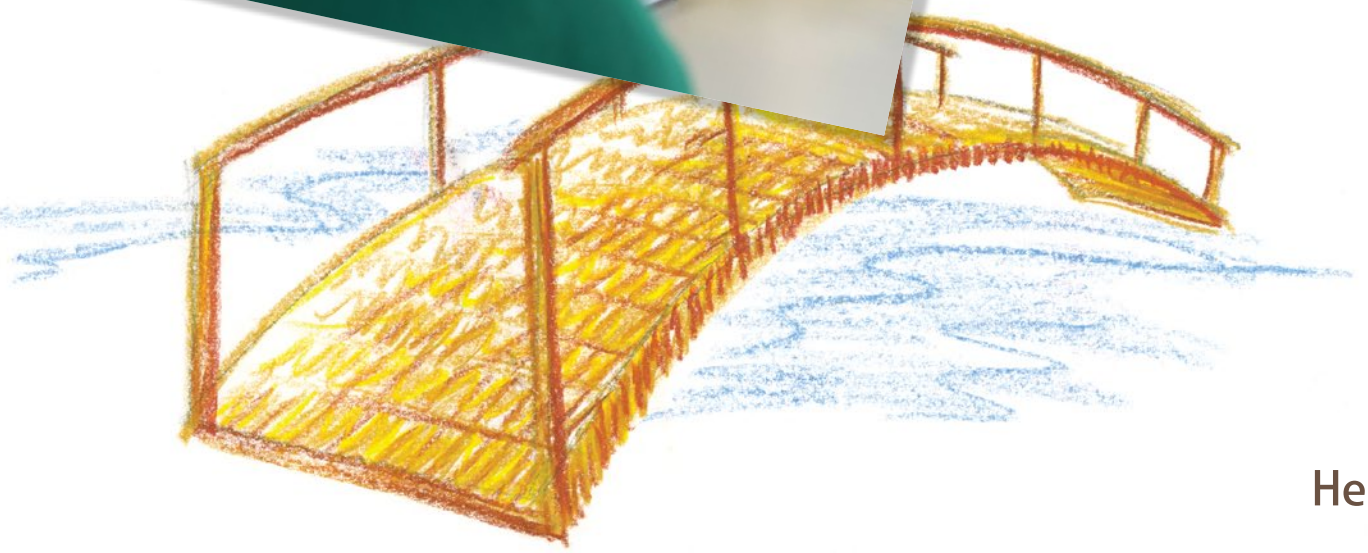
Renewal *Guide*

Geoffrey Gomez,
Health Net
We build tools to simplify administration and sales.



Health Net®

Health Net®

Dear Valued Client,

Thank you for choosing Health Net to serve the health care needs of your employees this past year. We appreciate your business and look forward to continuing our partnership during the coming year. This guide includes all the information you need to make renewing your Health Net plan(s) fast and easy.

Among the highlights:

- Important updates about Health Net plans, benefits and health care reform
- Medical underwriting guideline summary
- Understanding rates
- Plans-at-a-glance

We've also included information about the member extras that come with every Health Net plan, resources to make plan administration easier for you, as well as all the forms you'll need.

If you have any questions or would like additional information, please call your Health Net account manager.

Thank you for the opportunity to earn your business.

Sincerely,

Scott Shaffer
Director of Account Management

Karen Boyd,
Health Net
We translate expertise into innovation.

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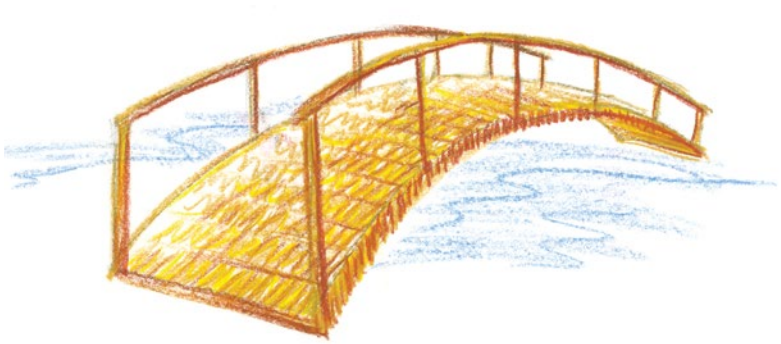


What's New *for* You

51–100 *Choice*

Health Net has always offered the full spectrum of health plan designs and quality, cost-effective networks; traditional and open access HMOs, PPOs and consumer-directed health plans; not to mention our budget-friendly, community-based and culturally competent plans for the Hispanic community. Health Net has the whole nine yards.

Now we're bringing our robust portfolio to groups with 51–100 employees, combining the flexible choices of our small business group plans with large group composite rate simplicity.

Whether you're renewing from one of our older plans or want to evaluate your choices, you'll find **Health Net 51–100 Choice** offers the coverage and cost combinations that deliver the most value – for your business *and* your employees.

Plan combinations meet composite rate simplicity

- Offer your employees the number and types of plans you want from our full portfolio.
- Choose the contribution level that works for your business – either a percentage or flat dollar amount.
- Skip the rate headaches with our 4-tier composite rate structure.
- Take a break from making all the decisions – employees pick the plan they want from the choices you offer.

Plus! We prepare employee worksheets for you. Customized to the plans you decide to offer, the worksheets detail employee benefits and costs so it's easy for them to make their choices.

