Small Business

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

2026 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").

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:
800-522-0088 *(English)*
800-331777 *(Spanish)*
877-899053 *(Mandarin)*

Health Net Life: 800-865-6288

Health Net Dental: 866-249-2382

Health Net Vision: 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 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]			SmartCare HMO Network[2]		
Platinum	**Gold**	**Silver**	**Platinum**	**Gold**	**Silver**
☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55	☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55
WholeCare HMO Network[1]			**Salud HMO y Más Network[3]**		
Platinum	**Gold**	**Silver**	**Platinum**	**Gold**	**Silver**
☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55	☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	☐ $55

Full PPO Network

☐ Platinum PPO 0/5	☐ Gold PPO 500/20	☐ Gold HDHP PPO 1800/20%	☐ Silver PPO 2500/50
☐ Platinum PPO 0/15	☐ Gold PPO 750/15	☐ Silver HDHP PPO 1800/50%	☐ Silver PPO 2500/55
☐ Platinum PPO 250/15	☐ Gold PPO 1000/35	☐ Silver PPO 1700/50	☐ Bronze PPO 5800/60
☐ Gold PPO 0/35	☐ Gold PPO 1500/20	☐ Silver PPO 2250/60	☐ Bronze HDHP PPO 7200/0%
☐ Gold PPO 350/25			

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
	☐ Classic 7 Unlimited	☐ Essential 6 1500	☐ Preferred Value 10-3	☐ Plus 20-1
	☐ Classic 11 Unlimited (w/ortho)	☐ Essential 10 3000 (w/ortho & implant)	☐ Exam Only	
		☐ Essential 11 5000 (w/ortho & implant)		

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)

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.[4]

   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.): _____
7. Total current Full Time and Full Time Equivalent employees in: CA _____ OOS_____

(continued)

4. Eligibility information (continued)

	Medical	Dental	Vision	Life
8. Number of eligible employees (including eligible owner(s)):	_____	_____	_____	_____
9. Number of employees enrolling with Health Net (including enrolling owners):	_____	_____	_____	_____
10. Number of Health Net COBRA enrollees (applying for coverage):	_____	_____	_____	_____
11. Number of waivers:	_____	_____	_____	_____

12. What type of COBRA[5] 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

13. Does the group file a DE-9C? ☐ Yes ☐ No[6]

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: _____

If any members of your company are currently enrolled on another Health Net policy or plan, indicate Policy or Group ID:

_____

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.

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. §§ 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. Authorization for Agent Access to Group Information

On behalf of the group applicant, I hereby authorize our designated agent, producer, broker, agency, brokerage, general agency, and their respective employees (Agent) currently on file with Health Net to automatically be granted access to our health plan information, including protected health information, through Health Net's Employer & Broker Access system (Portal) or any other access points Health Net may offer.

Our Agent is authorized to make changes to our information including but not limited to:

- Detail about members
- Plan selections and bills/invoices
- Adding/deleting plans and members
- Changing member demographic information

If our Agent on file changes, these authorizations will apply with respect to our successor Agent.

☐ Only select this box if you, as the employer, **DO NOT** want Health Net to automatically authorize the Agent of Record to access and change the group's information on behalf of the group through the Health Net Employer & Broker Access System (Portal).

9. 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:

10. 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

11. 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
- ☐ 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 ineligible employees with wages exceeding part-time status, or eligible employees with wages below full-time status, 2 weeks of 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 city, county, or state. Documentation may include:
  - For sole proprietor:
    - Business License
    - Fictitious Business Name Statement
    - Schedule C Tax Form
  - For partnership:
    - 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
  - For Limited Liability Corporation (LLC):
    - Articles of Organization
    - Operating Agreement
    - Statement of Information
    - Schedule K Tax Form (for all eligible owners)

  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 Imperial and Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

[4]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.

[5]**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.

[6]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.

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SBG_GSA_CA (1/26) REV

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).

FRM065772EP01
SBG_GSA_CA (1/26) REV

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. 54.9806, and 29 C.F.R. 2590.706.

FRM065772EP01
SBG_GSA_CA (1/26) REV

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 us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) 1-800-522-0088

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088 (TTY: 711)。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711)।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088 、(TTY: 711)。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711).។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-800-522-0088 (TTY: 711).

Navajo
Saad Bee Áká E’eyeed T’áá Jíík’e. Ata’ halne’ígíí hóló. T’áá hó hazaad k’ehjí naaltsoos hach’į’ wóltah. Shíká a’doowoł nínízingo naaltsoos bee néího’dólzinígíí bikáa’gi béésh bee hane’í bikáá’ áajį’ hodíílnih éí doodaii’ 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-800-522-0088 (TTY: 711).

Panjabi (Punjabi)

ਬਨਿਾਂ ਕਸਿੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦੱਤਿ�े ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711).

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (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. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711).

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