Health Net®

Small Business Application

for Group Service Agreement/Group Policy

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 not obligations of, and are not guaranteed by, Health Net.

Application is hereby made for a Group Service Agreement/Group Policy provided by Health Net, DBP and/or Fidelity, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring or requiring coverage hereunder. The following information regarding employee and/or dependent data is being submitted to allow Health Net, DBP and/or Fidelity to determine the eligibility of employees and/or dependents seeking enrollment.

Welcome to Health Net

Simple steps for completing the form:

1. Carefully review and select the plan option(s) that is/are best for your business.
2. 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.**

Health Net Medical: 1-800-522-0088 *(English)*
1-800-331-1777 *(Spanish)*
1-877-891-9053 *(Mandarin)*

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

For administrative use only:	
Existing Business/Group	**New Business/Group**
PO Box 9103 Van Nuys, CA 91409-9103 www.healthnet.com	Please send all completed paperwork to your designated account executive or broker.

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Important: If adding Dental or Vision to your existing coverage, please complete sections 2, 3, 4, 6, 7, 9, 10, and 11; for all other changes to existing coverage, please complete only sections 2, 3, 4, and 10.

1. Health plan information

Select an Enhanced Choice option, then select your plan(s):

☐ Enhanced Choice A ☐ Enhanced Choice B

Full HMO Network[1]					**SmartCare HMO Network**[2]				
Platinum	☐ $10	☐ $20	**Gold**	☐ $30 ☐ $40 ☐ $50	**Platinum**	☐ $10	☐ $20	**Gold**	☐ $30 ☐ $40 ☐ $50
WholeCare HMO Network[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]			
Gold	☐ $5	**Silver**	☐ $20

PureCare One EPO[1]	**PureCare HSP**[1]	
☐ Gold 80 EPO 1300/20 + Child Dental Alt	☐ Health Net Platinum 90 HSP 0/15	☐ Health Net Silver 70 HSP 2000/45
☐ Silver 70 EPO 2000/20 + Child Dental Alt	☐ Health Net Gold 80 HSP 0/30	☐ Health Net Bronze 60 HSP 6300/75

PPO

☐ Platinum 90 PPO 0/15 + Child Dental	☐ Gold 80 PPO 0/30 + Child Dental	☐ PPO Gold Value
☐ Silver 70 PPO 2000/45 + Child Dental	☐ PPO Silver Value	
☐ Bronze 60 PPO 6300/75 + Child Dental	☐ PPO Bronze HSA	

Other plan(s):

_____

Ancillary options

Note: All medical plans include pediatric dental and pediatric vision coverage. Individuals will receive pediatric dental and vision coverage under the medical plan until the last day of the month in which the individual turns 19.

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

Optional Rider ☐ Chiropractic (Optional coverage available on all plans except PPO.) ☐ Infertility

Life and AD&D options (If Health Net Life is selected, all full-time employees are eligible.)

☐ **Option A** – $15,000 flat amount for all employees.	☐ **Option B** – $25,000 flat amount for all employees (15–50 employees).	☐ **Option C** – $50,000 flat amount for all employees (25–100 employees).

2. Employer group information

Company name:	DBA:	Group #:	SIC code:
Tax ID number (TIN):	Type of business:		
Type of entity *(corporation, sole prop., LLC, partnership):*		How long in business:	Effective date *(renewal date):*
Company contact:	Telephone:	Fax:	
Physical address:	City:	State:	ZIP:
Billing address *(if different from physical address):*	City:	State:	ZIP:
Email address *(print clearly):*			
Company contact for coordination of benefits (COB) *(if different from above):*			
COB address *(if different from physical address):*	City:	State:	ZIP:

3. Employer contribution *(Note: Employer contribution for Health is a minimum of 50% of the lowest cost plan or $100 per employee, and for Life is 100% (1–9 enrollees) and 50% (10–100 enrollees)).*

Employee Health: _____% or $_____ Employee Life: _____% Employee Dental: _____% Employee Vision: _____%

Dependent Health: _____% or $_____ Dependent Dental: _____% Dependent Vision: _____%

Note: Dental and Vision can be either voluntary or employer-paid. If employer-paid, you must complete the employer contribution. If you select Dental and/or Vision with no contribution, indicate "0."

4. Eligibility information

1. Will there be eligibility conditions that will apply prior to the probationary period (e.g., being in an eligible job classification, achieving job-related licensure requirements, or satisfying a "reasonable and bona fide employment-based orientation period")? ☐ Yes ☐ No
2. Employer's probationary period for new hires/rehires – First of the month following: ☐ Date of hire ☐ 1 mo. ☐ 30 days ☐ 60 days*

   *Health Net will adjust the effective date for new enrollees if needed to ensure that the waiting period does not exceed 90 days.
3. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No
4. Average number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30
5. Total number of employees worldwide: _____

