Health Net®

Health Net Health Plan of Oregon, Inc.

Individual & Family Application

Please complete in blue or black ink.

Effective date of coverage: Coverage is only available for enrollment during the annual open enrollment period, which is November 1, 2016, through January 31, 2017, or during a special enrollment period. Applications must be received within 60 days of a qualifying event. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of application.

Important note: If you are currently enrolled in a Medicare plan, you are ineligible to apply for an Individual & Family Plan.

Health Net Health Plan of Oregon, Inc. (Health Net) **requires** a Social Security number (SSN) for everyone enrolling for health insurance, including spouses or Registered Domestic Partners and dependent children. This is necessary so that we can provide you with verification of coverage for your tax return, as required by the Affordable Care Act. Health Net will not use your SSN for other purposes or share it with anyone other than as required by law. For newborns, you have six months to provide the newborn's SSN.

Part I: Applicant information (The oldest family member to be enrolled must be the applicant and will be the policy subscriber. If you are adding a newborn or adopted child, please provide policy subscriber information.)

I (and my dependents if applicable) am applying during (check one):
☐ Annual open enrollment period ☐ Special enrollment period (see page 5)

Reason (check one):
☑ New enrollment ☐ Change request

☐ Check this box to add a newborn or adopted child to an existing policy, and complete the "Addition of a newborn or adopted child to an existing policy" section on page 4.

Primary applicant's last name:	First name:	MI:	☐ Male ☐ Female

Permanent home street address. (Proof of permanent residency document is required for PPO plans or if you provide a PO Box – See Proof of permanent residency requirement, page 8.):

City:	State:	ZIP:	County applicant resides in:

Billing address:

Mailing address:

Home phone number:	Work phone number:	Cell phone number:	Email address:

Primary applicant's birth date (mm/dd/yy):	Primary applicant's Social Security number (required):

Primary subscriber's Health Net ID (applicable for adding dependents and change requests only):

If you are applying for a CommunityCare POS plan, you must select a primary care physician from the CommunityCare Network.

Primary care physician ID: Current patient: ☐ Yes ☐ No

Last 4 digits of primary applicant's Social Security #: __ __ __ __

I am applying to Health Net Health Plan of Oregon, Inc. for an Individual & Family medical/surgical/hospital policy, with benefits selected as follows:

Health Net Individual & Family plans (Please select one.)	
CommunityCare POS plans ☐ Health Net Oregon Standard Silver Plan (CommunityCare POS) ☐ Health Net Oregon Standard Bronze Plan (CommunityCare POS)	**PPO plans** ☐ Health Net Oregon Standard Silver Plan (PPO) ☐ Health Net Oregon Standard Bronze Plan (PPO)

Proof of pediatric dental coverage – This section requires a response and may not be left blank.

Pediatric dental coverage attestation

You are required by the ACA mandate to purchase pediatric dental coverage. Health Net does not offer this coverage. Therefore, please check "Yes" to confirm that you are purchasing pediatric dental coverage from another carrier.

☑ Yes, I confirm that I am purchasing pediatric dental coverage with another carrier as required by the ACA mandate.

Complete Spouse/Registered Domestic Partner and Dependent sections only if they are to be covered. Dependent children must be under 26 years old. If you and your eligible dependents are applying for a CommunityCare POS plan, you must select a primary care physician from the CommunityCare Network for each applicant.

Spouse/Registered Domestic Partner			
Last name:	First name:	MI:	☐ M ☐ F
Social Security number (required for all applicants):	Birth date (mm/dd/yy):		
Primary care physician ID:		Current patient: ☐ Yes ☐ No	
Child 1			
Last name:	First name:	MI:	☐ M ☐ F
Social Security number (required for all applicants):	Birth date (mm/dd/yy):		
Primary care physician ID:		Current patient: ☐ Yes ☐ No	
Child 2			
Last name:	First name:	MI:	☐ M ☐ F
Social Security number (required for all applicants):	Birth date (mm/dd/yy):		
Primary care physician ID:		Current patient: ☐ Yes ☐ No	

(continued)

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Child 3			
Last name:	First name:	MI:	☐ M ☐ F
Social Security number (required for all applicants):	Birth date (mm/dd/yy):		
Primary care physician ID:		Current patient: ☐ Yes ☐ No	
If last name of a dependent differs from yours, explain relationship:			

Part II: Payment information (First full monthly premium payment is required for your PPO application to be considered.)

