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

Large Business

2026 Application for Group Service Agreement/Group Policy

Medical plans are provided by Health Net of California, Inc. and Life/ADD&D insurance plans are underwritten by Health Net Life Insurance Company. Dental HMO and PPO plans are provided by Dental Benefit Providers of California ("DBP"). Vision plans are underwritten by Health Net Life Insurance Company and serviced by EyeMed Vision Care, LLC (EyeMed).

DBP is not affiliated with Health Net. Obligations under dental plans are neither obligations of, nor guaranteed by, Health Net.

Application is hereby made for a Group Service Agreement/Group Policy provided by Health Net and/or DBP, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring coverage hereunder. The following information regarding employee and/or dependent data is being submitted to allow Health Net and/or DBP 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: 800-522-0088 (English)
877-891-9050 (Cantonese)
877-339-8596 (Korean)
877-891-9053 (Mandarin)
800-331-1777 (Spanish)
877-891-9051 (Tagalog)
877-339-8621 (Vietnamese)

Health Net Life: 800-865-6288

Health Net Dental: 866-249-2382

Health Net Vision: 866-392-6058

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.

Important: Please print all sections in black ink. If adding dental or vision to your existing coverage, please complete sections 1, 2, 3, 6, 7, 8, 11, and 12; for all other changes to existing coverage, please complete only sections 1, 2, 7, and 11.

Part 1. Employer group information

Corporate name or (DBA):	SIC:	Names of: ☐ Affiliates ☐ Subsidiaries to be included
Location address:		
City:	State:	ZIP:
Billing address (if different than location):		
City:	State:	ZIP:
Tax ID number (TIN):		
Is the group subject to ERISA? ☐ Yes ☐ No, government, public plan or church plan ☐ No (please specify reason)_____		

Administrator contact:	Phone number:	Email address:
Billing contact:	Phone number:	Email address:
COBRA administrator:	Phone number:	Email address:
COBRA billing:	Phone number:	Email address:

Part 2. Eligibility information

	Medical	Dental	Vision	Life[1]
A) Total number of **eligible employees** (all active, full-time, permanent employees working the minimum number of hours per week who are eligible for benefits): Note: Do not include employees who have not satisfied the probationary period.				
B) Total number of **ineligible employees** (any category of employees which is not specifically stated as eligible, including but not limited to contracting employees, board members and part-time employees):				
C) Total number of employees (A+B):				
D) Total number of Health Net enrollees (excluding COBRA enrollees):				
E) Number of Health Net COBRA enrollees (applying for health coverage):				
F) Number of waivers (Please include a member enrollment form with the "Declination of Coverage" section completed):				

Average number of employees (including full-time equivalents) 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 (or # of months in business if less than 12 months). Round up or down to the nearest whole number – example: 300.5 = 301. Do not spell out the number – example: write 300, not three hundred.

(continued)

Part 2. Eligibility information (continued)

Total number of employees worldwide: Count all employees regardless of whether they are eligible for coverage. Include full-time and part-time employees. Do not include 1099 and seasonal employees: _____

Are employees eligible for all products? ☐ Yes ☐ No If "No," define criteria: _____.

Are all eligible employees presently, actively employed? ☐ Yes ☐ No If "No," list names and explanations.

Indicate how many full-time employees, including full-time equivalents (FTEs), you employed in the most recent calendar year based on available information:_____

How did you determine group size? ☐ Prior calendar quarter ☐ Prior calendar year

Note: A "large employer" must employ at least 101 full-time employees, including full-time equivalents, on business days during the preceding calendar year.

☐ Group meets the definition of a **"large employer"** for the upcoming coverage period

Eligible dependents

☐ Spouse/domestic partner, children (from birth to age 26), disabled children.[3] (For Dependent Life Insurance, children are covered through age 25.)

1. How would you like your COBRA enrollees to be billed? ☐ Group billed ☐ Member billed ☐ COBRA TPA
2. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No
3. Do the eligible enrollees represent a carve-out either by class, location or union affiliation? ☐ Yes ☐ No

Part 3. Effective date information

	Medical	Dental	Vision	Life and/or AD&D
Requested effective date (mm/dd/yy):				
Requested renewal date (mm/dd/yy):				

Part 4. Current carrier (Determination of full-time employee status and eligibility)

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," confirm rate structure is similar amongst all carriers: ☐ Yes ☐ No

And, if "No," list other carrier(s):

_____

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.)