	Medical	Dental	Vision	Life
6. Number of eligible employees (including eligible owner(s)):	_____	_____	_____	_____
7. Total number of Health Net enrollees (excluding COBRA enrollees):	_____	_____	_____	_____
8. Number of Health Net COBRA enrollees (applying for health coverage):	_____	_____	_____	_____
9. Number of waivers (Please include an enrollment form with Section 7 "Declination of Coverage" indicated.):	_____	_____	_____	_____

10. What type of COBRA[5] are you subject to? ☐ Federal COBRA ☐ Cal-COBRA

    If federal COBRA, how would you like your COBRA enrollees to be billed? ☐ Group billed ☐ Member billed
11. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No
12. Do the eligible enrollees represent a carve-out either by location or union affiliation? ☐ Yes ☐ No
13. Does the group file a DE-9C? ☐ Yes ☐ No[6]

5. Pre-tax solutions *(e.g., IRS code section 125 premium-only plans and Flex plans.)*

If you are interested in learning about the tax savings potential for your employees and company, please contact Total Administrative Services Corporation (TASC) at 1-800-422-4661.

6. Current carrier *(List current carrier if any.)*

Is your company currently active with other health insurance? ☐ Yes ☐ No

If so, will you be canceling your other health insurance if approved with Health Net? ☐ Yes ☐ No

Current health insurance carrier: _____

Will Health Net be the only carrier? ☐ Yes ☐ No If "No," name of other carrier: _____

Plan(s) offered: _____

Workers' compensation carrier: _____

Number of enrollees not covered by workers' compensation: _____

(Employers required to have workers' compensation must have a policy in effect to be eligible with Health Net.)

7. Off-cycle dental/vision plan addition renewal cycle

Your renewal date for your dental and/or vision plan addition will be coordinated with your medical plan renewal date.

8. Mailing methods

Where would you like your Administration Kit mailed? ☐ Broker ☐ Employer

9. Underwriting criteria

General conditions

The issuance of coverage and a Group Service Agreement/Group Policy is subject to underwriting review and approval by Health Net, DBP and/or Fidelity and receipt of the first month's premium. The initial quoted rates are subject to Health Net, DBP and/or Fidelity's review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by Health Net, DBP and/or Fidelity as appropriate within specified time requirements.

10. Arbitration agreement and other important terms

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement/Group Policy is subject to review and approval by Health Net, DBP and/or Fidelity and receipt of the first month's premium.

The undersigned hereby acknowledge to the best of their knowledge or belief that the preceding information constitutes true and complete representations to Health Net, DBP and/or Fidelity. Should it be determined at the time of enrollment or during the 24-month period after the Group Agreement/Group Policy is issued that there has been an intentional misrepresentation of material fact, as prohibited by the terms of this Group Agreement/Group Policy, the Group Agreement/Group Policy may be canceled with 30 days advance notice of such cancellation.

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the Group Service Agreement/Group Policy and to forward such amounts in advance of the due date to Health Net, DBP and/or Fidelity, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group, and deletions from the group. Please return this application to your Health Net account executive or broker as specified.

Applicant, in the event this application is accepted, agrees to cooperate with Health Net in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information provided by the Health Net "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder. The undersigned hereby acknowledge responsibility for obtaining and for sending an electronic or printed copy of the Summary of Benefits and Coverage document ("SBC") to plan participants and beneficiaries. To retrieve your group's SBCs, go to www.healthnet.com/sbc.

The following standard minimum participation and contribution requirements apply unless modified in quote or renewal Underwriting assumptions.

Minimum contribution is defined as: The employer contribution toward Health Net's premium that must be equal to or greater than 50% or $100 of employee single premium.

Minimum participation is defined as: For groups of 1–5 eligible employees, a minimum of 66% participation is required. For groups of 6–100 eligible employees, a minimum of 50% participation is required.

Failure to maintain these minimum contribution and minimum participation requirements may result in termination or non-renewal.

This Application for Group Service Agreement/Group Policy and any attached Addendum, together with the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy (as referenced herein), and the employee enrollment forms form the entire agreement between the parties.

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.

(continued)

10. Arbitration agreement and other important terms (continued)

BINDING ARBITRATION AGREEMENT: On behalf of Group Applicant, and subject to certain restrictions prohibiting application of mandatory arbitration to members of employer groups subject to ERISA, 29 U.S.C. SECTION 1001, et seq., I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and Health Net, DBP and/or Fidelity regarding the construction, interpretation, performance or breach of the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy, whether stated in tort, contract or otherwise, 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 Health Net, DBP and/or Fidelity, are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with Health Net, DBP and/or Fidelity involving claims for medical services 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. In the event that the total amount of damages claimed is $50,000 or less with respect to disputes involving alleged professional liability or medical malpractice, the parties shall, within 30 days of submission of the demand for arbitration, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $50,000. If the parties fail to reach an agreement during this time frame, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter, in accordance with California Code of Civil Procedure 1281.6. A more detailed arbitration provision is included in the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy.

Officer of the company signature:	Officer title:	Date:

Applicant's signature above confirms to the best of their knowledge or belief: 1) Applicant's agreement to all the terms and conditions set out in this Application, including the conditions of enrollment and Underwriting Assumptions; and 2) the accuracy and completeness of the information that the Applicant has entered in this Application.