First premium payment. Pay by check (amount must match monthly premium).

Mailing application	**Faxing application**
Include completed check with completed application and mail to: Health Net Individual & Family Enrollment PO Box 1150 Rancho Cordova, CA 95741-1150	Fax completed application to 1-800-977-4161, and mail completed check to: Health Net Individual & Family Enrollment PO Box 1150 Rancho Cordova, CA 95741-1150

Current members can log in to **www.healthnet.com**, and click the *Make A Payment Now* button for additional payment options.

Payment of premiums

The subscriber is responsible for the payment of premiums to Health Net. Health Net does not accept direct or indirect payment of premiums from any person or entity other than the policyholder, his or her dependents, or an acceptable third-party payor. Acceptable third-party payors are the Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act; Indian tribes, tribal organizations or urban Indian organizations; state and federal government programs or grantees under such programs; charitable foundations which are not affiliated with providers of covered services and supplies and which make payments on behalf of subscribers, where eligibility is determined based on defined criteria without regard to health status.

Upon discovery that premiums were paid by a person or entity other than those listed above, Health Net will return such payments and rebill the subscriber.

Part III: Current or previous Health Net coverage

Member name:	Group number:	State:	Last date of coverage:

Continuation of present health coverage: If you have other health coverage now, will you continue the coverage in addition to the Health Net coverage you are applying for? ☐ Yes ☐ No

Name of company: _____

Address: _____

Phone number: _____

Information practices: Information about you or any enrolling family member may be obtained from medical records as indicated in the medical information release portion of the application form. Other than from medical records, personal information will not be collected from any sources other than the applicant or individuals proposed for coverage.

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Part IV: Addition of a newborn or adopted child to an existing policy *(See pediatric dental coverage on page 2.)*

Newborn/Adopted child's last name:	First name:	MI:

Effective date[1]:	Newborn/Adopted child's date of birth (mm/dd/yy):	Date of adoption/placement for adoption (mm/dd/yy):
☐ Male ☐ Female	Social Security number: – –	Primary subscriber's Health Net ID:

If you are adding an eligible newborn/adopted child to a CommunityCare POS plan, you must select a primary care physician from the CommunityCare Network.

Primary care physician ID:	Current patient: ☐ Yes ☐ No

Important provisions

General conditions: Health Net Health Plan of Oregon, Inc. (Health Net) reserves the right to reject any application for enrollment not received within 60 days of the birth date or date of adoption. Cashing your check does not mean your application is approved. If denied, your money will be returned to you. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The insured's broker or agent cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the agreement.

Please remit the first month's premium for your newborn or adopted child. You will be required to pay additional prorated premiums for the month your child is born or adopted, which will be added to your next regular premium billing.

The application must be signed by the insured. The insured must personally sign his or her name in ink and agree to comply with the terms, conditions and provisions of the application and the insurance policy in order for this application to be processed. For this application to be considered, neither broker nor any other person may sign this application. See page 10.

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[1]Effective date will be the date of birth, date of adoption, or placement for adoption or foster care if application is received within 60 days of the birth date or date of adoption, or placement for adoption or foster care. If an additional premium is required, coverage shall not take effect unless the application and required premium are received by Health Net within 60 days after birth, adoption or placement for adoption or foster care. An additional premium is required if enrollment of the newborn or adopted/foster child places your family in a higher premium bracket.