More ways to build healthy habits

Every Health Net 51–100 plan comes with wellness resources and high-tech conveniences that help employees build healthy habits, which in turn help improve outcomes and productivity.

Health Care Reform

Important health care reform information for employers

The Affordable Care Act (ACA) was signed March 23, 2010. For the purposes of your plan renewal, there are a few items you need to know.

Grandfathered status

This section applies to groups with one or more grandfathered plans. Group health plans that were in effect on March 23, 2010, and have not been significantly changed, do not need to comply with certain health care reform provisions, such as no cost-sharing for preventive services.

If your plan was in effect on March 23, 2010, and you have not made significant changes that reduce benefits or increase cost-sharing for your employees, then you can renew a grandfathered plan without losing grandfathered status. Your account manager can provide an overview of changes that will trigger the loss of grandfathered status.

There are some health care reform changes which grandfathered plans do not need to make; however, many plan changes, including an increase of more than 5 percentage points in your employees' medical premium contribution rates (since March 23, 2010), may cause your plan to lose grandfathered status. When a plan loses grandfathered status, it must comply with some additional health reform changes. Please carefully review the impacts of maintaining or losing grandfathered status when making your selections. By renewing your plan, you certify that you have not made any changes, including increases to your employees' medical premium contribution rates, which would result in the loss of your plan's grandfathered status. Please also continue to notify Health Net of any future changes that may affect the grandfathered status of your selected plan(s), including changes in your contribution rates.

Nondiscrimination provision

Prior to the ACA and continuing after its passage, self-funded plans are required to comply with IRS code sections which provide that if a self-funded group health plan "discriminates," as that term is defined in the IRS Code of 1986 (the Code), in favor of "highly compensated employees," some or all of the value of the payments made by the employer to cover claims for medical services on behalf of the employee will be treated as income to the employee and thus taxable.

Under Public Health Service Act (PHSA) Section 2716, ACA-compliant insured plans also are required to comply with sections 105(h)(3), (4), and (8) of the Code, which provide that a group health plan may not "discriminate," as that term is defined in the Code, in favor of "highly compensated employees." If such discrimination occurs, the employer could be subject to an excise tax penalty of $100 per day.

Employers will have to determine whether they have a discriminatory plan or not and evaluate any necessary changes that may be required in order to assure compliance. Note that Health Net does not perform discrimination testing. Treasury Department Notice 2011-1 addresses the timing of the application of the ACA provisions,

prohibiting insured group health plans from discriminating in favor of highly compensated individuals. Notice 2011-1 states that the Treasury Department and the Internal Revenue Service (IRS), as well as the Departments of Labor (DOL) and Health and Human Services (DHHS), have determined that compliance with these requirements should not be required (and thus, any sanctions for failure to comply do not apply) until after regulations or other administrative guidance of general applicability have been issued. According to Treasury Department Notice 2011-1, sanctions for failure to comply with the nondiscrimination requirements will not be imposed upon insured group health plans immediately; however, the rules currently are under development by the government, and employers should carefully track this issue. Health Net recommends that employers consult with a tax advisor and/or legal counsel for advice regarding discrimination determinations as well as the timing of any plan changes that may be required to satisfy the new provisions.

Over-age dependent coverage

If a group health plan covers dependents, such dependent coverage has been extended to the dependent's 26th birthday. Such "over-age" dependents can join or remain on a group health plan whether or not they are married, living with their parents, in school, or financially dependent on a parent enrollee.

Elimination of pre-existing conditions

Under PHSA Section 2704, group health plans cannot impose pre-existing condition exclusions on enrollees for plan years beginning on or after January 1, 2014. This provision also applies to group grandfathered plans. Regulations passed pursuant to this provision prohibit both denials of coverage and denials or limitations of specific benefits based on pre-existing conditions for enrollees.

Lifetime limits and restrictions on annual limits

All group health plans are prohibited from imposing "annual limits on the dollar value of benefits for any participant or beneficiary." Lifetime limits on the dollar value of benefits are also prohibited. The restrictions on annual and lifetime limits do not apply to covered benefits that are not "essential health benefits" to the extent that such limits are otherwise permitted under federal or state law.

Medical Loss Ratio (MLR)

Pursuant to Section 2718 of the PHSA, health insurers offering group coverage must submit a report to DHHS concerning the ratio of the incurred loss plus the loss adjustment expense to earned premiums. Specifically, beginning in the 2011 plan year, insurers will be required to spend 80–85% of premium dollars on medical care and health care quality improvement activities.

Failure to meet these requirements will result in insurers owing rebates to their customers. Additional information on the MLR requirement and the related reporting obligations is available at cciio.cms.gov/programs/marketreforms/mlr/index/html.

Preventive services

All ACA-compliant plans are required to cover in-network preventive services without cost-sharing to participants. Specifically, such plans cannot require enrollees to pay copayments, coinsurance or deductibles on preventive services such as those evidence-based items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force; immunizations for routine use in children, adolescents and adults; evidence-informed preventive care and screenings supported by the Health Resources Services Administration (HRSA) for infants, children and adolescents;

and evidence-informed preventive screening and care for women based on guidelines supported by HRSA. A complete list of the required recommendations, services and guidelines is available at www.healthcare.gov/law/provisions/preventive/index/html.

