]

Platinum	Gold	Silver
☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55

WholeCare HMO Network[1]

Platinum	Gold	Silver
☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55

Salud HMO y Más Network[3]

Platinum	Gold	Silver
☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55

CommunityCare HMO Network[4]

Silver ☐ $2250/$50 **Bronze** ☐ $6300/$60

Full PPO Network

☐ Platinum PPO 0/15	☐ Gold PPO 500/20	☐ Gold HDHP PPO 1600/20%	☐ Silver PPO 1700/50
☐ Platinum PPO 250/15	☐ Gold PPO 1000/35	☐ Silver PPO 2500/55	☐ Bronze PPO 6300/60
☐ Gold PPO 0/35	☐ Gold PPO 1600/0	☐ Silver PPO 2250/60	☐ Bronze HDHP PPO 7050/0%
☐ Gold PPO 350/25	☐ Gold PPO 750/15	☐ Silver HDHP PPO 1600/50%	

Other plan(s):

_____

Optional Rider (Optional coverage available on all HMO and PPO plans) ☐ Chiropractic ☐ Infertility

Ancillary options

Note: All medical plans include pediatric dental and pediatric vision coverage. Individuals will receive pediatric dental and vision coverage under the medical plan until the last day of the month in which the individual turns 19. For off-cycle adult dental/vision plan additions, your renewal date will be coordinated with your medical plan renewal date.

Dental (DHMO)	Dental (DPPO)		Vision (PPO)	
☐ HN Plus 150	☐ Classic 4 1500	☐ Essential 2 1000	☐ Elite 1010-1	☐ Supreme 010-2
☐ HN Plus 225	☐ Classic 5 1500 (w/ortho)	☐ Essential 5 1500 (w/ortho)	☐ Preferred 1025-2	☐ Preferred 1025-3
		☐ Essential 6 1500	☐ Preferred Value 10-3	☐ Plus 20-1
			☐ Exam Only	

Life and AD&D options (If Health Net Life is selected, all full-time employees are eligible.)

☐ $15,000 (2–100 employees)	☐ $25,000 (15–100 employees)	☐ $50,000 (25–100 employees)

(continued)

2. Employer group information

Company name:	DBA:	Group #:	SIC code:
Tax ID number (TIN):	Type of business:		
Is the group subject to ERISA? ☐ Yes ☐ No, government, public plan or church plan ☐ No (please specify reason)			
Type of entity *(corporation, sole prop., LLC, partnership):*	Date of business inception:	Effective date:	

Company contact:	Telephone:		Fax:	
Physical address:	City:	State:	ZIP:	County:
Billing address *(if different from physical address):*	City:	State:	ZIP:	County:
Email address *(print clearly):*				
Company contact for coordination of benefits (COB) *(if different from above):*				
COB address *(if different from physical address):*	City:	State:	ZIP:	County:

3. Employer contribution

Note: Employer contribution for Health is a minimum of 50% of the lowest cost plan or $100 per employee, and for Life is 100% (2–9 enrollees) and 50% (10–100 enrollees).

Employee Health: ____% or $____ Employee Life: ____% Employee Dental: ____% Employee Vision: ____%

Dependent Health: ____% or $____ Dependent Dental: ____% Dependent Vision: ____%

Note: Dental and Vision can be either voluntary or employer-paid. If employer-paid, you must complete the employer contribution. If you select Dental and/or Vision with no contribution, indicate "0."

