Health Net®

Health Net of California, Inc.

Individual & Family Plans

HMO Enrollment Application

Requested effective date

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Application must be typed or completed in blue or black ink.

Effective date of coverage: Coverage is only available for enrollment during the annual open enrollment period, which is November 15, 2014, through February 15, 2015; October 15, 2015, through December 7, 2015; and October 15 through December 7 every year thereafter, 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.

If you are currently enrolled in a Medicare plan, you are ineligible to apply for an individual and family plan.

Health Net of California, Inc. (Health Net) needs a Social Security number (SSN) for everyone enrolling for health coverage, including spouses 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.

THE AGENT/BROKER MAY NOT SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.

IMPORTANT: Please see Part V if the applicant does not read/write English. The Individual & Family Plan HMO Enrollment Application is available in Chinese and Spanish language versions. You can also have someone help you read it. For free help, please call 1-877-609-8711.

If you need assistance in completing this application, an agent/broker may assist you. An agent/broker who helped you read and complete this application must sign the application (see Part VI).

I (and my dependents if applicable) are applying during:

☐ **Annual open enrollment period** ☐ **Special enrollment period (see Part IV)**

Part I. Applicant information

Primary applicant's last name:	First name:	MI:	☐ Male ☐ Female
Billing address:			
Mailing address:			
Home address:			
City:	State:	ZIP:	County applicant resides in:
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 for all applicants): – –	Primary subscriber's Health Net ID (applicable for adding dependents and change requests only):	
Primary care physician ID:	Primary group ID:	Current patient: ☐ Yes ☐ No	
Please select your language preference (optional): ☐ English ☐ Spanish ☐ Chinese			

Primary's Social Security Number

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Part II. Tell us who you are enrolling and select the product

A. Reason for application

☐ **New application (Check family type below)**

- ☐ Self
- ☐ Self and spouse/domestic partner[1]
- ☐ Self and child
- ☐ Self and children
- ☐ Self, spouse/domestic partner[1] and child(ren)
- ☐ Child-only

[1]Please **circle** spouse or domestic partner

☐ **Adding dependent**

☐ **Change request (only available during open or special enrollment period)**

B. Billing options

First premium payment (select one)

☐ Automated Bank Draft (Please complete the Simple Payment Option section on page 11.)

☐ Pay by check (Please include completed check and send with application. Amount must match monthly premium.)

☐ Credit card (Please complete the credit card section on page 11.)

Ongoing monthly premium payments (select one)

☐ Automated Bank Draft (Please complete the Simple Payment Option section on page 11.)

☐ Monthly bill

C. Choice of coverage

Health Net of California, Inc. –

☐ **CommunityCare HMO Platinum $20 / $0**

☐ **CommunityCare HMO Gold $30 / $0**

☐ **CommunityCare HMO Silver $45 / $2,000**

Optional coverage: Dental / Vision plan for Adults (over age 18) –

☐ **Dental and Vision Plus – If Dental and Vision Plus is purchased for the primary applicant, all family members over age 18 will also be enrolled in the Dental and Vision Plus plan.**

Note: All medical plans include pediatric dental HMO coverage.

Part III. Family member(s) to be enrolled

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

☐ Check here if a supplemental page is attached. Please write the primary applicant's Social Security number on the upper right hand corner of the supplemental page.

Note: When each family member chooses a different plan, each member will be on their own contract. To specify different plans for different family members, be sure to write the plan name you are choosing for each family member in the spaces provided below.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State.