Per subsequent rules released by HRSA, which expands women's preventive health services, as of August 1, 2012, ACA-compliant group (and individual) health benefit plans must cover additional services for females as preventive care without member cost-sharing. These additional services include, but are not limited to, FDA-approved contraception methods, contraceptive counseling and breastfeeding support, supplies, and counseling. A complete list of covered preventive services, including the expanded listing of women's preventive services, is available at www.hrsa.gov/womensguidelines.

Rescissions

The ACA amends Section 2712 of the PHSA to prohibit rescissions of coverage except in certain limited circumstances. Under the related regulations, plans cannot rescind existing coverage without 30 days advance notice to enrollees. Even with such notice, plans are prohibited from rescinding coverage, except in instances of fraud or intentional misrepresentation of material fact.

Changes to Health Savings Accounts (HSAs)

This section applies to groups that currently have or are considering an HSA plan. Only those drugs obtained with a prescription (whether or not such drugs are available without a prescription) and insulin are qualified tax-free medical expenses that can be covered by HSAs. If amounts are distributed from an HSA for any medicine or drugs that do not meet this requirement, those amounts will be considered nonqualified medical expenses and thus includable in gross income, generally subject to a 20% additional tax.

Emergency services

The ACA prevents ACA-compliant plans from charging higher cost-sharing amounts for out-of-network emergency services. Such plans are required to treat out-of-network emergencies the same way they do for in-network emergency services. Additionally, the ACA prohibits plans from requiring preauthorization for emergency services.

Choice of provider

All ACA-compliant group health plans must allow their enrollees to designate any available participating primary care provider as their provider. Under the regulations, plans must also provide notice to enrollees informing them of the terms of the plan regarding designation of primary care providers.

Notification of the exchange

- All employers subject to FSLA Section 18 must provide written notice about the health insurance exchange (also called the "Marketplace") to each new employee at the time of hire.
- The written notification **must** include information about the Marketplace and whether or not the employer's lowest cost health plan meets minimum value and affordability standards as defined under ACA.
- A plan meets minimum value if it covers at least 60% of allowable costs, and is considered affordable if the employee's share of the premium for the lowest cost plan available to the employee is not more than 9.5% of the employee's W-2 wages.

Employers may use model notices provided by the Department of Labor to meet this requirement. Model notices are available at http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf.

Probationary periods

Federal law requires that a group health plan and a health insurance issuer offering group health insurance coverage shall not apply any probationary period that exceeds 90 days. The probationary period is the period of time set by an employer before coverage becomes effective for a new employee enrolling into the group's health benefit coverage.

The following probationary periods are available:

- First of the month following:
  - Date of hire
  - 1 month
  - 30 days
  - 60 days

We cannot allow split probationary periods. Please give us a call if you have questions about how these issues may impact your health plan. We recommend that, before making any new health care coverage decisions, you consult with your legal counsel and tax advisors to determine the best approach for your company in light of health care reform.

Summary of Benefits and Coverage document requirements[1]

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. To search for an SBC, go to **www.healthnet.com/sbc** and follow the instructions as indicated.

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.

[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).

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:

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: https://www.healthnet.com/portal/shopping/sbc.action or 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 the 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.

[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.

Underwriting Guideline Summary

Effective on the first day of your renewal month, you can choose between SmartCare as a standalone option or three different open plan selections to offer employees:

Choice programs

1. Enhanced Choice, which includes all plans except ExcelCare and SmartCare Network plans.
2. ExcelCare Choice, which includes all HMO ExcelCare Network, HMO Dual Network and EOA ExcelCare Network plans, PPO, HSA-compatible, HRA-eligible, Salud and Flex Net plans. (ExcelCare Choice plans are available only where the ExcelCare Network is available.)
3. SmartCare Choice, which includes all HMO SmartCare Network and HMO Dual Network plans, PPO, HSA-compatible, HRA-eligible, Salud and Flex Net plans. (No ExcelCare Network HMO or EOA plans included; SmartCare Choice plans are available only where SmartCare Network is available.)

Requirements and guidelines:

- Sole carrier
  - Minimum 38 enrolled employees and minimum 75% participation
- Alongside Kaiser
  - Minimum 50% or 19 enrolled employees, whichever is greater, and minimum 75% participation across both carriers
- When writing alongside Kaiser, Kaiser plans must be composite rated.
- Minimum employer contribution of $175 per employee or 50% of the base plan premium.
- Minimum employer contribution cannot be lower than Kaiser.
- Rates are available on a four-tier composite basis.

Group number assignments

Certain plan changes will result in a new group number assignment.

Medicare secondary payer data collection

You may have received a request from Health Net asking for some additional data that is missing from our records. This request is the result of a new federal reporting requirement for health plans to provide CMS (Centers for Medicare & Medicaid Services) with certain information that will enable CMS to more effectively pay for the health insurance benefits of Medicare beneficiaries who also have coverage under group health plan arrangements.

Types of data may include the following:

- Group legal name, if different than the name noted on the Health Net Group Service Agreement.
- Tax Identification Number (TIN).
- Total number of employees company-wide – includes full-time and part-time employees.
- Social Security numbers for members who meet any one of the following criteria:
  - Active employees and dependents who are age 45–64,
  - Members 65 and older who have coverage based on their own – or a spouse's – current employment status,
  - All group members of any age who are receiving kidney dialysis or have had a kidney transplant, and
  - All active employees and dependents who are under age 45 and who are known to be entitled to Medicare.

