Health Net® Health Net® LIFE INSURANCE COMPANY

MEMBER ENROLLMENT AND CHANGE FORM

EMPLOYER NAME

COVERAGE EFFECTIVE DATE | EMPLOYER GROUP NUMBER *(Medical)*

IMPORTANT – Please print all sections in black ink. For the application to be valid you must submit all applicable pages.

1 SELECTED COVERAGE

1a: CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:

MEDICAL PLAN (write the plan number next to the product, if known)

- ☐ HMO _____
- ☐ HMO HRA _____
- ☐ HMO Silver Network _____
- ☐ HMO Variable Copay _____
- ☐ HMO y Más _____
- ☐ ELECT℠ Open Access (EOA) _____
- ☐ EOA Silver Network _____
- ☐ ELECT (POS) _____
- ☐ EPO _____
- ☐ FLEX NET (Indemnity) _____
- ☐ PPO _____
- ☐ PPO HSA _____
- ☐ Out-Of-State PPO (OOS PPO) _____
- ☐ Out-Of-State PPO HSA _____
- ☐ SALUD con Health Net _____
- ☐ SELECT (POS) _____
- ☐ SELECT 3-tier POS _____
- ☐ Other _____

Complete sections 1b /1c only if Health Net will be your dental and/or vision provider.

1b: DENTAL PLAN (choose one)
(write the plan number next to the product)

- ☐ HMO _____
- ☐ PPO _____
- ☐ INDEMNITY _____

1c: VISION PLAN
(write the plan number next to the product)

- ☐ PPO _____

REASON FOR APPLICATION:

- ☐ New hire
- ☐ Open Enrollment
- ☐ Loss of prior coverage date _____
- ☐ COBRA effective date _____
- Qualifying event _____
- Qualifying event date _____
- ☐ Add dependent
- Qualifying event _____
- Qualifying event date _____

REASON FOR CHANGE:

- ☐ Plan change
- ☐ Change address/name
- ☐ Delete dependent(s) (list names in Section 3)
- ☐ Other _____

2 EMPLOYEE PERSONAL INFORMATION

Last Name	**First Name**	**M.I.**	☐ **Male** ☐ **Female**
Residence Address	**City**	**State**	**Zip**
Mailing Address (if different from residence)	**City**	**State**	**Zip**

Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID#**	**Job Title**
Telephone No. ( )	**Work Telephone No.** ( )	**Email Address**

Date of Hire / /	**Job Class**	**Dept. no.**	**Employment Status** ☐ Salaried ☐ Hourly	**Marital Status** ☐ Single ☐ Married ☐ Domestic Partner

Are you choosing to decline coverage? ☐ **Yes** ☐ **No**
If yes skip to Section 4.

For HMO y más or Salud con Health Net Members: If available, I would prefer to receive communication and plan information in Spanish.
☐ Yes ☐ No

Coverage Type ☐ Medical ☐ Dental ☐ Vision	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN #**	**Participating Physician Group/PPG#**	**Primary Care Physician/PCP#**
			☐ N/A I'm enrolling in a PPO or Flex Net Plan	

Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** (complete only if electing Health Net Dental)

Do you have other Health Care coverage? ☐ **Yes** ☐ **No** If yes, complete the following:
Name of Insurance Carrier _____ **Prior coverage start date** _____

Are you enrolling dependents? ☐ **Yes** ☐ **No**
If yes, complete and submit all pages of the form. If no, skip to Section 5 and submit pages 1& 3.

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Employee Name ____

3 FAMILY INFORMATION Please list all eligible family members to be enrolled. (Attach additional sheets if necessary)

☐ Spouse ☐ M ☐ Domestic Partner ☐ F	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Participating Physician Group/PPG#**	**Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** (complete only if electing Health Net Dental)	

Do you have other Health Care coverage? ☐ **Yes** ☐ **No** If yes, complete the following:
Name of Insurance Carrier ______________________________ **Prior coverage start date** ______________

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** (complete only if electing Health Net Dental)	

Do you have other Health Care coverage? ☐ **Yes** ☐ **No** If yes, complete the following:
Name of Insurance Carrier ______________________________ **Prior coverage start date** ______________

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** (complete only if electing Health Net Dental)	

Do you have other Health Care coverage? ☐ **Yes** ☐ **No** If yes, complete the following:
Name of Insurance Carrier ______________________________ **Prior coverage start date** ______________

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** (complete only if electing Health Net Dental)	

Do you have other Health Care coverage? ☐ **Yes** ☐ **No** If yes, complete the following:
Name of Insurance Carrier ______________________________ **Prior coverage start date** ______________

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4 DECLINATION OF COVERAGE (complete this section if any coverage is to be declined by you or your eligible dependents.)

☐ **Declining Medical coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(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:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(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:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(s)

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

STOP AND READ CAREFULLY.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).
By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Print Employee Name _____

Employee Signature _____ **Date** _____

(SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.)

5 ACCEPTANCE OF COVERAGE (signature required.)

THE 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 Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or Fidelity Entities use 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 evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

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.