Last 4 digits of primary applicant's Social Security #: __ __ __ __

Part V: Special enrollment period

In addition to the open enrollment period, you and your dependents are eligible to enroll or change plans during a special enrollment period, which is within 60 days of certain qualifying events. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of the application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of the application. Exceptions to these effective dates include birth, adoption, placement for adoption or foster care, or a child support order or other court order, for which coverage will be effective on the date of the qualifying event or court order. See page 4 "Addition of a newborn or adopted child to an existing policy." Coverage as a result of marriage and domestic partnership or loss of coverage will be effective the first day of the month after the application receipt.

For applications submitted before loss of coverage, the effective date will be the first day of the month following the loss of coverage. For a list of special enrollment qualifying events, please see below. Applications must be received within 60 days of the qualifying event.[2] Documentation of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person to whom it applies. For additional dependents, please attach a separate sheet of paper.

Qualifying event # (see chart below)	Date of event[2]	Primary applicant	Spouse/Registered Domestic Partner	Dependent 1	Dependent 2	Dependent 3

Qualifying events for special enrollment periods for individual and family plans

Qualifying event		Examples of Oregon documentation
1)	The qualified individual, or his or her dependent, loses minimum essential coverage, which could be due to one of the following reasons (not including voluntary termination or termination due to failure to pay premium):	
	A. The death of the covered employee.	Copy of one of the following: • Front and back of previous insurance carrier's ID card. • Proof of creditable coverage from previous insurance carrier. • Max Age Letter from previous carrier. • Termination or hour reduction confirmation from employer (must be on employer letterhead and signed by employer management).
	B. The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.	
	C. The divorce or legal separation of the covered employee from the employee's spouse/Registered Domestic Partner.	
	D. The covered employee becoming entitled to benefits under Medicare.	
	E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.	

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[2]If the application is received during the 60-day period after the loss of coverage, the effective date will be the first day of the month after the application receipt.

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Qualifying event (continued)		Examples of Oregon documentation
	F. A proceeding in a case under title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In this case, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary (spouse/ Registered Domestic Partner, dependent child or surviving spouse/Registered Domestic Partner) within one year before or after the date of commencement of the proceeding.	Copy of one of the following: • Front and back of previous insurance carrier's ID card. • Proof of creditable coverage from previous insurance carrier. • Max Age Letter from previous carrier. • Termination or hour reduction confirmation from employer (must be on employer letterhead and signed by employer management).
	G. Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.	
2)	The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption or foster care.	• Marriage certificate. • Declaration of domestic partnership. • Certificate of registered domestic partnership. • Notarized affidavit of assumption of parent-child relationship. • Birth certificate. • Discharge records. • Court order documentation for adoption.
3)	The qualified individual's, or his or her dependent's, enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange.	• Front and back of previous carrier ID card. • Proof of creditable coverage.
4)	The enrollee, or his or her dependent, adequately demonstrates to Health Net that the health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.	Resolution document from the Exchange or other plan.

(continued)

Last 4 digits of primary applicant's Social Security #: __ __ __ __

Qualifying event (continued)		Examples of Oregon documentation
5)	The qualified individual or enrollee, or his or her dependent, gains access to a new health plan as a result of a permanent move. To qualify for a special enrollment period as the result of a permanent move, an individual must have had minimum essential coverage for one or more days in the 60 days preceding the permanent move, unless they were living outside the United States or in a United States Territory at the time of the permanent move.	Copy of acceptable proof of residency documents: • Current driver's license or identification card. • Current and valid state vehicle registration form in the applicant's name. • Evidence the applicant is employed. • Evidence the applicant has registered with a public or private employment agency. • Evidence that the applicant has enrolled his or her children in a school. • Evidence that the applicant is receiving public assistance. • Voter registration form of receipt, voter notification card or an abstract of voter registration. • Current utility bill in the applicant's name. • Current rent or mortgage payment receipt in the applicant's name. Rent receipts provided by a relative shall not be accepted. • Mortgage deed showing primary residency. • Lease agreement in the applicant's name. • Government mail in the applicant's name (SSA statement, DMV notice, etc.). • Cell phone bill. • Credit card statement. • Bank statement or canceled check with printed name and address.
6)	Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.	Advanced Premium Tax Credit (APTC) paperwork that shows the premium assistance you are eligible for.
7)	He or she loses medically needy coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium).	Medicaid documentation.
8)	He or she loses pregnancy-related coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium).	Medicaid documentation.

