Small Business

Application for Group Enrollment and Change

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

Pediatric dental HMO and PPO plans are provided by Health Net of California, Inc. and administered by DBP.

Neither DBP nor EyeMed are affiliated with Health Net. Obligations under dental plans, other than pediatric dental, are not obligations of, and are not guaranteed by, Health Net.

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. In addition, California Senate Bill 78 requires all residents and their dependent to obtain and maintain monthly minimum essential coverage. The Social Security Numbers (SSN) are also provided to the Franchise tax Board. We request you provide an accurate Social Security number (SSN) or Tax Identification number (TIN) for yourself and each dependent you are enrolling. A Matricular ID # is requested for any enrollees residing in Mexico when enrolling on a Salud HMO y Más plan. 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 Full HMO, WholeCare HMO, CommunityCare HMO, SmartCare HMO, Salud HMO y Más, 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 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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To be completed by employer	
Employer name:	
Requested effecti e 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 ☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55	**Platinum** ☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55
WholeCare HMO Network[1]			**Salud HMO y Más Network[3]**		
Platinum ☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55	**Platinum** ☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55

CommunityCare HMO Network[4]	
Silver ☐ $2,250/$50	**Bronze** ☐ $6,300/$60

Full PPO Network

☐ Platinum PPO 0/15	☐ Gold PPO 1000/35	☐ Silver PPO 2500/55	☐ Bronze PPO 6300/60
☐ Platinum PPO 250/15	☐ Gold PPO 1600/0	☐ Silver PPO 2250/60	☐ Bronze HDHP PPO 7050/0%
☐ Gold PPO 0/35	☐ Gold PPO 750/15	☐ Silver HDHP PPO 1600/50%	
☐ Gold PPO 350/25	☐ Gold HDHP PPO 1600/20%	☐ Silver PPO 1700/50	
☐ Gold PPO 500/20			

Other plan(s):

Dental (DHMO)	Dental (DPPO)		Vision (PPO)	
☐ HN Plus 150 ☐ HN Plus 225	☐ Classic 4 1500 ☐ Classic 5 1500 (w/ortho)	☐ Essential 2 1000 ☐ Essential 5 1500 (w/ortho) ☐ Essential 6 1500	☐ Elite 1010-1 ☐ Preferred 1025-2 ☐ Preferred Value 10-3 ☐ Exam Only	☐ Supreme 010-2 ☐ Preferred 1025-3 ☐ Plus 20-1

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**[5] **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): _____	

[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, Orange and San Diego counties.

[5]Provide the effecti e date COBRA fi st began, whether you were eligible for a total of 18 months or 36 months of COBRA (including Cal-COBRA).

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

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:			
City:	State:	ZIP:	County:
Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:		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 #:		

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 #/TIN/Matricular ID #:	
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 #/TIN/Matricular ID #:	
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 #/TIN: __ __ __ __

4. Family information, please list all eligible family members to be enrolled. (continued)

(Attach additional sheets if necessary.)

☐ 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 #/TIN/Matricular ID #:	
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 #/TIN/Matricular ID #:	
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 #/TIN: __ __ __ __

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:	%

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit P oviders of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Group Policy and Certific te of Insurance.

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

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 (or e-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 and/or DBP 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, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, arising from or relating to the *Evidence of Coverage or Certificate of Insurance* or my Health Net coverage, must be submitted to individual, final and binding arbitration instead of a jury or court trial, and that I am waiving all rights to class arbitration. This agreement to arbitrate 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, except disputes concerning adverse benefit determinations, 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, except disputes concerning adverse benefit determinations, to binding arbitration instead of a court of law.

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

Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC. Health Net and Salud con Health Net are registered service marks of Health Net, LLC. All other identified t ademarks/service marks remain the property of their respective companies. All rights reserved.

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 ccording to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs fi st: (a) the member is no longer totally disabled, (b) the maximum benefit 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. offe s the following products: CommunityCare HMO Network, Full HMO Network, WholeCare HMO Network, SmartCare HMO Network, PPO Network and Salud HMO y Más Network.

Health Net Life Insurance Company offe s the following products: Life and AD&D insurance.

Dental Benefit P oviders of California, Inc. offe s the following products: Dental HMO (DHMO) and Dental PPO (DPPO).

Health Net Life Insurance Company offe s the following products serviced by EyeMed Vision Care, LLC ("EyeMed") and Envolve Vision, Inc.: 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.