We appreciate your assistance and timely response to our data request so that we may comply with this mandate.

Understanding Rates

At Health Net, we appreciate that the cost of employee benefit packages is a large business expense, and one that continues to grow along with health care cost inflation. While rate increases are typically necessary for us to continue providing quality care, we realize that higher health expenditures have an impact on employer groups, especially in today's challenging economy.

While we cannot single-handedly contain costs – that is a broad, long-term challenge requiring the participation of many – our goal always is to minimize the adjustments, so you can continue to provide health care benefits to your employees.

You may be able to offset a renewal rate increase or even save over current rates by switching to a different plan or plans. For example, a plan with a deductible or a higher office visit copayment could lower rates. To make evaluating your options easy, we've included our Plans-At-a-Glance in the next section.

Plans At-a-Glance

Health Net's plan portfolio for clients features a wide range of plan types and benefit combinations. Whether you're helping a current client evaluate choices at renewal time or searching for the perfect match for a new client, you'll find the primary features and benefits of our key plans right here. For information about our entire portfolio, please refer to the 51–100 Choice Portfolio Guide.

Janis E. Carter, Health Net
We focus our strength and stability on making health care accessible.

Choice portfolio

Plan name	*Benefits*						
	Office visit	Inpatient hospital	Outpatient surgery	Out-of-pocket maximum (Single / Family)	Emergency room	Pharmacy	
						Rx-brand deductible	Rx drug copayments
Standard EOA							
10	HMO: $10 PPO: $25	Covered in full	Covered in full	$1,500 / $3,000	$100	None	$10 / $25 / $50
15	HMO: $15 PPO: $30	$250/day[1]	$250	$1,500 / $3,000	$150	None	$15 / $30 / $50
20	HMO: $20 PPO: $35	$250/day[1]	$250	$2,000 / $4,000	$100	None	$15 / $30 / $50
25	HMO: $25 PPO: $40	$500/day[1]	$500	$2,000 / $4,000	$150	None	$15 / $30 / $50
30	HMO: $30 PPO: $45	$500/day[1]	$500	$3,000 / $6,000	$100	None	$15 / $30 / $50
35	HMO: $35 PPO: $50	$750/day[1]	$750	$3,000 / $6,000	$150	None	$15 / $30 / $50
40	HMO: $40 PPO: $55	$1,000/day[1]	$1,000	$4,000 / $8,000	$100	None	$15 / $30 / $50
50	HMO: $50 PPO: $65	$1,500/day[1]	$1,500	$4,500 / $9,000	$200	None	$15 / $30 / $50
Value EOA							
10	HMO: $10 PPO: $25	10%	10%	$2,000 / $4,000	$100	$100	$10 / $25 / $50
20	HMO: $20 PPO: $35	20%	20%	$2,500 / $5,000	$100	$150	$15 / $30 / $50
30	HMO: $30 PPO: $45	30%	30%	$3,500 / $7,000	$100	$200	$15 / $30 / $50
40	HMO: $40 PPO: $55	40%	40%	$4,500 / $9,000	$100	$250	$15 / $30 / $50
50	HMO: $50 PPO: $65	50%	50%	$5,750 / $11,500	$300	$250	$15 / $30 / $50
Advantage EOA							
25	HMO: $25 PPO: $45	25%	25%	$3,000 / $6,000	$100	$200	$15 / $40 / $60
35	HMO: $35 PPO: $55	35%	35%	$4,000 / $8,000	$100	$250	$15 / $40 / $60
45	HMO: $45 PPO: $65	45%	45%	$5,000 / $10,000	$100	$300	$15 / $40 / $60
SmartCare HMO[5]							
10 Standard	$10	$250/day[1]	$100	$1,500 / $3,000	$100	$100	$15 / $40 / $60
20 Standard	$20	$500/day[1]	$250	$2,500 / $5,000	$150	$150	$15 / $40 / $60
30 Standard	$30	$750/day[1]	$500	$3,500 / $7,000	$200	$200	$15 / $40 / $60
40 Standard	$40	$1,000/day[1]	$750	$4,500 / $9,000	$250	$250	$15 / $40 / $60
50 Standard	$50	$1,500/day[1]	$1,250	$5,500 / $11,000	$300	$300	$15 / $40 / $60
50 Value	$50	50%	45%	$5,750 / $11,500	$300	$300	$15 / $40 / $60
Standard HMO							
10	$10	Covered in full	Covered in full	$1,500 / $3,000	$100	None	$10 / $25 / $50
15	$15	$250/day[1]	$250	$1,500 / $3,000	$150	None	$15 / $30 / $50
20	$20	$250/day[1]	$250	$2,000 / $4,000	$100	None	$15 / $30 / $50
25	$25	$500/day[1]	$500	$2,000 / $4,000	$150	None	$15 / $30 / $50
30	$30	$500/day[1]	$500	$3,000 / $6,000	$100	None	$15 / $30 / $50
35	$35	$750/day[1]	$750	$3,000 / $6,000	$150	None	$15 / $30 / $50
40	$40	$1,000/day[1]	$1,000	$4,000 / $8,000	$100	None	$15 / $30 / $50
50	$50	$1,500/day[1]	$1,500	$4,500 / $9,000	$200	None	$15 / $30 / $50
20 Dual Network	$20	$250/day[1]	$250	$2,000 / $4,000	$150	None	$15 / $30 / $50
30 Dual Network	$30	$500/day[1]	$500	$3,000 / $6,000	$150	None	$15 / $30 / $50
Value HMO							
10	$10	10%	10%	$2,000 / $4,000	$100	$100	$10 / $25 / $50
20	$20	20%	20%	$2,500 / $5,000	$100	$150	$15 / $30 / $50
30	$30	30%	30%	$3,500 / $7,000	$100	$200	$15 / $30 / $50
40	$40	40%	40%	$4,500 / $9,000	$100	$250	$15 / $30 / $50
50	$50	50%	50%	$5,750 / $11,500	$300	$250	$15 / $30 / $50
30 Dual Network	$30	30%	30%	$3,500 / $7,000	$150	$200	$15 / $30 / $50
40 Dual Network	$40	40%	40%	$4,500 / $9,000	$150	$250	$15 / $30 / $50
Advantage HMO							
25	$25	25%	25%	$3,000 / $6,000	$100	$200	$15 / $40 / $60
35	$35	35%	35%	$4,000 / $8,000	$100	$250	$15 / $40 / $60
45	$45	45%	45%	$5,000 / $10,000	$100	$300	$15 / $40 / $60
Salud HMO y Más							
15	$15	$250	20%	$1,500 / $4,500	$50	None	$5 / $15 / $35
25	$25	$250/day[2]	20%	$3,500 / $7,000	$100	$250	$10 / $35 / $50
35	$35	$500/day[2]	20%	$4,000 / $8,000	$100	$250	$10 / $35 / $50
Mexico	$5	Covered in full	Covered in full	$1,500 / $4,500	$10 (Mexico)	None	$5