Part 5. Employer's probationary period

1. Will there be eligibility conditions that will apply prior to the probationary period? ☐ Yes ☐ No
   (E.g., being in an eligible job classification, achieving job-related licensure requirements or satisfying a "reasonable and bona fide employment-based orientation period")

2. Employer's probationary period for new hires/rehires – **first of the month** following:

   ☐ Date of hire ☐ 1 month ☐ 30 days ☐ 60 days* ☐ Trust account (Trust rules apply.) ☐ Other:[4] _____

   *Health Net will adjust the effective date for new enrollees if needed to ensure that the waiting period does not exceed 90 days. This would not apply to self-managed groups.

Part 6. Employer contribution

Product	Percentage of employer contribution (%)	
	Employee	Dependent
Medical		
Dental		
Vision		
Life and/or AD&D		
Basic Life Coverage		
Please indicate benefits being applied for:		
Medical	☐ Health Net of California, Inc. HMO (Full Network, ExcelCare, SmartCare, Salud HMO y Mas), POS (Elect Open Access, ExcelCare Elect Open Access, Select), PPO, PPO HSA-Compatible, PPO Integrated HSA, PPO Integrated HRA, Seniority Plus	
Life/AD&D	☐ Health Net Life Insurance Company	
Dental	☐ Dental Benefit Providers of California, Inc. (DHMO and DPPO)	
Vision	☐ Health Net Life Insurance Company (PPO Vision)	

Part 7. Plan selection and rates

Medical

	Plan codes				Total rates				
	Medical	Rx	Mental Health	Chiro/ Acupuncture	Single	2-Party	EE and Sp	EE and Child(ren)	Family
Product name:									
Codes:									
Product name:									
Codes:									
Product name:									
Codes:									
Product name:									
Codes:									
Product name:									
Codes:									
Product name:									
Codes:									

Dental

	Single	2-Party	EE and Sp	EE and Child(ren)	Family
Plan code:					
Plan code:					

Vision

	Single	2-Party	EE and Sp	EE and Child(ren)	Family
Plan code:					
Plan code:					

Medicare

Plan name and plan code	Supplemental plan	Total rates

HRA

Plan name and plan code (select one option only)

Plan A: HRA pays first ☐	**Plan B: Member pays first** ☐	**Plan C: HRA with debit card** ☐

Part 8. Life, AD&D and Supplemental benefits (applicable to Life and/or AD&D insurance only)

Life and AD&D benefits

Class	Flat amount	Salary-based	For salary-based benefits, round to:	Minimum benefits	Maximum benefits
1.	$	or _____ x salary	☐ Next higher ☐ Next lower ☐ Nearest $1,000	$	$
2.	$	or _____ x salary	☐ Next higher ☐ Next lower ☐ Nearest $1,000	$	$
3.	$	or _____ x salary	☐ Next higher ☐ Next lower ☐ Nearest $1,000	$	$
4.	$	or _____ x salary	☐ Next higher ☐ Next lower ☐ Nearest $1,000	$	$
5.	$	or _____ x salary	☐ Next higher ☐ Next lower ☐ Nearest $1,000	$	$

Age-benefit reduction schedule:

☐ Standard (Basic Life benefits terminate on the first of the month coinciding with or following retirement.)

Age	65-69	70-74	75-79	80-84	85+
% of original benefit	65%	45%	30%	20%	15%

Dependents benefits: ☐ Yes ☐ No

Options:

	Spouse	Child
☐ High:	$5,000	$2,000
☐ Low:	$2,000	$1,000

Supplemental Life ☐ Yes ☐ No

Supplemental AD&D[5] ☐ Yes ☐ No

Rates[5]

Basic Life	Basic AD&D	Dependent Life[6]	Supplemental Life	Supplemental AD&D
$ _____ / $1,000	$ _____ / $1,000	$ _____ / family unit	$ _____ / $1,000	$ _____ / $1,000

Part 9. Underwriting criteria

General conditions

1. The issuance of coverage and a Group Service Agreement and/or Group Policy is subject to underwriting review and approval by Health Net and/or DBP, and receipt of the first month's premium. The initial quoted rates are subject to Health Net and/or DBP's review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwritng Assumptions.
2. Coverage will be effective on the noted effective date if the Application is accepted and approved by Health Net and/or DBP, as appropriate.