4. Eligibility information

1. Will there be eligibility conditions that will apply prior to the probationary period (e.g., being in an eligible job classification, achieving job-related licensure requirements, or satisfying a "reasonable and bona fide employment-based orientation period")? ☐ Yes ☐ No
2. Employer's probationary period for new hires/rehires – first of the month following: ☐ Date of hire ☐ 1 mo. ☐ 30 days ☐ 60 days*
   *Health Net will adjust the effective date for new enrollees if needed to ensure that the waiting period does not exceed 90 days.
3. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No
4. Average number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30
5. Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: _____

   An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.[5]

   To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12 (or the number of months in business if less than 12 months). Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.
6. Total number of employees worldwide (Count all employees throughout the U.S. regardless of if they are eligible for coverage, including full-time, part-time, leased, etc. Do not include 1099 employees or seasonal workers.): _____

(continued)

4. Eligibility information (continued)

	Medical	Dental	Vision	Life
7. Number of eligible employees (including eligible owner(s)):	_____	_____	_____	_____
8. Total number of Health Net enrollees (excluding COBRA enrollees):	_____	_____	_____	_____
9. Number of Health Net COBRA enrollees (applying for health coverage):	_____	_____	_____	_____
10. Number of waivers (Please include an enrollment form with Section 7 "Declination of Coverage" indicated.):	_____	_____	_____	_____

11. What type of COBRA[6] are you subject to? ☐ Federal COBRA ☐ Cal-COBRA

    If federal COBRA, how would you like your COBRA enrollees to be billed? ☐ Group billed ☐ Member billed

12. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No

13. Do the eligible enrollees represent a carve-out either by location or union affiliation? ☐ Yes ☐ No

14. Does the group file a DE-9C? ☐ Yes ☐ No[7]

5. Current carrier (List current carrier if any.)

Is your company currently active with other health insurance? ☐ Yes ☐ No

If so, will you be canceling your other health insurance if approved with Health Net? ☐ Yes ☐ No

Current health insurance carrier: _____

Will Health Net be the only carrier? ☐ Yes ☐ No If "No," name of other carrier: _____

Plan(s) offered: _____

Workers' compensation carrier: _____

Number of enrollees not covered by workers' compensation: _____

(Employers required to have workers' compensation must have a policy in effect to be eligible with Health Net.)

6. Underwriting criteria

General conditions

The issuance of coverage and a Group Service Agreement/Group Policy is subject to underwriting review and approval by Health Net and/or DBP and receipt of the first month's premium. The initial quoted rates are subject to Health Net and/or DBP's review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Guidelines.

Coverage will be effective on the noted effective date if the application is accepted and approved by Health Net and/or DBP as appropriate within specified time requirements.

7. Arbitration agreement and other important terms

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement/Group Policy is subject to review and approval by Health Net and/or DBP and receipt of the first month's premium.

The undersigned hereby acknowledge to the best of their knowledge or belief that the preceding information constitutes true and complete representations to Health Net and/or DBP. Should it be determined at the time of enrollment or during the 24-month period after the Group Agreement/Group Policy is issued that there has been an intentional misrepresentation of material fact, as prohibited by the terms of this Group Agreement/Group Policy, the Group Agreement/Group Policy may be canceled with 30 days advance notice of such cancellation.

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the Group Service Agreement/Group Policy and to forward such amounts in advance of the due date to Health Net and/or DBP together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group, and deletions from the group. Please return this application to your Health Net account executive or broker as specified.

Applicant, in the event this application is accepted, agrees to cooperate with Health Net in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information provided by the Health Net "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder. The undersigned hereby acknowledge responsibility for obtaining and for sending an electronic or printed copy of the Summary of Benefits and Coverage document (SBC) to plan participants and beneficiaries. To retrieve your group's SBCs, go to www.healthnet.com/sbc.

(continued)

7. Arbitration agreement and other important terms (continued)

The following standard minimum participation and contribution requirements apply unless modified in quote or renewal underwriting guidelines.

Minimum contribution is defined as: The employer contribution toward Health Net's premium that must be equal to or greater than 50% or $100 of employee single premium.

Minimum participation is defined as: For groups of 1–4 enrolling employees, a minimum of 70% participation is required. For groups of 5–100 enrolling employees, a minimum of 25% participation is required.

Failure to maintain these minimum contribution and minimum participation requirements may result in termination or non-renewal.