How to make different plan choices:

a. Health Net bills to only one address per subscriber. Therefore, to be processed under one subscriber, all family members must be billed to the same address.

b. You must select a physician group and primary care physician. You may choose the same or different physician group and primary care physician for each family member you are enrolling. If you do not select a primary care physician, one will be selected for you within your regional area. To find the most up-to-date list of Health Net contracted physicians, log in to www.healthnet.com > *ProviderSearch*. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county, or doctor's name. You can also call 1-877-609-8711 to request provider information, or contact your Health Net authorized agent/broker.

c. For Dental and Vision Plus coverage, please provide the dentist number for the HMO dentist you've chosen. You may choose a different dentist for each family member. If you do not select a dental office, one will be selected for you in your area. For names, addresses, primary dentist number, and telephone numbers of participating dental providers, or for help in selecting a provider, call Health Net at 1-866-249-2382 or log in to www.healthnet.com.

(continued)

Primary's Social Security Number

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Part III. Family member(s) to be enrolled (continued)

Relation	Last name	First name	MI	Social Security number	Date of birth
☐ Spouse ☐ Domestic partner				– –	/ /

HMO primary care physician ID	HMO physician group ID	If Dental and Vision Plus is purchased, please note HMO primary dentist #

Medical plan choice for each family member if different

Relation Child 1	Last name	First name	MI	Social Security number	Date of birth
☐ Son ☐ Daughter				– –	/ /

HMO primary care physician ID	HMO physician group ID	If Dental and Vision Plus is purchased, please note HMO primary dentist #

Medical plan choice for each family member if different

Relation Child 2	Last name	First name	MI	Social Security number	Date of birth
☐ Son ☐ Daughter				– –	/ /

HMO primary care physician ID	HMO physician group ID	If Dental and Vision Plus is purchased, please note HMO primary dentist #

Medical plan choice for each family member if different

Relation Child 3	Last name	First name	MI	Social Security number	Date of birth
☐ Son ☐ Daughter				– –	/ /

HMO primary care physician ID	HMO physician group ID	If Dental and Vision Plus is purchased, please note HMO primary dentist #

Medical plan choice for each family member if different

Primary's Social Security Number

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Part IV. 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 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. **Exceptions to these effective dates include birth, adoption or placement for adoption being effective the date of the qualifying event, and marriage or loss of minimum essential coverage being effective the first day of the following month.** For a list of special enrollment period qualifying events, please refer to page 9. The application must be received within 60 days of the qualifying event. Proof of the qualifying event is required. Please write in the applicable qualifying event below and check whom it applies to. For additional dependents, please attach a separate sheet of paper.

Qualifying event	Date of event	Primary applicant	Spouse/Domestic partner	Dependent 1	Dependent 2	Dependent 3

Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance.

Instructions for Part V: The following process is to be used when the applicant cannot complete the application because he or she cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must employ the services of a qualified interpreter. Please contact Health Net at 1-877-609-8711 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan enrollment application when applicable.

Health Net qualified interpreter – Please complete the following when assisted by a Health Net qualified interpreter.

I,_____, was assisted in the completion of this application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this application.
☐ Do not speak the language of this application.
☐ Do not write the language of this application.
☐ Other (explain): _____

A qualified interpreter assisted me with the completion of: ☐ The entire application.

☐ Other (explain): _____

A qualified interpreter read this application to me in the following language: _____

Signatures and date (required in ink)

Signature of applicant:	Today's date:
Date application was interpreted:	Time application was interpreted:
Qualified interpreter number:	

(continued)

Primary's Social Security Number

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Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance. (continued)

Qualified interpreter other than a Health Net qualified interpreter – Please complete the following when assisted by a qualified interpreter other than a Health Net qualified interpreter.

If a qualified interpreter, other than a qualified interpreter provided by Health Net, assisted you in completing this application, the interpreter must complete the following:

I,_____, understand that a qualified interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration that every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a qualified interpreter, I personally read and completed the application for the applicant named above because:

☐ Applicant does not read the language of this application.
☐ Applicant does not speak the language of this application.
☐ Applicant does not write the language of this application.
☐ Other (explain): _____

Under the penalty of perjury, I declare that I read to the applicant:

☐ The entire application.

