

Health Net of California, Inc. and
Health Net Life Insurance Company (Health Net)



Health Net's Exclusive ID Card Express

EMPLOYER GUIDE

For groups of 101–500

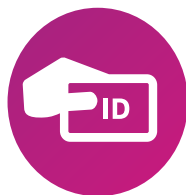


HealthNet.com



You Have Our Word, Backed by \$7,500!

As a new Health Net employer group, we want to make sure your employees have access to their health care benefits right away. We guarantee we'll mail out their ID cards in ten working days, or we'll pay you \$7,500. No other California health care company offers a promise like that.



The Health Net guarantee

Our exclusive **ID Card Express** is the perfect way to ensure your employees have access to their health care benefits right away. Here's everything you need to know about who's eligible for this guarantee and how it works.

Who is Eligible?

- New California groups only;
- With 101 to 500 employees; and
- Choose from Health Net's Enhanced Choice or Starting Line-Up (SLU) plan options.

Here's how it works

1. Once we approve your application and enrollment package, you'll receive a welcome letter from Health Net. This letter will let you know you qualify for ID Card Express.
2. We guarantee Health Net ID cards will be mailed to your group within 10 working days from the date of the welcome letter.
3. If we don't live up to our promise, we'll pay you \$7,500!

Here are some tips to help you meet the guarantee rules. Your broker or Health Net sales consultant will provide you with the required enrollment spreadsheet, called the Census Robotech Member Enrollment Template or Generic 349 Layouts Medical Dental Vision Life. You will need to fill out one of these spreadsheets based on your enrollment type.

- Provide all your employee enrollment forms or the required spreadsheet to Health Net as soon as possible so they can be processed with the initial submission.
 - Late or incomplete packages may be disqualified.
- Check your spreadsheet or enrollment forms. **Make sure they are complete and contain no errors.** Enrollment Packages with more than 30 percent discrepancies will delay ID cards and are not covered by this offer.

Your broker or Health Net sales consultant will work closely with you to keep you informed about your eligibility and if your employees' enrollment materials meet the qualification requirements for this guarantee. If there are any issues with the materials, or if your eligibility changes during the process, you'll be advised right away.

Employee name: _____ [Last 4 digits of Social Security] _____

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

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

Spouse	Name	Group of other insurance carrier	Is this your dependent's primary coverage?	Does it cover?	Medicare	Medicaid	Medicaid (claim)
Prior coverage and date (mm/yyyy)	Reason for ending coverage	Group # of policy #	Yes / No	Medical / Dental / Vision	Yes / No	Yes / No	Yes / No
<p><input type="checkbox"/> Spouse Name: _____</p> <p><input type="checkbox"/> Domestic partner Name: _____</p>							
Prior coverage and date (mm/yyyy)	Reason for ending coverage	Group # of policy #	Is this your dependent's primary coverage?	Does it cover?	Medicare	Medicaid	Medicaid (claim)
			Yes / No	Medical / Dental / Vision	Yes / No	Yes / No	Yes / No
<p><input type="checkbox"/> Son Name: _____</p> <p><input type="checkbox"/> Daughter Name: _____</p>							
Prior coverage and date (mm/yyyy)	Reason for ending coverage	Group # of policy #	Is this your dependent's primary coverage?	Does it cover?	Medicare	Medicaid	Medicaid (claim)
			Yes / No	Medical / Dental / Vision	Yes / No	Yes / No	Yes / No
<p><input type="checkbox"/> Son Name: _____</p> <p><input type="checkbox"/> Daughter Name: _____</p>							
Prior coverage and date (mm/yyyy)	Reason for ending coverage	Group # of policy #	Is this your dependent's primary coverage?	Does it cover?	Medicare	Medicaid	Medicaid (claim)
			Yes / No	Medical / Dental / Vision	Yes / No	Yes / No	Yes / No
<p><input type="checkbox"/> Son Name: _____</p> <p><input type="checkbox"/> Daughter Name: _____</p>							
Prior coverage and date (mm/yyyy)	Reason for ending coverage	Group # of policy #	Is this your dependent's primary coverage?	Does it cover?	Medicare	Medicaid	Medicaid (claim)
			Yes / No	Medical / Dental / Vision	Yes / No	Yes / No	Yes / No
<p><input type="checkbox"/> Son Name: _____</p> <p><input type="checkbox"/> Daughter Name: _____</p>							

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

☐ No ☐ Yes If "Yes," then:

Life beneficiary (Full name)	Relationship	%
Life beneficiary (Full name)	Relationship	%
Life beneficiary (Full name)	Relationship	%
Life beneficiary (Full name)	Relationship	%

Employee name _____		Use a capital of social security # _____	
7. Declaration of coverage (Complete this section if any coverage is being declined by you or your eligible dependent(s)).			
Employee personal information			
First name _____		Last name _____	
Lasting medical coverage for _____ (Other group coverage through this employer _____ individual coverage _____)		Reason: _____ Other _____	
Name(s) _____		Other _____	
Declining dental coverage for _____ (Other group coverage through this employer _____ individual coverage _____)		Reason: _____ Other _____	
Name(s) _____ Dependent(s) _____		Other _____	
Declining vision coverage for _____ (Other group coverage through this employer _____ individual coverage _____)		Reason: _____ Other _____	
Name(s) _____ Domestic partner _____ Dependent(s) _____		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. I understand that coverage has been applied to me by the employer, and I have given the choice to accept for the available coverage. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as stated on this form. I understand that I will be responsible for my own health care costs.			
Employee signature _____		Date: _____	
(Sign only if declining coverage. If signed in error, please cross out and initial.)			
8. Acceptance of coverage (signature required)			
California law prohibits an employer from being required or used by health insurance companies as a condition of obtaining health insurance. I understand that I am not required to accept coverage.			
ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with and accepting benefits of health, dental, and/or any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan/Contract or other applicable plan documents and understand that the plan documents and provisions are subject to change without notice. In this acknowledgement, I agree to be bound to the level of my employee and family, and 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 47.136, 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 Arbitration includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my membership or non-membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents and representatives, are involved in the dispute. I understand that, by agreeing to this arbitration agreement, I am waiving my right to bring a lawsuit in state or federal court. I understand that, by agreeing to this arbitration agreement, I am waiving my right to bring a lawsuit to individual, 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 and 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 whether they were performed negligently or incompetently rendered) are also subject to individual and binding arbitration. I understand that more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.			
Employee signature: _____		Date: _____	
(Sign only if accepting coverage. If signed in error, please cross out and initial.)			



Section 7 is only critical if the member wants to **decline coverage** for themselves or their eligible dependent(s).



Next steps

You're all set – there's nothing else for you to do. We'll make sure your group receives their ID cards promptly, as promised.

You and your employees will be able to access benefits right away. And you'll find more helpful services online at **www.healthnet.com**.

- **For you:** Easy-to-use online billing and enrollment.
- **For your employees:** Online tools and resources to view benefits and claims, find doctors, and access wellness programs.

Health Net – your trusted partner for better health



Call your broker or your Health Net sales consultant today to find out more about our ID Card Express program. We look forward to partnering with you to help your employees live and work well.