This Application for Group Service Agreement/Group Policy and any attached Addendum, together with the Health Net and/or DBP Plan Contract or Insurance Policy (as referenced herein), and the employee enrollment forms form the entire agreement between the parties.

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

BINDING ARBITRATION AGREEMENT: On behalf of Group Applicant, and subject to certain restrictions prohibiting application of mandatory arbitration to members of employer groups subject to ERISA, 29 U.S.C. SECTION 1001, et seq., I understand and agree that any and all disputes, except adverse benefit determinations, as defined at 45 CFR 147.136, or disagreements between Group and Health Net and/or DBP regarding the construction, interpretation, performance or breach of the Health Net and/or DBP Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net and/or DBP Plan Contract or Insurance Policy, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes, except disputes concerning adverse benefit determinations, to individual, final and binding arbitration, all parties, including Health Net and/or DBP are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also hereby waive all rights to participate in any class arbitration. I also understand that disputes with Health Net and/or DBP involving claims for medical services 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. In the event that the total amount of damages claimed is $500,000 or less with respect to disputes involving alleged professional liability or medical malpractice, the parties shall, within 30 days of submission of the demand for arbitration, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000. If the parties fail to reach an agreement during this time frame, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter, in accordance with California Code of Civil Procedure 1281.6. A more detailed arbitration provision is included in the Health Net and/or DBP Plan Contract or Insurance Policy.

Officer of the company signature:	
Officer title:	Date:

Applicant's signature above confirms to the best of their knowledge or belief: 1) Applicant's agreement to all the terms and conditions set out in this Application, including the conditions of enrollment and Underwriting Guidelines; and 2) the accuracy and completeness of the information that the Applicant has entered in this Application.

8. Broker information

Broker name:	Health Net broker ID #:	Broker lic. #:	Date submitted:
Agency name:	Telephone #:	Fax #:	Email address:
Address:	City:	State:	ZIP:
Broker/Consultant signature:			Date:
Account executive name:			Date:
General agent/ID #:	General Agent Sales Representative Name:		Date:

9. Agent/Broker certification

I, _____ (name of agent/broker),

(NOTE: You must select the appropriate box. You may only select one box.)

☐ did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

OR

☐ assisted the applicant(s) in submitting this application. I advised the applicant(s) that the applicant(s) should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

If I willfully state as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to twenty thousand dollars ($20,000).

Please answer all questions 1 through 3:

1. **Who filled out and completed the application form?** _____

2. Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3. Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

10. For Health Net use only

Underwriter signature:	Date:	Approved: ☐ Medical ☐ Dental ☐ Vision Declined: ☐ Medical ☐ Dental ☐ Vision	Billing #:	Effective date:
SBG representative signature:	Date:	Group # (Health):	Policyholder # (Life):	Medical plan:

Small Business Group submission checklist

To ensure prompt processing, please make sure to include the following documents.

Groups applying for a 1st-of-the-month effective date must be submitted to Health Net by the 5th of the month. Paperwork must be completed by the 20th of the month; otherwise, the group will be rolled to the following month.

- ☐ A signed original Application for Group Service Agreement (GSA)/Group Policy
- ☐ A complete employee application for each eligible employee enrolling/waiving coverage
- ☐ A check or an Electronic Check form for the first month's premium drawn from the group account
- ☐ The latest quarter DE-9C, reconciled:
  - If the group has not been in business long enough to have a DE-9C, two weeks of group-wide payroll, including withholdings, may be submitted.
  - 2-week payroll is required for all employees that don't appear on the current DE-9C.
  - For wages exceeding part-time and wages below full-time status, payroll will be required.
  - To reconcile the DE-9C, please indicate next to each employee's name one of the following:
    T – Terminated (including termination date)
    E – Eligible and enrolling
    W – Eligible and waiving coverage
    S – Seasonal
    WP – Waiting period (include date of hire for those in waiting period)
    TEMP – Temporary employees
    PT – Part-time
    Covered by another carrier – add carrier name.
- ☐ Ownership paperwork (required if owner/partners' names do not appear on the DE-9C or payroll records). Must list each person's first and last name. Paperwork must be filed with the state or county. Documentation may include:
  - For sole proprietor:
    - California Business License
    - Fictitious Business Name Statement
    - Schedule C Tax Form
  - For partnership:
    - California Business License (showing both names)
    - Fictitious Business Name Statement (showing both names)
    - Schedule K Tax Form (for all eligible owners)
    - Tax certificate (showing both names)
  - For corporation:
    - Articles of Incorporation
    - Statement of Information
    - Tax Form 1120