11. Broker information

Broker name:	Health Net broker ID #:	Broker lic. #:	Date submitted:
Agency name:	Telephone #:	Fax #:	Email address:
Address:	City:	State:	ZIP:
Broker/Consultant signature:	Date:	Account executive name:	Date:
General agent/ID #:			Date:

12. 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.

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 explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

If I willfully state as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($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

13. For Health Net use only

Underwriter signature:	Date:	Approved: ☐ Medical ☐ Dental ☐ Vision Declined: ☐ Medical ☐ Dental ☐ Vision	Billing #:	Effective date:
SBG representative signature:	Date:	Group # (Health):	Policyholder # (Life):	Medical plan:

Health Net of California, Inc. offers the following products: HMO, Salud con Health Net HMO y Más and HSP. Health Net Life Insurance Company offers the following products: PPO, EPO and Life and AD&D insurance. Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity. Dental Benefit Providers of California, Inc. offers the following product: Dental HMO. Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: Vision PPO.

"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 Group Policy and Certificate of Insurance.

Small Business Group submission checklist

To ensure prompt processing, please make sure to include the following documents.

Groups applying for a 1st-of-the-month effective date must be submitted to Health Net by the 5th of the month. Paperwork must be completed by the 20th of the month; otherwise, the group will be rolled to the following month.

- ☐ A signed original application for Group Service Agreement (GSA)/Group Policy
- ☐ A complete employee application for each eligible employee enrolling/waiving coverage
- ☐ A check or a Check-by-Fax form for the first month's premium drawn from the group account
- ☐ The latest quarter DE-9C, reconciled:
  - If the group has not been in business long enough to have a DE-9C, six weeks of payroll, including withholdings, may be submitted.
  - 2-week payroll is required for all employees that don't appear on the current DE-9C.
  - For wages exceeding part-time and wages below full-time status, payroll will be required.
  - To reconcile the DE-9C, please indicate next to each employee's name one of the following:

    T – Terminated (including termination date)

    E – Eligible and enrolling

    W – Eligible and waiving coverage

    S – Seasonal

    WP – Waiting period (include date of hire for those in waiting period)

    TEMP – Temporary employees

    PT – Part-time

    Covered by another carrier – add carrier name.
- ☐ Ownership paperwork (required if owner/partners' names do not appear on the DE-9C or payroll records). Must list each person's first and last name. Paperwork must be filed with the state or county. Documentation may include:

  For sole proprietor:
  - California Business License
  - Fictitious Business Name Statement
  - Schedule C Tax Form

  For partnership:
  - California Business License (showing both names)
  - Fictitious Business Name Statement (showing both names)
  - Schedule K Tax Form (for all eligible owners)
  - Tax certificate (showing both names)

  For corporation:
  - Articles of Incorporation
  - Statement of Information
  - Tax Form 1120

  Note: Please consult your sales representative for acceptable ownership documentation for other business structures.

For PPO plans:

- ☐ Copies of EOBs for employees requesting Deductible Credit from prior carrier

Send all completed paperwork to your designated account executive or broker.

[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]**Note:** Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2–19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

[6]If a DE-9C is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

Health Net®

Ensure *Your Employees* Understand *Their Health Care*

Summary of Benefits and Coverage to eligible and covered persons

Instructions for reproduction and distribution.

Affordable Care Act (ACA)[1] *requirement for employers that sponsor group health plans*

As required by the ACA, health plans and employer groups must provide the Summary of Benefits and Coverage (SBC) to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA Continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in paper or electronic form (i.e., email or Internet posting).

- If you provide a paper copy, the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on *four double-sided pages*.
- If you mail a paper copy, you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.
- For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.[2]
- If you email the SBC, you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- If you post the SBC on the Internet, you must advise your employees by email or paper that the SBC is available on the Internet, and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request. You may use the Model Language below for an e-card or postcard in connection with a website posting of a SBC:

(continued)

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.
[2]Such requirements can be found at 29 C.F.R. § 2520.140b-1(b)

Availability of Summary Health Information
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: <group's website.com>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

Timing of SBC distribution

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC *by the first day the employee is eligible to enroll in the plan*.
- **Special enrollees.** For special enrollees[3], you must provide the SBCs *within 90 days following enrollment*.
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed*. If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year*. If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than 7 business days after issuance of new policy or the receipt of written confirmation of intent to renew your group health plan*.

At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than 7 business days following your receipt of the request.

Notice of SBC modification

Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees *no later than 60 days prior to the date on which change(s) become effective*. You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary of bolded terms used in the SBC by visiting www.cciio.cms.gov, or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within 7 business days after Health Net receives their request.

If you have any questions, please contact your Health Net client manager.

[3]Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at **1-800-522-0088 (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: Health Net, PO Box 10348, Van Nuys, California 91410-0348, by fax: 1-877-831-6019, or 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.

Pending state regulatory review

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 [IFP 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'áą́h 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'áą́h 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 ਈਓਪੋ 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 สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ 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.