Health Net®

Small Business Application

for Group Enrollment and Change

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

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

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

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.

2b. **If you are *accepting* coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 8 are required.

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

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

Note: If you do not select a PPG, PCP and/or a dental provider, one will be selected for you.

4. If you choose to enroll in a PPO or EPO insurance plan, you are not required to select a PPG or PCP to enroll.

5. 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.**

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.

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Health Net®

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

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

1. Health plan information *(All medical plans include pediatric dental and vision coverage.)*

Full HMO Network[1]					SmartCare HMO Network[2]				
Platinum	☐ $10	☐ $20	**Gold**	☐ $30 ☐ $40 ☐ $50	**Platinum**	☐ $10	☐ $20	**Gold**	☐ $30 ☐ $40 ☐ $50
WholeCare HMO[1]					**Salud HMO y Más Network**[3]				
Platinum	☐ $10	☐ $20	**Gold**	☐ $30 ☐ $40 ☐ $50	**Platinum**	☐ $10	☐ $20	**Gold**	☐ $30 ☐ $40 ☐ $50

CommunityCare HMO Network[4]		PureCare One EPO[1]	
Gold ☐ $5	**Silver** ☐ $20	☐ Gold 80 EPO 1300/20 + Child Dental Alt	☐ Silver 70 EPO 2000/20 + Child Dental Alt

PureCare HSP[1]	PPO	
☐ Health Net Platinum 90 HSP 0/15	☐ Platinum 90 PPO 0/15 + Child Dental	☐ Bronze 60 PPO 6300/75 + Child Dental
☐ Health Net Gold 80 HSP 0/30	☐ Gold 80 PPO 0/30 + Child Dental	☐ PPO Silver HSA
☐ Health Net Silver 70 HSP 2000/45	☐ PPO Gold Value	☐ PPO Silver Value
☐ Health Net Bronze 60 HSP 6300/75	☐ Silver 70 PPO 2000/45 + Child Dental	☐ PPO Bronze HSA

EnhancedCare PPO[5]

☐ EnhancedCare PPO Gold Value ☐ EnhancedCare PPO Silver HSA
☐ EnhancedCare PPO Silver Value ☐ EnhancedCare PPO Bronze HSA

Other plan(s):

_____

Dental (DHMO)	Dental (DPPO)	Vision (PPO)
☐ HN Plus 150 ☐ HN Plus 225	☐ Classic 5 1500 (w/ortho) ☐ Essential 2 1000 ☐ Classic 4 1500 ☐ Essential 6 1500 ☐ Essential 5 1500 (w/ortho)	☐ Preferred 1025-2 ☐ Preferred 1025-3 ☐ Preferred Value 10-2

2. Reason for application

☐ Plan change
☐ Change address/name
☐ Delete dependent *(list names below)*
☐ Other: _____

☐ New hire ☐ Open Enrollment
Special Enrollment Period
Qualifying event date: _____/_____/_____

☐ **COBRA**[6] Effective date: _____/_____/_____
Qualifying event: _____
Qualifying event date: _____/_____/_____

Add dependent:
☐ Marriage ☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship
☐ Loss of prior coverage ☐ Domestic partnership ☐ Other (specify): _____

3. Employee personal information

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

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

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

Participating physician group:	Primary care physician:
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:	Is this your current PCP? ☐ Yes ☐ No
Dental HMO provider name:	Dental HMO provider ID #:

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

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

(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers):*		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers):*		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers):*		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers):*		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

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

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

☐ No ☐ Yes If "Yes," please complete this section including Medicare.

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

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

Life/AD&D coverage: ☐ Yes ☐ No

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

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

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

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

[4]Available in Los Angeles and Orange counties.

[5]Available in Los Angeles County.

[6]Provide the effective date COBRA first began, whether you were eligible for a total of 18 months or 36 months of COBRA (including Cal-COBRA).

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

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

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

Employee personal information

Last name:	First name:	MI:	Social Security #/Matricular ID #:

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

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

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

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

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

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

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, that the reason I am declining coverage is accurate as indicated by the check marks above.

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

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

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

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

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

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

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

English	1-800-522-0088
Cantonese	1-877-891-9053
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

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

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

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

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

Emergency and urgently needed care:

- If your situation is life-threatening or an emergency: Call 911 or go to the nearest hospital.
- If your situation is not so severe: If you cannot call your primary care physician or physician group, or you need medical care right away, go to the nearest hospital or urgent care center.
- If you are outside your physician group's service area: Go to the nearest hospital, medical center or call 911. In all cases, contact your primary care physician or participating physician group as soon as possible to inform them about your condition.
- Call the number on your ID card within 48 hours of being admitted, or as soon as possible.

Precertification:

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

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

Disabling conditions:

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

Products/Entities:

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

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

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

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

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

Declination of coverage:

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

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net Life Insurance Company and Health Net of California, Inc. (Health Net) comply with applicable federal civil rights laws and do 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:

Group Employer Applicants 1-800-522-0088 (TTY: 711)

Individual & Family Plan Applicants 1-877-609-8711 (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 grievance by mail, fax or online at:

Health Net of California, Inc. / Health Net Life Insurance Company Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348
Fax: 1-877-831-6019

Online: healthnet.com

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.