  Note: Please consult your sales representative for acceptable ownership documentation for other business structures.

For PPO plans:

- ☐ Copies of EOBs for employees requesting Deductible Credit from prior carrier

Send all completed paperwork to your designated account executive or broker.

[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]Available in Los Angeles, Orange and San Diego counties.

[5]This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.

[6]**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.

[7]If a DE-9C is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

FRM1097502EC01w (7/23)
SBG GSA 1/24

Ensure Your Employees Understand Their Health Care Coverage

SUMMARY OF BENEFITS AND COVERAGE TO ELIGIBLE AND COVERED PERSONS

Affordable Care Act (ACA) requirement for employers that sponsor group health plans

As required by the ACA, health plans and employer groups must provide the *Summary of Benefits and Coverage* (SBC)[1] to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA Continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in **paper or electronic** form (i.e., email or Internet posting).

Paper SBC

- **If you provide a paper copy,** the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on four double-sided pages.
- **If you mail a paper copy,** you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.

Electronic SBC

For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.[2]

- **If you email the SBC,** you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- **If you post the SBC on the Internet,** you must advise your employees by email or paper that the SBC is available on the Internet and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request. You may use the Model Language below for an e-card or postcard in connection with a website posting of the SBC:

(continued)

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.

[2]Such requirements can be found at 29 C.F.R. § 2520.104b-1(c).

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Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a *Summary of Benefits and Coverage* (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: <[group's website.com]>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

Timing of SBC distribution

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC by the first day the employee is eligible to enroll in the plan.
- **Special enrollees.** For special enrollees,[3] you must provide the SBCs within 90 days following enrollment.
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC no later than the date on which the open enrollment materials are distributed. If renewal is automatic, you must provide the SBC no later than 30 days prior to the first day of the new plan year.

  If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC as soon as practicable, but no later than 7 business days after issuance of new policy or the receipt of written confirmation of intent to renew your group health plan.

  At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than 7 business days following your receipt of the request.

Notice of SBC modification

Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees no later than 60 days prior to the date on which change(s) become effective. You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary of bolded terms used in the SBC by visiting www.cciio.cms.gov or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within 7 business days after Health Net receives their request.

If you have any questions, please contact your Health Net client manager.

[3]Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6.

FRM1097502EC01w (7/23)
SBG GSA 1/24

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (Health Net) complies with applicable federal 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, 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. Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

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.