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

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, 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 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, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the DBP Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

Print Employee Name _____

Employee Signature _____ **Date** _____

"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 Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

Health Net®

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 new applicants please call 1-800-522-0088. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO or EPO plan.
English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación o, si es un solicitante nuevo, llame al 1-800-522-0088. Para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357 si se inscribe en un plan PPO o EPO.
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，部分文件可以翻譯成您的語言並寄送給您。欲取得協助，請撥您會員卡上所列電話號碼和我們聯絡，新申請人請撥 1-800-522-0088。如果您加入的是 PPO 或 EPO 計畫而想取得更多協助，請致電加州保險部，電話 1-800-927-4357。
Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và có thể được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc các đương đơn mới có thể gọi số 1-800-522-0088. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO hoặc EPO.
Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 연락해 주시거나 신규 신청자님의 경우 1-800-522-0088 번으로 문의해 주십시오. PPO 혹은 EPO 플랜에 가입하신 경우 보다 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357 번으로 문의하십시오.
Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga bagong aplikante, mangyaring tumawag sa 1-800-522-0088. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO o EPO plan.
Tagalog

Անվճար Լեզվական Ծառայություններ: Կարող եք թարգմանիչ ձեռք բերել և փաստաթղթերը ձեր լեզվով ընթերցել տալ: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա գտնվող համարով, կամ եթե նոր դիմորդ եք՝ 1-800-522-0088 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով, եթե գրանցվում եք PPO կամ EPO ծրագրում:
Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами устного переводчика, который прочитает вам документы на вашем родном языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному в вашей карточке-удостоверении. Если вы являетесь новым участником, пожалуйста, звоните по номеру 1-800-522-0088. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357, если вы регистрируетесь как участник плана PPO или EPO.
Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の場合、ID カード記載の番号までお問い合わせください。新規お申し込みの方は、1-800-522-0088 までご連絡ください。更なるお問い合わせは、PPO または EPO プラン会員の方に限り、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。
Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا متقاضیان جدید لطفاً با شماره 1-800-522-0088 تماس بگیرند. برای دریافت کمک بیشتر یا اگر در یک طرح PPO یا EPO ثبت نام می کنید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید.
Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਅਤੇ ਨਵੇਂ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰਨ। ਜੇ ਤੁਸੀਂ PPO ਜਾਂ EPO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਫ਼ੋਨ ਕਰੋ।
Punjabi

សេវាភាសាដែលឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងអាចឱ្យគេអានឯកសារផ្សេងៗឱ្យអ្នក ស្តាប់ជាភាសារបស់អ្នក ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬបេក្ខជនថ្មីសូមទូរស័ព្ទទៅលេខ 1-800-522-0088 ។ សម្រាប់ព័ត៌មានបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 ប្រសិនបើអ្នកកំពុងចុះឈ្មោះនៅក្នុងគម្រោង PPO ឬ EPO ។
Cambodian

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Yuav muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tshiab thov hu rau 1-800-522-0088. Yog xav tau kev pab ntxiv hu rau CA Lub Caj Meem Fai Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 yog hais tias koj koom rau hauv qhov kev pab them nqi los ntawm PPO los sis EPO.
Hmong

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານຣເອ ງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ ຫລືຜູ້ທີ່ຈະຂໍເອົາ ແຜນການໃໝ່ໃຫ້ໂທຕາມໝາຍເລກ 1-800-522-0088. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ PPO ຫລື EPO ໃຫ້ໂທໄປ ຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມໝາຍເລກ 1-800-927-4357 ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ.
Lao

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك. بالنسبة للأعضاء الجدد، رجاء الاتصال بالرقم 1-800-522-0088. للحصول على المساعدة الإضافية، يرجى الاتصال بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت منضما لبرنامج PPO أو EPO.
Arabic

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

English	1-800-522-0088
Spanish	1-800-331-1777
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

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

Dental	1-866-249-2382
Vision	1-866-392-6058

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

HMO, HMO HRA, HMO Silver Network, HMO Variable Copay, HMO y más, ELECT Open Access (EOA), ELECT (POS), EPO, Salud con Health Net EPO or SELECT (POS) Enrollees: select a Participating Physician Group (PPG) and a Primary Care Physician (PCP).

Dental HMO Enrollees: select a participating dentist.

Please note, if you do not select a participating physician group, primary care physician, or dental provider for yourself and each of your eligible dependents, a physician group, primary care physician, and dental provider will be selected for you.

PRE-CERTIFICATION

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

For pre-certification, please call 1-800-977-7282

Preexisting Conditions and Creditable Coverage
Your coverage under the PPO, PPO HSA, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance Company will credit any prior coverage that you document at the time you apply to enroll in PPO, PPO HSA, EPO or Flex Net, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.

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 occur 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

Medical plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the “Health Net Entities”). Dental plans are provided by Dental Benefit Providers of California, Inc. and / or Unimerica Insurance Company (together, the "DBP Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the “Fidelity Entities”).

Neither the DBP Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Health Net of California, Inc. offers the following products: HMO, HMO HRA, HMO Silver Network, HMO Variable Copay, HMO y más, Salud con Health Net HMO, ELECT Open Access (EOA), ELECT (POS) and SELECT (POS).

Health Net Life Insurance Company offers the following products: PPO, PPO HSA, EPO, Flex Net and Salud con Health Net EPO & PPO.

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

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

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

PLEASE VISIT US AT WWW.HEALTHNET.COM