Plan name	Benefits								
	Office visit	Deductible (Single / Family)	Coinsurance	Inpatient hospital	Outpatient surgery	Out-of-pocket maximum (Single / Family)	Emergency room	Pharmacy	
								Rx-brand deductible	Rx drug copayments
Standard PPO									
10	$10	None	90 / 60	10%	10%	$2,500 single / 2 per family	$100 + 10%	None	$10 / $25 / $50
15	$15	$250 / $500	85 / 50	$250 + 15%[3]	15%	$3,000 single / 2 per family	$200 + 15%	None	$10 / $25 / $50
20	$20	$250 / $500	90 / 50	$250 + 10%[3]	$250 + 10%[4]	$3,000 single / 2 per family	$100 + 10%	None	$15 / $30 / $50
25	$25	$500 / $1,000	75 / 50	$250 + 25%[3]	$250 + 25%[4]	$3,500 single / 2 per family	$200 + 25%	None	$15 / $30 / $50
30	$30	$500 / $1,000	80 / 50	$250 + 20%[3]	$250 + 20%[4]	$3,500 single / 2 per family	$100 + 20%	None	$15 / $30 / $50
35	$35	$750 / $1,500	65 / 50	$250 + 35%[3]	$250 + 35%[4]	$4,000 single / 2 per family	$200 + 35%	None	$15 / $30 / $50
40	$40	$500 / $1,000	60 / 50	$500 + 40%[3]	$250 + 40%[4]	$5,000 single / 2 per family	$100 + 40%	None	$15 / $30 / $50
45	$45	$1,000 / $2,000	55 / 50	$500 + 45%[3]	$250 + 45%[4]	$5,000 single / 2 per family	$200 + 45%	None	$15 / $30 / $50
Value PPO									
10	$10	$1,000 / $2,000	80 / 60	20%	20%	$2,500 single / 2 per family	$100 + 20%	$100	$10 / $25 / $50
15	$15	$750 / $1,500	75 / 50	$250 + 25%[3]	25%	$4,000 single / 2 per family	$250 + 25%	$100	$10 / $25 / $50
20	$20	$1,250 / $2,500	80 / 50	$250 + 20%[3]	$250 + 20%[4]	$3,500 single / 2 per family	$100 + 20%	$150	$15 / $30 / $50
25	$25	$1,000 / $2,000	65 / 50	$250 + 35%[3]	$250 + 35%[4]	$5,000 single / 2 per family	$250 + 35%	$150	$15 / $30 / $50
30	$30	$1,500 / $3,000	70 / 50	$250 + 30%[3]	$250 + 30%[4]	$4,500 single / 2 per family	$100 + 30%	$200	$15 / $30 / $50
35	$35	$1,250 / $2,500	55 / 50	$250 + 45%[3]	$250 + 45%[4]	$6,000 single / 2 per family	$250 + 45%	$200	$15 / $30 / $50
40	$40	$1,500 / $3,000	50 / 50	$500 + 50%[3]	$250 + 50%[4]	$5,000 single / 2 per family	$100 + 50%	$250	$15 / $30 / $50
45	$45	$1,500 / $3,000	50 / 50	$500 + 50%[3]	$250 + 50%[4]	$6,350 single / 2 per family	$250 + 50%	$250	$15 / $30 / $50
Advantage PPO									
35	$35	$3,000 / $6,000	60 / 50	40%	40%	$6,350 single / 2 per family	$150 + 40%	$250	$15 / $30 / $50
45	$45	$4,000 / $8,000	50 / 50	50%	50%	$6,350 single / 2 per family	$150 + 50%	$250	$15 / $30 / $50
Value HSA									
4500	$40	$4,500 / $9,000	50 / 50	$500 + 50%[3]	$250 + 50%[4]	$5,950 / $11,900	$100 + 50%	Subject to annual ded.	$15 / $30 / $50
HRA									
3000	50%	$3,000 / $6,000	80 / 60	20%	20%	$4,000 / $8,000	$100 + 20%	Subject to annual ded.	$10 / $25 / $50
5000	50%	$5,000 / $10,000	80 / 60	20%	20%	$6,000 / $12,000	$100 + 20%	Subject to annual ded.	$10 / $25 / $50
POS (HMO Tier)									
10	$10	No deductible	N/A	Covered in full	Covered in full	$1,500 / $3,000	$100	None	$10 / $25 / $50
20	$20	No deductible	N/A	$250 / day[1]	$250	$2,000 / $4,000	$100	None	$15 / $30 / $50