☐ Other (explain): _____

I read this application to the applicant in the following language: _____

Please provide the following information regarding the qualified interpreter who assisted the applicant and who is not a Health Net qualified interpreter:

Last name:	First name:		
Address of qualified interpreter:			
City:	State:	ZIP:	Phone:
Qualified interpreter signature:			Date:

Primary's Social Security Number

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Part VI. Applicant's agent/broker information

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Health Net Broker ID:	**Health Net direct sales agent ID:**

Name (print):	Phone number:	Fax number:

Address:	Email address:

Applicant's agent/broker signature/number ***(required):***	**Date signed** ***(required):***

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. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(☐) assisted the applicant(s) in submitting this application. I advised the applicant(s) that he or she 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 he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

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

Primary's Social Security Number

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Part VII. Conditions of enrollment

GENERAL CONDITIONS: **Health Net reserves the right to reject any application for enrollment if the applicant is not eligible for coverage due to not meeting eligibility conditions.** There is no coverage unless this application is accepted by Health Net's Membership Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The applicant's agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

WHEN HEALTH NET CAN RESCIND A PLAN CONTRACT
Within the first 24 months of coverage, Health Net may rescind a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you or on your behalf on or with your enrollment application.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

If the Plan Contract is rescinded, Health Net shall have no liability for the provision of coverage under the Plan Contract.

By signing this application, you represent that all responses are true and that the application will become part of the Plan Contract between Health Net and you. By signing this application, you further agree to comply with the terms of the Plan Contract.

If, after enrollment, Health Net investigates your application information, Health Net must notify you of this investigation, the basis of the investigation, and offer you an opportunity to respond.

If Health Net makes a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by Health Net.

If the Plan Contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the rescission that will:

1. explain the basis of the decision, and your appeal rights;
2. clarify that all members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered;
3. explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract; and
4. explain your right to appeal Health Net's decision to rescind coverage.

If the Plan Contract is rescinded:

1. Health Net may revoke your coverage as if it never existed, and you will lose health benefits including coverage for treatment already received;
2. Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you and may recover from you any amounts paid under the Plan Contract from the original date of coverage; and
3. Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Plan Contract, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature on the next page.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this application and for payments of premiums. If such responsible party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with this application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the Statement of Accountability (see Part V of this application, "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance").

Primary's Social Security Number

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Part VIII. Important provisions

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

HIV TESTING PROHIBITED: 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.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Plan Contract. To obtain a copy of the Plan Contract, call Health Net at 1-877-609-8711. **I, the applicant, have read and understand the terms of this application, and my signature on the next page indicates that the information entered in this application is complete, true and correct, and I accept these terms.**

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

Applicant or parent or legal guardian's signature if applicant is under 18 years old:	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of spouse/domestic partner or applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:

The application and this Arbitration Clause must be signed by the applicant(s). The applicant(s) must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither agent/broker nor any other person may sign this application and Arbitration Clause.

Make personal check payable to "Health Net." Return completed application to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150.

You may submit a photocopy or facsimile of the application and authorizations. Health Net recommends that you retain a copy of this application and authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this enrollment application applies. "Plan Contract" refers to the Health Net of California, Inc. combined Plan Contract and Evidence of Coverage.

Primary's Social Security Number

Qualifying events for special enrollment periods for Individual & Family Plans

	Qualifying event	Submit required proof of qualifying event
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.	Death certificate.
	B. The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.	Termination or hour reduction confirmation from employer.
	C. The divorce or legal separation of the covered employee from the employee's spouse.	Divorce or separation documentation.
	D. The covered employee becoming entitled to benefits under Medicare.	Eligibility document.
	E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.	Termination/Cancellation notice from prior coverage.
	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/domestic partner, dependent child or surviving spouse/domestic partner) within one year before or after the date of commencement of the proceeding.	Employer documentation.
2)	The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.	Court documentation or discharge records.
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, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange.	Documentation would depend on circumstance.
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.	Documentation would depend on circumstance.
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.	Copy of lease, mortgage statement, phone or utility bill.
6)	With respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.	Termination/Cancellation notice from prior coverage.
7)	He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.	Court documentation.
8)	He or she has been released from incarceration.	Probation or parole paperwork.
9)	He or she was receiving services under another health benefit plan, from a contracting provider who is no longer participating in that health plan, for any of the following conditions: (a) an acute or serious chronic condition; (b) a terminal illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contract's termination date or the effective date of coverage for a newly covered member.	Letter from primary care physician (PCP).
10)	He or she demonstrates to Health Net, with respect to health benefit plans offered through the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.	Notice from other coverage.
11)	He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.	Active duty status documentation.

