*Health Net Health Plan of Oregon, Inc. (Health Net)*

Small Business Group

# Group Plan Contract Application

Medical insurance plans are offered by Health Net Health Plan of Oregon, Inc. (Health Net). Life/AD&D insurance plans are underwritten by Health Net Life Insurance Company. Dental PPO insurance plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by Dental Benefit Providers, Inc. (DBP). Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and serviced by Envolve Vision, Inc. Health Net Health Plan of Oregon, Inc., Health Net Life Insurance Company and Envolve Vision, Inc. are subsidiaries of Centene Corporation.

Application is hereby made for a Group Plan Contract provided by Health Net, 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 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 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.
3. **Note:** Health Net auto-enrolls the employee and their eligible dependents who elect medical coverage into dental and/or vision coverage, if offered by their employer group. If an employee wishes to decline dental and/or vision coverage for an eligible dependent, the employee must complete the ***Declination of Coverage*** section of the ***Enrollment and Change Application***.

**Health Net Medical:** 1-888-802-7001

**Health Net Life:** 1-800-865-6288

**Health Net Dental:** 1-877-410-0176

**Health Net Vision:** 1-866-392-6058

| FOR ADMINISTRATIVE USE ONLY: |
| --- |
| **New Business/Group**<br>Please send all completed paperwork to your designated account executive or broker. |

Health Net®

Small Business Group

# Group Plan Contract Application

**Important: Please print all sections in black ink. If adding Dental or Vision to your existing coverage, please complete sections 2, 3, 4, 5, 6, 8, and 10; for all other changes to existing coverage, please complete only sections 2, 3, 4, and 8.**

## 1. Health plan information

### COMMUNITYCARE 1T[1]

**Platinum**
- ☐ CC1T15-500-1-3000DX
- ☐ CC1T20-750-2-3000DX

**Gold**
- ☐ CC1T25-1000-2-7900DX
- ☐ CC1T25-2000-2-7900DX
- ☐ CC1T25-3500-2-7900DX

**Silver**
- ☐ CC1T40-3000-3-8150ES
- ☐ CC1T40-4500-3-8150ES

### COMMUNITYCARE 3T

**Platinum**
- ☐ CC3T15-500-1-3000DX
- ☐ CC3T20-750-2-3000DX

**Gold**
- ☐ CC3T25-1000-2-7900DX
- ☐ CC3T25-2000-2-7900DX
- ☐ CC3T25-3500-2-7900DX

**Silver**
- ☐ CC3T40-3000-3-8150ES
- ☐ CC3T40-4500-3-8150ES

### PPO

**Platinum**
- ☐ P10-250-1-4000LX
- ☐ P10-500-2-4000LX
- ☐ P10-750-2-4000LX

**Gold**
- ☐ P50-0-5-5000
- ☐ P0-1500-4-7900DX
- ☐ P0-3500-4-7900DX
- ☐ P20-500-3-7900DX
- ☐ P20-1000-2-7900DX
- ☐ P20-2000-2-7900DX
- ☐ P20-2500-3-7900DX
- ☐ P30-1500-2-7900DX
- ☐ P30-3500-3-7900DX

**Silver**
- ☐ P20-5000-5-8150DX
- ☐ P40-3000-3-8150ES
- ☐ P40-4000-3-8150ES
- ☐ P45-3500-5-8150ES
- ☐ P45-5000-5-8150ES

**Bronze**
- ☐ P8250-0-8250ES

### HIGH DEDUCTIBLE PPO

**Silver**
- ☐ HD2800-2-5500ES
- ☐ HD3000-3-6750ES
- ☐ HD4000-3-6750ES

**Bronze**
- ☐ HD6900-0-6900ES

### HEALTH NET OREGON STANDARD PPO

- ☐ Health Net Oregon Standard Gold Plan
- ☐ Health Net Oregon Standard Bronze Plan
- ☐ Health Net Oregon Standard Silver Plan

### OTHER PLAN

_____

### DENTAL

- ☐ Plus D50-1855-1500
- ☐ Preferred Plus DP50-1855-1500
- ☐ Value D50-185-1500V
- ☐ Essentials D50-16-500

### VISION

- ☐ Elite 1010-1
- ☐ Preferred 1025-2
- ☐ Preferred 1025-3

### ALTERNATIVE CARE BUY-UP

- ☐ CAM 15-1000
- ☐ CAM 15-1500
- ☐ CAM 15-1000 Plus

Purchasing pediatric dental coverage with Health Net? ☐ Yes ☐ No *(I confirm that I am purchasing pediatric dental coverage with another carrier as required by ACA mandate.)*