[1]Three-day copayment maximum.
[2]Four-day copayment maximum.
[3]Deductible required for first inpatient hospital admission each calendar year.
[4]Calendar year outpatient surgery deductible applies.
[5]Acupuncture and chiropractic benefits are included in all SmartCare plans.

Ancillary *Programs*

Dental. Vision. Chiropractic and Acupuncture. Life and AD&D.

Designing a well-rounded benefits package is easy with Health Net. Complementing our collection of medical plans are the essentials that help employees reach their optimum health. These benefits help members lead a healthier lifestyle, so they can be more productive.

Your ancillary rates are included in your proposal.

Save up to 2%

Groups with 51–100 eligible employees can pay less for medical premiums when they add Health Net Dental, Vision and/or Life to the quote.

Product added	*Savings realized*
Dental	1.0%
Vision	0.5%
Life	0.5%

Contact your Health Net sales representative for more details.

Experts by the numbers

Ancillary statewide network:

- More than 2,200 dental HMO providers in California
- More than 36,000 dental PPO providers in California and over 229,000 DPPO providers nationwide
- More than 5,500 vision providers in California and 45,000 vision providers nationwide

Alternative medicine statewide network:

- More than 3,300 chiropractors
- More than 1,400 acupuncturists

Dental *Plans That Make Them* Smile

Health Net makes available a choice of HMO and PPO dental plan designs, along with access to one of the largest dental networks in California. Health Net Dental HMO and Dental PPO plans include robust benefits covering most dental procedures. All of these dental plans may be purchased on a standalone basis or in conjunction with a Health Net medical plan.

Dental Plan highlights

Dental HMO

The Dental HMO (DHMO) plans give members access to an extensive network of providers, and the convenience of having a set copayment for many dental procedures. Among the covered benefits are:

- Cleanings and adult fluoride.
- Material upgrades, such as porcelain and semiprecious or precious metal molar crowns.
- General anesthesia, cosmetic and elective dentistry – procedures typically not covered under most other carriers' dental plans.

The DHMO plans may be purchased separately or as a dual choice with Dental PPO plans, and they are underwritten by Dental Benefit Providers of California, Inc. The key coverage details for these plans are shown on the next page.

Category	*Procedure code*	*Description*	*Member copayment*	
			Plus DHMO 150	Plus DHMO 225
Diagnostic	D0150	Comprehensive oral evaluation	$0	$0
	D0210	Intraoral X-rays – complete series	$0	$0
	D9491	Office visit (Including all fees for sterilization and infection control)	$5	$5
Preventive	D1110	Prophylaxis (cleaning) – adult	$0	$0
	D1110	Additional prophylaxis (up to 2 per year) – adult	$20	$35
	D1204	Topical application of fluoride – adult	$0	$0
Restorative	D2150	Amalgam (silver filling) – two surfaces	$0	$0
	D2331	Composite (white filling) – two surfaces anterior	$0	$0
	D2392	Composite (white filling) – two surfaces posterior	$30	$45
Crowns and pontics	D2751[1]	Crown – porcelain fused to predominantly base metal	$150	$225
	D2960	Labial veneer (resin laminate) – chairside	$250	$250
Endodontics	D3320	Root canal – bicuspid (excluding final restoration)	$95	$125
	D3330	Root canal – molar (excluding final restoration)	$125	$210
Periodontics	D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	$35	$40
Prosthodontics	D5110	Complete denture – upper	$175	$260
Oral surgery	D7220	Removal of impacted tooth – soft tissue	$35	$45
Orthodontics	D8070-80	Comprehensive orthodontic treatment – adult or child	$1,695	$1,695
Other general services	D9230	Nitrous oxide, analgesia, anxiolysis (inhalation)	$15 per half hour	$15 per half hour
	D9972	External bleaching (teeth whitening) – per arch	$125	$125

This is only a summary of benefits. Please refer to the Evidence of Coverage for terms and conditions of coverage, including which services are limited or excluded from coverage.

Dental PPO

Health Net makes available a range of affordable, flexible Dental PPO plans (DPPO), underwritten by Unimerica Life Insurance Company, that offer:

- A wide range of deductibles and coinsurance choices.
- Access to a large statewide and national network of DPPO providers.
- No waiting periods.
- Cleanings and periodontal maintenance when medically necessary for pregnant women (not subject to deductible and does not apply to the calendar year maximum).