Last 4 digits of primary applicant's Social Security #: __ __ __ __

Part VI: Proof of permanent residency requirement

Health Net requires that a PPO applicant must currently be a permanent Oregon resident and that your initial premium be paid prior to considering your enrollment application.

Please provide one (1) acceptable proof of permanent residency document, showing the home address that matches the one you listed on page 1 of this application. **If we do not receive your proof of permanent residency document upon submission of your application, your application will be denied.** Health Net reserves the right to investigate the information related to any proof of residency submitted by or on behalf of the applicant and to request additional information in order to establish the applicant's residency.

Acceptable proof documents include:

- Current Oregon driver's license or identification card.
- Current and valid Oregon vehicle registration form in the applicant's name.
- Evidence the applicant is employed in Oregon.
- Evidence the applicant has registered with a public or private employment agency in Oregon.
- Evidence that the applicant has enrolled his or her children in an Oregon school.
- Evidence that the applicant is receiving public assistance in Oregon.
- Voter registration form of receipt, voter notification card or an abstract of a voter registration.
- Current Oregon utility bill in the applicant's name.
- Current Oregon rent or mortgage payment receipt in the applicant's name. Rent receipts provided by a relative shall not be accepted.
- Mortgage deed showing primary residency.
- Lease agreement in the applicant's name.
- Government mail in the applicant's name (SSA statement, DMV notice, etc.).
- Cell phone bill.
- Credit card statement.
- Bank statement or canceled check with printed name and address.

If the application is for a child-only policy, proof of residency for where the child resides is required from a parent or legal guardian.

Part VII: Certification and authorization

Certification of completion and correctness:

I/We affirm that the answers given in this application are complete and correct. I/We have provided these answers as part of the application procedure required by Health Net Health Plan of Oregon, Inc. to enroll in the insurance coverage.

I/We understand that if this application contains any intentional misstatements or omissions of material fact, Health Net may, within the first 2 years of coverage, deny coverage, modify, rescind or cancel the contract, or take other legal action. Any fraudulent or intentional omission or misrepresentation of material facts in written information submitted by me/us or on my/our behalf on or with my/our application materials may be cause for disenrollment and rescission of the agreement, and Health Net may recoup from the policyholder (or from me/us or from the applicant) any amounts paid under the agreement obtained as a result of such fraudulent or intentional omission or misrepresentation of material facts. In addition, if a policyholder makes any fraudulent or intentional omission or misrepresentation of material facts in written information submitted on or with the application, Health Net shall have no liability for the provision of coverage under the agreement.

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Last 4 digits of primary applicant's Social Security #: __ __ __ __

By signing this application, I/we represent that all responses are true, complete and accurate, and that, should my/our application be accepted by Health Net, the application will become part of the agreement between Health Net and myself/ourselves. By signing this application, I/we further represent and agree to abide by the terms of the agreement. Before the agreement is denied, Health Net will provide a written notice that will explain the basis of the decision and my/our appeal rights. Health Net will refund all amounts paid by me/us, less any medical expenses that Health Net paid.

I/We will promptly inform Health Net in writing if anything happens before my/our coverage takes effect that makes this incomplete or incorrect. I/We understand and agree that no coverage shall be in force until approved by Health Net. If approved, coverage will be in force as of the effective date determined by Health Net. Health Net may contact me/us to clarify answers on this application. As the applicant(s), I/we understand I/we have the right to inspect the information in my/our file.