### LIFE AND AD&D OPTIONS (IF HEALTH NET LIFE IS SELECTED, ALL FULL-TIME EMPLOYEES ARE ELIGIBLE.)

- ☐ $15,000 *(all employees)*
- ☐ $25,000 *(15–50 employees)*
- ☐ $50,000 *(25–50 employees)*

## 2. Employer group information

| | | | |
|---|---|---|---|
| Company name *(including 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: |
| Company contact *(Administrative contact)*: | Telephone: | Fax: | |
| Administrative email: | | | |
| Physical address: | City: | State: | ZIP: |
| Billing contact name *(list 'same' if the same as administrative contact)*: | | Telephone: | |
| Billing address *(if different from physical address)*: | City: | State: | ZIP: |
| Billing contact email *(if different from administrative)*: | | | |
| Company contact for coordination of benefits (COB) *(if different from above)*: | Telephone: | Email: | |
| 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 and for Life is 100% (2–9 enrollees) and 50% (10–50 enrollees)).

| | | | |
|---|---|---|---|
| Employee Health: _____% or $_____ | Employee Dental: _____% or $_____ | Employee Vision: _____% or $_____ | Employee Life: _____% or $_____ |
| Dependent Health: _____% or $_____ | Dependent Dental: _____% or $_____ | Dependent Vision: _____% or $_____ | |

**Note:** If you select Dental and/or Vision with no contribution, indicate "0."

## 4. Monthly rates (including riders)

Oregon Small Employer Group rates are guaranteed for 12 months from the effective date, except for any government mandated benefits or tax changes. Rates are also based on actual group enrollment and may differ from quoted rates if there is a change in group composition.

| | | | |
|---|---|---|---|
| Employee: _____ | Employee + spouse or Registered Domestic Partner: _____ | Employee + child(ren): _____ | Employee + family: _____ |
| Employee: _____ | Employee + spouse or Registered Domestic Partner: _____ | Employee + child(ren): _____ | Employee + family: _____ |
| Employee: _____ | Employee + spouse or Registered Domestic Partner: _____ | Employee + child(ren): _____ | Employee + family: _____ |
| Employee: _____ | Employee + spouse or Registered Domestic Partner: _____ | Employee + child(ren): _____ | Employee + family: _____ |

Attach quote output sheet for any additional plans chosen.

## 5. 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: _____

5. How many employees are there as of the effective date of coverage?_____

6. Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: _____

   An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.[2]

   To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.

7. Total number of employees worldwide: _____

| | MEDICAL | LIFE | DENTAL | VISION |
|---|---|---|---|---|
| 8. Number of eligible employees *(including eligible owner(s))*: | _____ | _____ | _____ | _____ |
| 9. Total number of Health Net enrollees *(excluding COBRA enrollees)*: | _____ | _____ | _____ | _____ |
| 10. Number of Health Net COBRA enrollees *(applying for health coverage)*: | _____ | **N/A** | _____ | _____ |
| 11. Number of waivers *(Please include an enrollment form with Section 7 "Declination of Coverage" indicated.)*: | _____ | _____ | _____ | _____ |

*(continued)*

## 6. Eligibility information (continued)

12. What type of Continuation are you subject to? ☐ Federal COBRA[3] ☐ State Continuation

13. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No

14. Do the eligible enrollees represent a carve-out either by location or union affiliation? ☐ Yes ☐ No

15. Does the group file a Form 132? ☐ Yes ☐ No

16. Is the group subject to ERISA? ☐ Yes, month: _____ ☐ No, government or public plan or church plan
☐ No *(please specify reason)*: _____

17. Are you part of a controlled group? ☐ Yes ☐ No

18. If you are a part of a controlled group, who is the employer for purposes of filing taxes? _____

19. How many full-time employees were in the group during the prior calendar year? _____

20. How many full-time equivalent employees were in the group during the prior calendar year? _____
*(For the purposes of determining eligibility, employers must have one common law employee at the time of enrollment.)*

## 7. 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:_____ Current carrier policy number: _____

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: _____

Names 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.)*

## 8. Underwriting criteria

**General conditions**

The subscriber group must employ at least one eligible employee for enrollment and must be an Oregon small employer as defined by Oregon and/or federal regulations. Eligibility rules must be the same for medical and dental enrollment. All enrolled employees must have a bona fide partnership, independent contractor, or employer-employee relationship with the subscriber group. If the subscriber group includes leased employees and independent contractors under the health plan, all leased employees and independent contractors must be covered. Health Net is not required to be sole carrier as long as participation guidelines are met. Eligible employees waiving coverage due to group coverage through another employer *(e.g., spousal coverage)* will not count against participation.