	Classic Plus 1 & 2 2000		*Classic 1 & 2 1500*		*Classic 3 & 4 1500*		*Classic 5 & 6 1500*	
	In-network	Out-of-network[2]	In-network	Out-of-network[2]	In-network	Out-of-network[2]	In-network	Out-of-network[2]
Calendar year maximum	$2,000		$1,500		$1,500		$1,500	
Calendar year deductible	$50 single $150 family	$75 single $225 family	$50 single $150 family	$75 single $225 family	$50 single $150 family	$75 single $225 family	$50 single $150 family	$75 single $225 family
Preventive services (initial/routine oral exam, teeth cleaning and routine scaling, fluoride treatment, sealant – children under 16, space maintainers, X-rays as part of a general exam, emergency exam)	100% deductible waived		100% deductible waived		100% deductible waived		100% deductible waived	80% deductible waived
General services (fillings, general anesthetics, oral surgery, periodontics, endodontics)[3]	90% after deductible	80% after deductible	90% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Major services (crowns, removable and fixed bridges, complete and partial dentures)	60% after deductible	50% after deductible	60% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontia[4] (adult and child)	50% after deductible / $1,500 lifetime maximum		**Classic 1** 50% after deductible / $1,500 lifetime maximum **Classic 2** Not covered		**Classic 3** 50% after deductible / $1,500 lifetime maximum **Classic 4** Not covered		**Classic 5** 50% after deductible / $1,500 lifetime maximum **Classic 6** Not covered	
Dental implants	**Classic Plus 1** 50% after deductible / $1,500 calendar year maximum **Classic Plus 2** Not covered		Not covered		Not covered		Not covered	

Reimbursement: Classic and Classic Plus plans reimburse out-of-network benefits at Usual, Customary and Reasonable (UCR) amounts. Essential and Basic plans reimburse out-of-network benefits on a limited fee schedule. This is only a summary of benefits. Please refer to the Certificate of Coverage for terms and conditions of coverage, including which services are limited or excluded from coverage.

[1] There is a maximum charge of $150 in addition to the listed copayment if noble, high noble or titanium metal is used. Porcelain on molars is an additional charge of $75.

[2] Out-of-network benefits for Classic Plus and Classic plans are reimbursed at the Usual, Customary and Reasonable (UCR) amounts as determined by FAIR Health, Inc.

- Full amount of the orthodontia lifetime maximum for employees and dependents, even if they have begun treatment under another carrier's dental PPO plan (applies only to DPPO plans with orthodontia coverage).
- The option for employers to purchase separately or as a dual choice with Dental HMO plans.

Plus, all plan[1] periodontics, endodontics and oral surgery are covered as general services with our Classic and Classic Plus plans.

For easy comparison, we've provided a chart of our DPPO plans with key coverage details.

Essential 1 & 2 1000		*Essential 3 & 4 1000*		*Essential 5 & 6 1500*		*Essential Value 1 1000*		*Basic 500*	
In-network	Out-of-network[3]	In-network	Out-of-network[3]	In-network	Out-of-network[3]	In-network	Out-of-network[3]	In-network	Out-of-network[3]
$1,000		$1,000		$1,500		$1,000		$500	
$50 single $150 family	$75 single $225 family	$50 single $150 family	$75 single $225 family	$50 single $150 family	$75 single $225 family	$50 single $150 family	$75 single $225 family	$50 per person	$50 per person
100% deductible waived		100% deductible waived	80% deductible waived	100% deductible waived		100% deductible waived	50% deductible waived	100% deductible waived	80% deductible waived
80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80%[5] after deductible	50%[5] after deductible	60%[5] after deductible	50%[5] after deductible
50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	Not covered	
Essential 1 50% after deductible / $1,000 lifetime maximum		**Essential 3** 50% after deductible / $1,000 lifetime maximum		**Essential 5** 50% after deductible / $1,500 lifetime maximum		Not covered		Not covered	
Essential 2 Not covered		**Essential 4** Not covered		**Essential 6** Not covered					
Not covered		Not covered		Not covered		Not covered		Not covered	

Limitations	
Initial / routine oral exam	2 per consecutive 12 months
Teeth cleaning	2 per consecutive 12 months (additional services available for pregnant members)
Fluoride treatment	2 per consecutive 12 months
Sealants	1 per 36 months, children under 16 years on permanent molars only
Emergency treatment	For relief of pain only

[3]Out-of-network benefits for Essential, Essential Value and Basic plans are based on the allowable amount applicable for the same service that would have been rendered by a network provider.

[4]For employer-paid DPPO plans and voluntary DPPO plans, orthodontia available for groups of 10 or more enrollees.

[5]Endodontics, periodontics and oral surgery are covered under General Services under the Classic, Classic Plus, Essential, and Essential Value plan and not covered services under the Basic 500 plan.

MaxAdvantage *with* Classic Plus 2000

Plans 1 and 2

Our Classic Plus 2000 Plans 1 and 2 come with another employee-friendly benefit: calendar year maximum rollover. MaxAdvantage allows employees and dependents to carry forward a portion of their unused calendar year maximum for future use.

It's easy to use – We do all the tracking!