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, 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:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc. Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, 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, if you have an ID card, please call the Customer Contact Center number. Employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة، يرجى الاتصال برقم مركز خدمة العملاء المبين على بطاقتك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في Health Net عبر الرقم: 1-800-522-0088 (TTY: 711). فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم 1-877-609-8711 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Եթե ID քարտ ունեք, օգնության համար խնդրում ենք զանգահարել Հաճախորդների սպասարկման կենտրոնի հեռախոսահամարով: Գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել Health Net-ի Կոմերցիոն սպասարկման կենտրոն՝ 1-800-522-0088 հեռախոսահամարով (TTY՝ 711): Individual & Family Plan (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助且如果您有會員卡，請撥打客戶聯絡中心電話號碼。雇主團保計畫的申請人請撥打 1-800-522-0088（聽障專線：711）與 Health Net 私人保險聯絡中心聯絡。Individual & Family Plan (IFP) 的申請人請撥打 1-877-609-8711（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोक्ता सामूहिक आवेदक कृपया हेल्थ नेट के कमर्शियल संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) आवेदक कृपया 1-877-609-8711 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab cuam, yog tias koj muaj daim npav ID, thov hu rau Neeg Qhua Lub Chaw Tiv Toj tus npawb. Tus tswv ntiav neeg ua haujlwm pab pawg sau ntawv thov ua haujlwm thov hu rau Health Net Qhov Chaw Tiv Toj Kev Lag Luam ntawm 1-800-522-0088 (TTY: 711). Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) cov neeg thov ua haujlwm thov hu rau 1-877-609-8711 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプについては、IDカードをお持ちの場合は顧客連絡センターまでお電話ください。雇用主を通じた団体保険の申込者の方は、Health Netの顧客連絡センター（1-800-522-0088、TTY: 711）までお電話ください。個人・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。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ដាល់មាត់។ លោកអ្នកអាចស្ដាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានបំណុសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំគម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-609-8711 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하십시오. 고용주 그룹 신청인의 경우 Health Net의 상업 고객서비스 센터에 1-800-522-0088(TTY: 711)번으로 전화해 주십시오. 개인 및 가족 플랜(IFP) 신청인의 경우 1-877-609-8711(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada’iiyeed. Ata’ halne’ígíí da ła’ ná hádídóot’įįł. Naaltsoos da t’áá shí shizaad k’ehjí shichį́’ yídooltah nínízingo t’áá ná ákódoolnííł. Ákót’éego shíká a’doowoł nínízingo Customer Contact Center hoolyéhíjį’ hodíílnih ninaaltsoos nanitingo bee néého’dolzinígíí hodoonihjį’ bikáá’. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį’ hodíílnih Health Net’s Commercial Contact Center 1-800-522-0088 (TTY: 711). T’áá hó dóó ha’áłchíní (IFP) báhígíí éí kojį’ hojilnih 1-877-609-8711 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس مشتریان تماس بگیرید. متقاضیان گروه کارفرما لطفاً با مرکز تماس تجاری Health Net به شماره 1-800-522-0088 (TTY:711) تماس بگیرند. متقاضیان طرح فردی و خانوادگی (IFP)* لطفاً با شماره 1-877-609-8711 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਆਈਡੀ ਕਾਰਡ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਮਾਲਕ ਦਾ ਗਰੁੱਪ ਬਿਨੈਕਾਰ, ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਬਿਨੈਕਾਰਾਂ ਨੂੰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь и у Вас при себе есть карточка участника плана, звоните по телефону Центра помощи клиентам. Участники коллективных планов, предоставляемых работодателем: звоните в коммерческий центр помощи Health Net по телефону 1-800-522-0088 (TTY: 711). Участники планов для частных лиц и семей (IFP): звоните по телефону 1-877-609-8711 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, si tiene una tarjeta de identificación, llame al número del Centro de Comunicación con el Cliente. Los solicitantes del grupo del empleador deben llamar al Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, kung mayroon kayong ID card, mangyaring tumawag sa numero ng Customer Contact Center. Para sa mga grupo ng mga aplikante ng tagapag-empleyo, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088 (TTY: 711).
Para sa mga aplikante ng Planong Pang-indibiduwal at Pampamilya (Individual & Family Plan, IFP), mangyaring tumawag sa 1-877-609-8711 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ และคุณมีบัตรประจำตัว โปรดโทรหมายเลขศูนย์ลูกค้าสัมพันธ์ ผู้สมัครกลุ่มนายจ้าง โปรดโทรหาศูนย์ลูกค้าสัมพันธ์เชิงพาณิชย์ของ Health Net ที่หมายเลข 1-800-522-0088 (โหมด TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`âu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nếu quý vị có thẻ ID, vui lòng gọi đến số điện thoại của Trung Tâm Liên Lạc Khách Hàng. Những người nộp đơn xin bảo hiểm nhóm qua hãng sở vui lòng gọi Trung Tâm Liên Lạc Thương Mại của Health Net theo số 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình (IFP), vui lòng gọi số 1-877-609-8711 (TTY: 711).