The issuance of coverage and a Group Plan Contract is subject to underwriting review and approval by Health Net and receipt of the first month's premium. The initial quoted rates are subject to Health Net'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 as appropriate within specified time requirements. A member's coverage terminates the last day of the month in which that member ceases to be eligible under group eligibility provisions. There will be one open enrollment period per contract year. The period will be for 30 days prior to the renewal effective date.

## 9. Subscriber group statement 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 Plan Contract is subject to review and approval by Health Net and receipt of the first month's premium.**

**The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to Health Net. Should it be determined at the time of enrollment or during the 24-month period after the Group Plan Contract is issued that there has been an intentional misrepresentation of material fact, as prohibited by the terms of this Group Plan Contract, the Group Plan Contract 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 Plan Contract and to forward such amounts in advance of the due date to Health Net, 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 producer 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 must be equal to or greater than 50%.**

**Minimum participation is defined as: For groups of 1–5 eligible employees, a minimum of 66% participation is required. For groups of 6–50 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 Plan Contract and any attached Addendum, together with the Health Net Plan Contract or Insurance Policy (as referenced herein), and the employee enrollment forms form the entire agreement between the parties in order to provide eligible enrolled employees and eligible enrolled dependents with the health care benefits as specified in the Plan Contract or Insurance Policy. The Agreement may be amended with the mutual written consent of the Subscriber Group and Health Net at any time, subject to state and federal regulations.**

| 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.**

## 10. Producer information and certification

**PRODUCER 1**

| | | | |
|---|---|---|---|
| Producer name: | | Health Net Producer ID #: | |
| Department of Insurance license #: | | Tax ID #: | Agent NPN #: |
| Agency name: | Phone #: | Fax #: | |
| Address: | City: | State: | ZIP: |
| Email: | | | |
| Producer commission split: | | | |

**PRODUCER 2 (ONLY REQUIRED IF SPLITTING COMMISSION)**

| | | | |
|---|---|---|---|
| Producer name: | | Health Net Producer ID #: | |
| Department of Insurance license #: | | Tax ID #: | Agent NPN #: |
| Agency name: | Phone #: | Fax #: | |
| Address: | City: | State: | ZIP: |
| Email: | | | |
| Producer commission split: | | | |

I certify that all information contained in this application is correct to the best of my knowledge. I also certify that this firm is a bona fide business establishment or is otherwise eligible to contract for insurance coverage in the State of Oregon. All participation requirements have been explained and the minimum participation requirements have been met. Coverages, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer. Deductibles, copayments and coinsurance *(if applicable)* have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

**Note: If you are not currently appointed by Health Net, commissions will not be paid. An active license confirmation and formal appointment with Health Net, prior to the group plan's effective date, is required to receive commissions payment.**

Producer 1 signature: _____ Date: _____

Producer 2 signature *(if applicable)*: _____ Date: _____

## 11. For Health Net use only

| | | |
|---|---|---|
| Account executive signature: | Date: | Name: |

## SMALL BUSINESS GROUP SUBMISSION TIMELINE

**15th of the month prior to the group's effective date of coverage:**

When we receive fully-completed new group applications in-house by the 15th of the month prior to the group's effective date of coverage, we are able to provide some important services before coverage actually begins. These services include sending member identification cards to new members prior to their effective date of coverage. Please note that new case submissions that are not received by the 15th of the prior month and incomplete case submissions cannot be processed in time to provide member identification cards to the new members before their effective date.

**20th of the month prior to group's effective date of coverage:**

We must receive fully-completed new group applications in-house by this date in order to set up a group's coverage to be effective the first of the following month. New case submissions that are received by this date and incomplete case submissions will not be processed in time to provide member identification cards to the new members before their effective date.