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% of employee single premium.

Minimum Participation is defined as: Where coverage is offered on a contributory basis, health plan enrollment represents the greater of 75% of the eligible active employee population or 76 enrolled active employees; if more than one health plan is offered, Health Net's enrollment represents the greater of 38% of the eligible employee population or 38 enrolled active employees; if coverage is offered on a non-contributory basis, health plan enrollment will be 100% of the eligible employee population.

Failure to maintain these minimum contribution and minimum participation requirements may result in termination or nonrenewal.

[1]Life insurance.

[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]Children who, upon reaching the age of 26, are incapable of self-support because of a physical or mental disability which existed continuously from the date prior to attainment of age 26, are chiefly dependent upon the principal covered person for support and maintenance, and for whom timely proof of disability and dependency are provided to Health Net.

[4]Requires underwriting approval.

[5]Supplemental AD&D is only available if supplemental life has been selected.

[6]For Life and AD&D, if age-banded, please attach rate table only.

Part 10. Disclaimer/Binding Arbitration Agreement

Applicant, in the event this Application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the agreement(s)/Policy and to forward such amounts in advance of the due date to Health Netand/or DBP, 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 Health Net's "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.

This "Application for Group Service Agreement/Group Policy" and any attached Addendum, together with the Health Net and/or DBP 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 insurance companies as a condition of obtaining health insurance coverage.

Electronic Document Consent – Signature Required

Certain group plan documents (e.g., Summary of Benefits and Coverage (SBC), Group Service Agreement/Group Policy) are posted electronically on Health Net's secure website or distributed electronically to the group's email address(es) listed on this application. (The group's administrator can access, download and print the documents that are posted on the Health Net website by registering and logging on to www.healthnet.com) and you may opt out at any time and receive your plan documents by mail. By signing immediately below, the applicant agrees to receive documents electronically and consents to the electronic retrieval and/or delivery of such documents. Your participation in our electronic document retrieval/delivery program is voluntary. If you require your plan documents to be delivered by mail, or if you require an email address change, please contact your account representative as soon as possible to ensure timely delivery. If you do not sign immediately below you will receive plan documents by mail.

Officer of the company signature:	Officer title:	Date:
Email address:		

BINDING ARBITRATION AGREEMENT: On behalf of the group applicant, I understand and agree that any and all disputes or disagreements between the group (or enrolled members) and Health Net and/or DBP regarding the construction, interpretation, performance, or breach of the Health Net and/or DBP Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net and/or DBP Plan Contract or Insurance Policy, whether stated in tort, contract or otherwise, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, must be submitted to individual, final and binding bilateral arbitration in lieu of a jury or court trial, and that I am waiving all rights to class arbitration. I understand that, by agreeing to submit all disputes to individual, final and binding arbitration, all parties, including Health Net and/or DBP 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, and waiving any right to pursue class claims. I also understand that disputes with Health Net and/or DBP 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 bilateral arbitration. In the event that the total amount of damages claimed is $500,000 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 $500,000. 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 and/or DBP 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.

Part 11. Authorization for Agent Access to Group Information

On behalf of the group applicant, I hereby authorize our designated agent, producer, broker, agency, brokerage, general agency, and their respective employees (Agent) currently on file with Health Net to automatically be granted access to our health plan information, including protected health information, through Health Net's Employer & Broker Access system (Portal) or any other access points Health Net may offer.

Our Agent is authorized to make changes to our information including but not limited to:

- Detail about members
- Plan selections and bills/invoices
- Adding/deleting plans and members
- Changing member demographic information

If our Agent on file changes, these authorizations will apply with respect to our successor Agent.

☐ Only select this box if you, as the employer, **DO NOT** want Health Net to automatically authorize the Agent of Record to access and change the group's information on behalf of the group through the Health Net Employer & Broker Access System (Portal).

Part 12. 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:
General agent verification: Open enrollment materials provided to the employer included the applicable Summary of Benefits and Coverage (SBC).		General agent representative signature:	

Second 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:
General agent verification: Open enrollment materials provided to the employer included the applicable Summary of Benefits and Coverage (SBC).		General agent representative signature:	

Part 13. 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

FRM065773EP01
LBG_GSA_CA (1/26)

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

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: <[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.