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, if you have an ID card, please call the Customer Contact Center number. Employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة، يرجى الاتصال برقم مركز خدمة العملاء المبين على بطاقتك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في Health Net عبر الرقم: 1-800-522-0088 (TTY: 711). فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم 1-877-609-8711 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Եթե ID քարտ ունեք, օգնության համար խնդրում ենք զանգահարել Հաճախորդների սպասարկման կենտրոնի հեռախոսահամարով: Գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել Health Net-ի Կոմերցիոն սպասարկման կենտրոն՝ 1-800-522-0088 հեռախոսահամարով (TTY՝ 711): Individual & Family Plan (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 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。如需協助且如果您有會員卡，請撥打客戶聯絡中心電話號碼。雇主團保計畫的申請人請撥打 1-800-522-0088（聽障專線：711）與 Health Net 私人保險聯絡中心聯絡。Individual & Family Plan (IFP) 的申請人請撥打 1-877-609-8711（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, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोक्ता सामूहिक आवेदक कृपया हेल्थ नेट के कमर्शियल संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) आवेदक कृपया 1-877-609-8711 (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 cuam, yog tias koj muaj daim npav ID, thov hu rau Neeg Qhua Lub Chaw Tiv Toj tus npawb. Tus tswv ntiav neeg ua haujlwm pab pawg sau ntawv thov ua haujlwm thov hu rau Health Net Qhov Chaw Tiv Toj Kev Lag Luam ntawm 1-800-522-0088 (TTY: 711). Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) cov neeg thov ua haujlwm thov hu rau 1-877-609-8711 (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。ヘルプについては、IDカードをお持ちの場合は顧客連絡センターまでお電話ください。雇用主を通じた団体保険の申込者の方は、Health Netの顧客連絡センター（1-800-522-0088、TTY: 711）までお電話ください。個人・家族向けプラン（IFP）の申込者の方は、1-877-609-8711（TTY: 711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យ លោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានបំណុលសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំគម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-609-8711 (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 연락하십시오. 고용주 그룹 신청인의 경우 Health Net의 상업 고객서비스 센터에 1-800-522-0088(TTY: 711)번으로 전화해 주십시오. 개인 및 가족 플랜(IFP) 신청인의 경우 1-877-609-8711(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įį́ł. Naaltsoos da t'áá shí shizaad k'ehjí shichį́' yídooltah nínízingo t'áá ná ákódoolnííł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá'. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį' hodíílnih Health Net's Commercial Contact Center 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'ałchíní (IFP) báhígíí éí kojį' hojilnih 1-877-609-8711 (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، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس مشتریان تماس بگیرید. متقاضیان گروه کارفرما لطفاً با مرکز تماس تجاری Health Net به شماره 1-800-522-0088 (TTY:711) تماس بگیرند. متقاضیان طرح فردی و خانوادگی (IFP)* لطفاً با شماره 1-877-609-8711 (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, ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਆਈਡੀ ਕਾਰਡ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਮਾਲਕ ਦਾ ਗਰੁੱਪ ਬਿਨੈਕਾਰ, ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਬਿਨੈਕਾਰਾਂ ਨੂੰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (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 и у Вас при себе есть карточка участника плана, звоните по телефону Центра помощи клиентам. Участники коллективных планов, предоставляемых работодателем: звоните в коммерческий центр помощи Health Net по телефону 1-800-522-0088 (TTY: 711). Участники планов для частных лиц и семей (IFP): звоните по телефону 1-877-609-8711 (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, si tiene una tarjeta de identificación, llame al número del Centro de Comunicación con el Cliente. Los solicitantes del grupo del empleador deben llamar al Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (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, kung mayroon kayong ID card, mangyaring tumawag sa numero ng Customer Contact Center. Para sa mga grupo ng mga aplikante ng tagapag-empleyo, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Planong Pang-indibiduwal at Pampamilya (Individual & Family Plan, IFP), mangyaring tumawag sa 1-877-609-8711 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ และคุณมีบัตรประจำตัว โปรดโทรหมายเลขศูนย์ลูกค้าสัมพันธ์ ผู้สมัครกลุ่มนายจ้าง โปรดโทรหาศูนย์ลูกค้าสัมพันธ์เชิงพาณิชย์ของ Health Net ที่หมายเลข 1-800-522-0088 (โหมด TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (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 c`ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nếu quý vị có thẻ ID, vui lòng gọi đến số điện thoại của Trung Tâm Liên Lạc Khách Hàng. Những người nộp đơn xin bảo hiểm nhóm qua hãng sở vui lòng gọi Trung Tâm Liên Lạc Thương Mại của Health Net theo số 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình (IFP), vui lòng gọi số 1-877-609-8711 (TTY: 711).