## CONTROLLED AND AFFILIATED GROUPS

Controlled and Affiliated Groups means groups that are commonly controlled and/or affiliated as described in subsection (b), (c), (m), or (0) of section 414 of the Internal Revenue Code of 1986. If a group is a controlled or affiliated group of employers, a carrier must treat the group as a single group, and the controlled group must complete one group profile form. Controlled Groups include parent-subsidiary, brother-sister and the combination of both of the preceding.

## FULL-TIME EMPLOYEES (FTES)

The total number of employees, full-time and part-time, who work an average of 30 hours or more a week.

When counting employees to determine group size, temporary, seasonal, leased, and contracted employees are excluded.

In answering the questions about employees, an owner is generally not considered an employee even if the owner performs services for the business for compensation; however, an owner may participate in a group plan as long as the group employs at least one common law employee. An owner includes:

- A sole proprietor and the sole proprietor's spouse;
- A member of a single-member limited liability company and the member's spouse;
- The owner of a wholly owned corporation and the owner's spouse.

**FTE counting instructions:**

**A.** Count each employee working 30 hours or more as 1 FTE.

**B.** Total the hours worked per week by all employees working less than 30 hours, and divide by 30.

**C.** Add the numbers from A and B together. This is your FTE count.

You may also use the FTE calculator at healthcare.gov: [**https://www.healthcare.gov/shop-calculators-fte/**].

*(continued)*

## BENEFIT-ELIGIBLE EMPLOYEES

The total number of employees eligible for coverage as determined by the employer.

**Dependents:** Legal spouse, Registered Domestic Partner, and child(ren), from birth to age 26, of employee, spouse or Registered Domestic Partner.

**Local government retiree:** "Local government" means any city, county, school district, or other special district in this State. "Retired employee" means a former officer or employee of a local government who is retired for service or disability, and who received or is receiving retirement benefits under the Public Employees Retirement System or any other retirement system or plan applicable to officers and employees of the local government.

**Newly eligible employees – first day of the month following date of eligibility**

Definition of "newly eligible employee":

- Part-time employee who has been employed for the length of the probationary period and is moving to regular, full-time employee
- Transfer who has been employed for the length of the probationary period
- Laid-off employee rehired within 9 months
- Other (must be pre-approved by Underwriting)

**Definition of "newly eligible dependents":** For child: date of birth or placement for adoption. For spouse, Registered Domestic Partner and stepchild(ren): first day of the month on or following the date of marriage or certification of registered domestic partnership.

[1]Available to employer groups located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties. Available to employees in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.

[2]This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.

[3]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 State Continuation. Please consult your legal counsel if you need help determining which law applies to you.

# Ensure Your Employees Understand Their Health Care Coverage

## SUMMARY OF BENEFITS AND COVERAGE TO ELIGIBLE AND COVERED PERSONS

### Affordable Care Act (ACA) 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)[1] 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).

PAPER SBC

- **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.

ELECTRONIC SBC

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 the 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. § 2520.104b-1(c).

## 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: www.healthnetoregon.com/sbc. 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 seven 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 seven 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 seven 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.

## Nondiscrimination Notice

Health Net Health Plan of Oregon, 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 1-888-802-7001 (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 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 https://www.hhs.gov/ocr/complaints/index.html.



FLY039290ET00 (1/21)

**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 the Customer Contact Center at the number on your ID card or call 1-888-802-7001 (TTY: 711).

**Amharic**
ለቋንቋ አገልግሎት ምንም ክፍያ የለውም። አስተርጓሚ ማግኘት ይችላሉ። የተነበበልዎትን እና የተወሰኑ በቋንቋዎ የተላኩልዎትን ሰነዶች መግኘት ይችላሉ። ለእርዳታ፣ ለደንበኞች ግንኙነት ማዕከል በመታወቂያ ካርድዎ ላይ ያለውን ቁጥር ይደውሉ ወይም በ 1-888-802-7001 (TTY: 711) ይደዉሉ።

**Arabic**
الخدمات اللغوية المجانية. يمكنك الاستعانة بمترجم فوري، كما يمكنك طلب قراءة المستندات عليك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، يمكنك الاتصال بمركز اتصالات العملاء على الرقم الموجود على بطاقة معرف العضوية الخاصة بك أو الاتصال على (711 :TTY) 1-888-802-7001.