Conditional authorization to use and disclose protected health information:

To any physician; health care provider, including Oregon Health and Science University (OHSU); hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB); pharmacy benefit manager; or other insurance information exchange:

Each of us authorizes you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information you have about me/us or any of my/our family members. Such information may be used for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I/We understand that I/we may receive a copy of this authorization upon request.

This authorization takes effect on the date signed, and it remains in effect as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

I/We understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected by federal privacy rules governing the privacy of health information.

I/We understand that I/we may revoke this authorization in writing at any time, except to the extent that action has been taken by Health Net or its business associates in reliance on this authorization. I/We may send a written and dated revocation to Health Net at:

Health Net, Inc., PO Box 1150, Rancho Cordova, CA 95741-1150

I/We affirm that I/we received a disclosure statement and outline of coverage from Health Net Health Plan of Oregon, Inc. or its authorized agent. I/We understand that if my/our application for coverage is accepted, I/we will have 10 days after receiving notice of acceptance during which I/we may cancel the policy for a full refund. I/We affirm that my/our employer is not paying the premium for this coverage.

I/We further understand that any person who, with fraudulent intent, knowingly presents an application or claim containing false, incomplete or misleading information to an insurance company may be guilty of a crime. In addition to denial of insurance coverage, penalties may include imprisonment, fines and civil damages.

(continued)

Last 4 digits of primary applicant's Social Security #: __ __ __ __

Be sure to sign and date the application. Spouse's or Registered Domestic Partner's signature is required if applicable. Signature applies to both "Certification of completeness and correctness" and "Conditional authorization to use and disclose protected health information."

Incomplete applications will be returned. The effective date will be delayed until the completed application has been received.

Signature of applicant (parent or legal guardian if applicant is legally incompetent or a minor):	Relationship:	Date:
Print name of applicant (parent or legal guardian if applicant is legally incompetent or a minor):		Date:
Signature of applicant's legal spouse or Registered Domestic Partner (if applying for coverage):		Date:
Signature of child 18 years of age or older:		Date:
Signature of child 18 years of age or older:		Date:
Signature of child 18 years of age or older:		Date:

No alteration of any written application for any health insurance policy shall be made by any person other than the applicant without the written consent of the applicant, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Part VIII: Insurance producer's use only

I certify that the information supplied by the applicant(s) has been truly and accurately recorded and that I have made no representation about benefits, conditions or limitations of the policy except through written material furnished by Health Net Health Plan of Oregon, Inc.

Insurance producer's signature:		Date:
Insurance producer's name *(please print)*:	Insurance producer's number:	
Agency name:	Insurance producer's phone number:	
Agency address:		
City:	State:	ZIP:
Producer's email:		

Make personal check payable to "Health Net." If your are returning the completed application by mail, send to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150.

If you want to fax your application, please fax to 1-800-977-4161, and mail your check to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150.

Health Net Health Plan of Oregon, Inc., 13221 SW 68th Pkwy., Ste. 200, Tigard, OR 97223 • 1-888-802-7001 • www.healthnet.com

Health Net®

Individual & Family Plans

Disclosure Statement

Health Net Health Plan of Oregon, Inc.

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

General questions and answers

1. ***Does the insurer have a list of doctors or hospitals, or both, under contract that are considered "preferred" or "participating"?*** Yes.

2. ***May I use doctors or hospitals that are not on the list under my IFP plan?*** Yes; however, it's important to keep in mind that your out-of-pocket costs may be more when using a noncontracted provider.

3. ***Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and copayments)?*** Yes.

4. ***When can I enroll or switch to another plan?*** You can enroll in a new plan or change enrollment to another plan only during annual open enrollment periods or during a special enrollment period.
   - **Annual open enrollment period:** The annual open enrollment period is from November 1, 2016, through January 31, 2017. During this time, you can make changes to your coverage.
   - **Special enrollment period:** Individuals who experience certain qualifying events can enroll in a new plan or change enrollment to another plan. Applications must be received within 60 days of the qualifying event. See the list of qualifying events shown on pages 5 and 6 of the application.