(continued)

Primary's Social Security Number

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Qualifying events for special enrollment periods for Individual & Family Plans (continued)

	Qualifying event	Submit required proof of qualifying event
12)	Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.	APTC paperwork.
13)	He or she loses medically needy coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium).	Medicaid documentation.
14)	He or she loses pregnancy-related coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium).	Medicaid documentation.

Primary's Social Security Number

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Primary applicant's name: _____

Simple Payment Option for Individual & Family Plans

Automatic Bank Draft (ABD) (select one): ☐ First month's premium only ☐ Ongoing monthly premium only ☐ First month's premium AND ongoing monthly premium

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Transit routing number (9 digits):	Account number:
Bank name:	State:

I understand that, by requesting the automatic payment option, I am authorizing Health Net of California ("Health Net") and my financial institution named above, to debit my checking or savings account for my monthly premium payment(s). I understand that the premium withdrawn from my account will be for the future billing period, plus any past due balances. I understand that my premium payments will automatically adjust if my monthly premium changes.

This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such debit. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with my bank.)***

ABD transmissions are withdrawn from my bank account on approximately the 20th of every month, for the following month's premium. I understand that if there are insufficient funds at the time my account is debited, a service fee of $25.00 (in addition to any fees my bank may charge me) will be assessed by Health Net for all dishonored payments. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the loss of health coverage.

Signature of account holder (required to process):	Date:

☐ **Credit card for first month's payment**

First month's premium can be charged directly to your credit card account. All future premiums due may be made by Automatic Bank Draft (complete the section above) or by mailing a check. **Your card will be charged for the first month's premium only.**

First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: ☐ Visa ☐ MasterCard
Account number 16 digits (complete):		Expiration date (mm/yy):	
Billing address:		City:	State: ZIP[1]:

As a convenience, I request and authorize Health Net to charge my credit card account identified above for the payment of my initial premium. I understand that my first month's withdrawal charge may be for multiple periods depending upon my date of approval and the billing period. This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, **I will be charged a $25 service charge.**

Signature of credit card account holder (required to process):	Date:

[1]The ZIP code must match the cardholder's address; otherwise, the credit card cannot be processed.

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No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call Health Net's Customer Contact Center at 1-800-522-0088. Individual and Family Plan (IFP) applicants please call 1-877-609-8711. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in a HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación con el Cliente de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (por sus siglas en inglés, IFP) deben llamar al 1-877-609-8711. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357 si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) de California al 1-888-HMO-2219.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，雇主團體申請人請撥 Health Net 的客戶聯絡中心，電話 1-800-522-0088。Individual and Family Plan (IFP) 申請人請撥 1-877-609-8711。如需其他協助：如果您投保的是 PPO 計畫，請撥 California Department of Insurance 電話 1-800-927-4357。欲投保管理式醫療組織 (HMO) 計畫，請撥加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

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

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 있는 안내번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 1-877-609-8711번으로 전화해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험국 (CA Dept. of Insurance) 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC (보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tumawag sa Customer Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual and Family Plan (IFP) mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 kung nag-e-enroll ka sa isang plano ng PPO. Kung nag-e-enroll ka sa isang plano ng HMO, tawagan ang DMHC Helpline sa 1-888-HMO-2219.