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 employer group applicants please call 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

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 يرجى من مقدمي طلبات مجموعة أصحاب العمل الاتصال بمركز الاتصال 1-800-522-0088 (TTY: 711).. يرجى من مقدمي طلبات خطة الأفراد والعائلة (IFP) الاتصال على الرقم 1-877-609-8711 (TTY: 711). وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc. , اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով, իսկ գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Անհատական և Ընտանեկան Ծրագրի անգլերեն հապավումը՝ (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար. եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով.

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，雇主團體申請人請致電 1-800-522-0088（TTY：711）。個人與家庭計畫 (IFP) 申請人請致電 1-877-609-8711（TTY：711）。如需進一步協助：如果您透過　Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線　1-888-HMO-2219。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज अपनी भाषा में पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या नियोक्ता समूह आवेदक कृपया 1-800-522-0088 (TTY: 711) संपर्क केंद्र पर कॉल करें। कृपया व्यक्तिगत और पारिवारिक प्लैन (IFP) के आवेदक 1-877-609-8711 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc., एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

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 ntawm tus xov tooj nyob ntawm koj daim npav, los yog tias koj yog tus neeg tso npe xav tau kev pab kho mob los ntawm koj txoj hauj-lwm thov hu rau 1-800-522-0088 (TTY: 711). Yog koj yog tus tso npe xav tau kev pab kho mob rau Ib Tug Neeg & Tsev Neeg Individual & Family Plan (IFP) thov hu 1-877-609-8711 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で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、雇用主を通じた団体保険の申込者の方は、 1-800-522-0088、(TTY: 711) までお電話ください。個人および家族向けプラン (IFP) の申込者の方は、 1-877-609-8711 (TTY: 711) までお電話ください。さらに援助が必要な場合: Health Net Life Insurance CompanyのPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នកនៅក្នុងភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ បេក្ខជនក្រុមនិយោជក អាចទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បេក្ខជនផែនការគ្រួសារ និងបេក្ខជនផែនការបុគ្គល សូមទូរសព្ទទៅលេខ 1-877-609-8711 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះ ឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO Health Net Life Insurance Company សូមទាក់ទងទៅនា យកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

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 고용주 그룹 신청인의 경우 1-800-522-0088 (TTY: 711) 번으로 전화해 주십시오. Individual & Family Plan (IFP) 신청인의 경우, 1-877-609-8711 (TTY: 711) 번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

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' employer groupǫjí ninaaltsoos siłtsoozgo éí 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'ałchíní bił hak'é'ésti'ígíí Į́IFP wolyéhígííÓ éí kojį' hojilnih 1-877-609-8711 (TTY: 711).Shíká anáá'doowoł jinízingo: PPO éí doodaii' EPOǫjí Health Net Life Insurance Company wolyéhíjí béeso ách'ą́ą́h naa'nil biniiyé hwe'iina' bik'é'ésti'go éí CA Dept. of Insurance bich'į' hojilnih 1-800-927-4357. HMO éí doodaii' HSPǫjí Health Net of Californiaǫjí béeso ách'ą́ą́h naa'nil biniiyé hats'íís bik'é'ésti'go éí kojį' hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد به زبان شما برایتان قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید، یا درخواست کنندگان گروه کارفرما لطفاً با مرکز تماس بازرگانی1-800-522-0088 (TTY: 711) تماس بگیرید. درخواست کنندگان برنامه انفرادی یا خانواده (IFP) لطفاً با شماره1-877-609-8711 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc. عضویت دارید، با خط راهنمایی تلفنی DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਾਰਿਵਾਰਕ ਪਲੈਨ (IFP) ਦੇ ਆਵੇਦਕ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ Health Net Life Insurance Company ਤੋਂ ਇੱਕ ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੇ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਹੈਲਥ ਨੈੱਟ ਆਫ਼ ਕੈਲੀਫ਼ੋਰਨੀਆਂ, ਇੰਕ ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы в переводе на ваш родной язык. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником группового плана, предоставляемого работодателем, звоните в коммерческий контактный центр компании 1-800-522-0088 (TTY: 711). Если вы хотите стать участником плана для семей и частных лиц (IFP), звоните по телефону 1-877-609-8711 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния CA Dept. of Insurance, телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания (DMHC), телефон 1-888-HMO-2219.

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. Los solicitantes del grupo del empleador deben llamar al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card, o para sa grupo ng mga aplikante ng employer, mangyaring tawagan ang 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Plano para sa Indibiduwal at Pamilya Individual & Family Plan, (IFP), mangyaring tawagan ang 1-877-609-8711 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ สำหรับความช่วยเหลือโทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ ผู้สมัครกลุ่มนายจ้าง กรุณาโทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว Individual & Family Plan (IFP) กรุณาโทร 1-877-609-8711 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese

Các Dị ch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị, hoặc người nộp đơn vào chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình viết tắt trong tiếng Anh là (IFP) vui lòng gọi số 1-877-609-8711 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đ ồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.