5. ***When does coverage become effective?*** Generally, for applications received between the 1st and the 15th of the month, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and the last day of the month, coverage will be effective the first day of the second month following submission of the application.

   For example, if an applicant submits an application January 15, coverage becomes effective February 1. If an applicant submits an application January 16, coverage becomes effective March 1. **Exceptions to these effective dates include birth, adoption, placement for adoption or foster care, or a child support order or other court order, for which coverage will be effective on the date of the qualifying event or court order. Coverage as a result of marriage and domestic partnership or loss of coverage will be effective the first day of the month after the application receipt.**

   For applications submitted before the loss of coverage, the effective date will be the first day of the month following the loss of coverage.

Are you replacing coverage?

6. ***Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductibles?*** No, unless you are transferring from another Health Net IFP plan to this plan.

7. ***Are there any exclusions and/or limitations on specific benefits?*** Yes. Refer to the attached benefit summary for a list of benefits that have exclusions and/or limitations.

(continued)

Are you adding coverage to your current policy?

8. ***If my coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays? (You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)*** No, not to the extent that there is other health plan coverage for those services. You may never receive a total from all sources of more than 100% of allowed charges.

Are you considering replacing current coverage?

Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences and whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are you considering adding to your current coverage?

Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Questions? Ask for help.

If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

Read your policy!

If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an Individual & Family policy, you will have an opportunity to send it back within 10 days of receipt and obtain a premium refund.

Fill out your application carefully!

Be sure to fill out all portions of your application completely and truthfully. If intentional misstatements are made or information is omitted from the application, the insurer may void the policy or deny your claims. We hope this disclosure statement will help you with your insurance purchase.

_____

(Agent or insurance company representative)

_____

(Address)

Completed this statement on _____ for _____

(Date) (Applicant)

Health Net Health Plan of Oregon, Inc., 13221 SW 68th Pkwy., Ste. 200, Tigard, OR 97223 • 1-888-802-7001 • www.healthnet.com

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. Applicants call 1-877-609-8715 (TTY: 711).

Arabic
اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. على مقدمي الطلبات الاتصال على الرقم 1-877-609-8715 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。申請人請致電 1-877-609-8715 (TTY: 711) 。

Cushite (Oromo)
Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha laguu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Wicitaanka codsadayaasha 1-877-609-8715 (TTY: 711).

French
Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Les demandeurs composent le 1-877-609-8715 (TTY : 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Antragsteller rufen unter 1-877-609-8715 (TTY: 711) an.

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ください。申込者の方は、1-877-609-8715 (TTY: 711) までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 신청자분은 1-877-609-8715 (TTY: 711) 번으로 전화해 주십시오.

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ បេក្ខជន សូមទាក់ទងទៅលេខ 1-877-609-8715 (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 کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. درخواست کنندگان با شماره 1-877-609-8715 (TTY: 711) تماس بگیرند.

Romanian
Servicii lingvistice gratuite. Puteţi obţine un interpret. Puteţi avea documente citite pentru dvs. Pentru asistenţă telefonaţi-ne la numărul indicat pe cardul de membru. Solicitanţii să telefoneze la 1-877-609-8715 (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. Если вы хотите стать участником плана, звоните по телефону 1-877-609-8715 (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 aparece en su tarjeta de identificación. Los solicitantes deben llamar al 1-877-609-8715 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ ผู้สมัคร โทร 1-877-609-8715 (TTY: 711)

Ukrainian
Безплатні послуги перекладу. Ви можете скористуватися послугами перекладача. Вам можуть прочитати ваші документи. Щоб отримати допомогу, телефонуйте нам за номером, який вказаний на вашій ідентифікаційній картці (ID). Заявники можуть телефонувати за номером 1-877-609-8715 (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. Người nộp đơn gọi số 1-877-609-8715 (TTY: 711).

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, 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 1-888-802-7001 (TTY: 711). If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.