Tagalog

Անվճար լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-877-609-8711 համարով: Լրացուցիչ օգնության համար՝ 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance), եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в Контактный центр для клиентов компании Health Net (Customer Contact Center) по телефону 1-800-522-0088. Участники планов индивидуального и семейного страхования (Individual and Family Plan, IFP): пожалуйста, звоните по номеру 1-877-609-8711. Если вы участвуете в плане Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане Организации медицинского обеспечения (Health Maintenance Organization, HMO), звоните на телефон Горячей линии Департамента организованного медицинского обслуживания по номеру 1-888-HMO-2219.

Russian

無料の言語サービス。 日本語の通訳が書類をお読みします。 サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体プランへの加入をお申込みの方は、Health Netの顧客コンタクト・センター、1-800-522-0088までお電話ください。 個人・家族プラン（IFP）への加入をお申込みの方は、1-877-609-8711までお電話ください。 さらに援助が必要な場合、PPOプランにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。 HMOプランにご加入の方は、カリフォルニア州管理医療庁（DMHC）のヘルプライン、1-888-HMO-2219までご連絡ください。

Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفا با مرکز تماس مشتریان Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਰਿਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈਟ ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਅਿਕਤੀਗਤ ਅਤੇ ਪਰਵਿਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਤਾ ਕਰਿਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਸਹਾਇਤਾ ਲਈ, ਜੇ ਤੁਸੀਂ PPO ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਖਿਵਾ ਰਹੇ ਹੋ ਤਾਂ ਕੈਲੀਫੋਰਨਆਿ ਬੀਮਾ ਵਭਿਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਸਿੇ HMO ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਖਿਵਾ ਰਹੇ ਹੋ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬក្រុមនិយោជកអ្នកដាក់ពាក្យសុំ សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនរបស់ Health Net តាមលេខ 1-800-522-0088។ អ្នកដាក់ពាក្យសុំគំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 1-877-609-8711។ សំរាប់ព័ត៌មានបន្ថែមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើអ្នកកំពុងចុះឈ្មោះក្នុងគំរោង PPO។ បើអ្នកកំពុងចុះឈ្មោះក្នុងគំរោង HMO ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។

Khmer

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

Hmong

Doo Bąąh ‘Alínígóó Saad Bee ‘áka’anída’awo’ígíí. ‘Ata’ halne’í dóó naaltsoos bee ‘éédahozinígíí t’áá ni nizaad bee hadadilyaago nich’į’ yídóoltah. ‘Áka’a’eyeed biniiyégo, ninaaltsoos nitł‘izí bee nééhozinígíí bine’dęę’ béésh bee haneí biká’ígíí bee nich’į’ hodíilnih, doodago ninaalishí bił hada’dil’ínígíí t’áá shǫǫdí Health Net Na’iiłniihí Hane’ ‘Íił‘íh Bił Haz’ánijį’ 1-800-522-0088 hodíilnih. Ła’ Jizíh dóó Hooghan Haz’ą́ągi Naaltsoos Hadadít’éhígíí (IFP) hada’dile’ígíí t’áá shǫǫdí kohjį’ 1-877-609-8711 hodíilnih. T’áá náásgóó ‘áka’a’eyeed biniiyégo: PPO bił ha’dít’éhígíí bił ha’diléehgo CA Dept. béeso ‘áchą́ą́h naa’nil bił haz’ánígíí bich’į’ kohjį’ 1-800-927-4357 hodíilnih. HMO bił ha’dít’éhígíí bił ha’diléehgo, DMHC ‘Áka’aná’awo’ Bił Haz’ánígíí kohjį’ 1-888-HMO-2219 hodíilnih.

Navajo

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدّمي الطلبات من الموظفين يُرجى الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدّمي طلبات خطة الفرد والأسرة (IFP)، فيُرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357 إذا كنت مسجلاً في خطة PPO. إذا كنت مسجلاً في خطة HMO، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219.

Arabic

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