**Chinese**
免費語言服務。您可以取得口譯服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥打會員卡上的電話號碼聯絡客戶聯絡中心，或撥打電話 1-888-802-7001 (聽障專線 (TTY)：711)。

**Cushite (Oromo)**
Tajaajila afaaniif kaffaltii hin qabu. Turjubaana argachuu ni dandeessu. Sanadii isiniif dubbifamee fi afaan keessaniin muraasaan isniif ergame argachuu ni dandeessu. Gargaarsaaf, Wiirtuu Qunnamtii Maamilaa tiif lakkoofsicha kaardii enyummaa keessan irra jirutti bilbilaa ykn 1-888-802-7001 (TTY: 711) itti bilbilaa.

**German**
Es stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Sie können einen Dolmetscher hinzuziehen. Die Dokumente können Ihnen vorgelesen werden und einige sind in Ihrer Muttersprache erhältlich. Für Unterstützung rufen Sie bitte unser Kundendienstzentrum unter der auf Ihrer Versicherungskarte angegebenen Nummer oder unter der Rufnummer 1-888-802-7001 (TTY: 711) an.

**Japanese**
無料の言語支援サービス。通訳をご利用いただけます。日本語で文書を読み上げたり、文書によっては日本語版をお届けすることも可能です。支援をご希望の方は、IDカードに記載の番号にてカスタマーコンタクトセンターまでお電話いただくか、1-888-802-7001 (TTY: 711)までお電話ください。

**Korean**
무료 언어 서비스. 귀하는 통역사를 이용하실 수 있습니다. 귀하에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 받으시려면 본인의 ID 카드에 기재된 고객 서비스 센터 안내번호 또는 1-888-802-7001 (TTY: 711)번으로 전화해주십시오.

**Cambodian (Khmer)**
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារជូនអ្នក និងឆ្លើឯកសារខ្លះជូនអ្នក ជាភាសារបស់អ្នក។ សំរាប់ជំនួយ ទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន តាមលេខនៅលើប័ណ្ណ D របស់អ្នក ឬហៅលេខ 1-888-802-7001 (TTY: 711)។

**Laotian**
ການບໍລິການດ້ານພາສາທີ່ບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍນາຍແປພາສາ. ທ່ານສາມາດອ່ານເອກະສານ ແລະ ຈໍານວນໜຶ່ງໄດ້ສົ່ງໃຫ້ທ່ານເປັນພາສາຂອງທ່ານແລ້ວ. ເພື່ອຂໍຄວາມ ຊ່ວຍເຫຼືອ, ໂທຫາສູນຕິດຕໍ່ລູກຄ້າໄດ້ທີ່ເລກໝາຍຢູ່ເທິງບັດ ID ຂອງທ່ານ ຫຼື ໂທ 1-888-802-7001 (TTY: 711).

**Punjabi**
ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਲਈ ਕੋਈ ਲਾਗਤ ਨਹੀਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਦਸਤਾਵੇਜ਼ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-802-7001 (TTY: 711)।

**Russian**
Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика.
Вам могут прочесть документы на русском языке и выслать переводы некоторых из них. Если вам требуется помощь, звоните в Центр обслуживания клиентов по номеру, указанному на вашей идентификационной карте, или по номеру 1-888-802-7001 (линия TTY: 711).

**Spanish**
Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llame al Centro de Comunicación con el Cliente al número que se encuentra en su tarjeta de identificación o llame al 1-888-802-7001 (TTY: 711).

**Tagalog**
Mga Walang Bayad na Serbisyo sa Wika. Maaari kayong kumuha ng tagasaling-wika (interpreter). Maaaring basahin sa inyo ang mga dokumento at ipadala sa inyo ang ilan nang nakasalin sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numero sa inyong ID card o tumawag sa 1-888-802-7001 (TTY: 711).

**Ukrainian**
Безкоштовні послуги перекладу. Ви можете скористатися послугами перекладача.
Вам можуть прочитати документи на українській мові та надіслати переклади деяких із них. Якщо вам потрібна допомога, телефонуйте у Центр обслуговування клієнтів за номером, вказаним на вашій ідентифікаційній карті, або за номером 1-888-802-7001 (лінія TTY: 711).

**Vietnamese**
Dịch vụ ngôn ngữ miễn phí. Quý vị có thể yêu cầu phiên dịch viên. Quý vị có thể yêu cầu đọc các tài liệu và gửi một số tài liệu cho quý vị bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi đến Trung tâm Liên lạc Hội viên theo số điện thoại trên thẻ nhận dạng của quý vị hoặc gọi đến số 1-888-802-7001 (TTY: 711).


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