An award balance is established for each enrolled employee and dependent when the total of all the submitted claims for each person is $1,000 or less for the calendar year. Each enrolled person qualifies for the MaxAdvantage award if they use in- or out-of-network providers, and use his or her dental benefits at least once a year. Plus, members can earn an additional $100 bonus if all claims are for network providers.

Angel Nazir, Health Net
We help people build healthy habits.

Example:

In 2015, Joe receives two oral exams, two cleanings, has X-rays taken and gets two fillings, all from an in-network dentist.

Total amount of claims = $650.

MaxAdvantage reward: $500 + 100 in-network bonus = $600 annual award.

Note that if Joe's annual claim total exceeded $1,000, he would not be eligible for the award.

In 2016, Joe's – and any enrolled dependents – calendar year maximum resets to $2,000 (the plan maximum) + $600 award = $2,600 calendar year maximum.

Joe can use the award for covered services (except for orthodontia or dental implants) in future years if he exceeds the calendar year maximum.

The average person can submit hundreds of dollars in dental claims every year, so MaxAdvantage is a real advantage for many employees and dependents! With MaxAdvantage, they can save for more extensive services – such as a crown.

Note that the maximum award amount is $600 per year, and $3,500 is the highest calendar year maximum with all awards. Funds are not physical and cannot be withdrawn. Employees and dependents must enroll by October 1 in order to qualify for the award on January 1.

Our Vision Plans *Have a Clear* Advantage

Health Net PPO Vision insurance plans provide the convenience of a large national network, our hassle-free implementation and administrative processing, and:

- A diverse network of independent and retail providers, including LensCrafters.
- Low copayments.
- The option for employees and dependents to see any provider they choose, either in-network or out-of-network, and be covered under the plan.
- Discounts of 5–15% on LASIK and PRK procedures from U.S. Laser Network.
- The only difference between the full service plans, Preferred 1025-2 and 1025-3, is the replacement of lenses, contact lenses or frames either every 12 or 24 months. For materials only, Health Net makes available the Preferred Value 10-2 plan.

Schedule of benefits and coverage	*Preferred Plan 1025-2*	*Preferred Plan 1025-3*	*Preferred Value Plan 10-2*
Vision exam copayment	$10	$10	Not covered
Lens copayment	$25	$25	$10
Frequency			
Exam	Every 12 months	Every 12 months	Not covered
Eyeglass or contact lenses	Every 12 months	Every 24 months	Every 12 months
Frames	Every 24 months	Every 24 months	Every 24 months
Retail frame allowance (in-network)	$100	$100	$100
Contact lens allowance (in-network)	$90	$90	$90

Employees and dependents will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to provider's professional services or to contact lenses. Retail prices vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

This is only a summary of benefits. Please refer to the Certificate of Insurance or Evidence of Coverage for terms and conditions of coverage, including which services are limited or excluded from coverage.

Health Net Vision plan benefits	*In-network (member cost)*	*Out-of-network (maximum benefit allowed)*
Vision exam (Preferred 1025-2 and Preferred 1025-3 plans only) Exam (with dilation as necessary)	$0 after copay	Up to $40
Standard contact lens fit and follow-up exam	Up to $55	Not covered
Standard plastic lenses Single vision	$0 after copay	Up to $40
Bifocal	$0 after copay	Up to $60
Trifocal	$0 after copay	Up to $80
Standard progressive (add-on to bifocal)	$65 copay (in addition to lens copay)	$60
Premium progressive (add-on to bifocal)	$65 copay (in addition to lens copay), plus 80% of retail charge less $120 allowance	$60
Lens options (in-network only) UV coating	$15 copay	Not covered
Tint (solid and gradient)	$15 copay	Not covered
Standard scratch-resistant	$15 copay	Not covered
Standard polycarbonate	$40 copay	Not covered
Standard anti-reflective	$45 copay	Not covered
Other add-ons and services	20% discount	Not covered
Frames (any frame available at a provider location)	Up to plan allowance, plus 20% discount off balance over allowance	Up to $45
Contact lenses (materials only) Medically necessary	$0	Up to $210
Conventional	Up to plan allowance, plus 15% discount off balance over allowance	Up to $105
Disposable	Up to plan allowance, plus balance over allowance	Up to $105
Laser vision correction (in-network only) LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	Not covered
Secondary purchase plan (in-network only) Discounts on eyewear purchases after initial benefits	40% off retail	Not covered

Employees and dependents will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to provider's professional services or to contact lenses. Retail prices vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

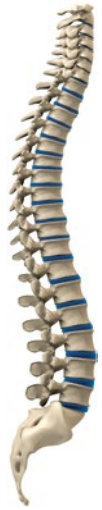
This is only a summary of benefits. Please refer to the Certificate of Insurance or Evidence of Coverage for terms and conditions of coverage, including which services are limited or excluded from coverage.

Chiropractic and Acupuncture

Health Net makes available quality, affordable chiropractic and acupuncture coverage – natural complements to traditional medical coverage. Available as separate riders, chiropractic and acupuncture services are provided through American Specialty Health Plans of California, Inc., a wholly owned subsidiary of American Specialty Health Incorporated (ASH). Key features are:

- Self-referral for medically necessary covered chiropractic and/or acupuncture services.
- Copayment for chiropractic and acupuncture office visits.
- Chiropractic plans cover medically necessary X-rays and lab tests.
- Annual chiropractic allowance applies toward purchase of medically necessary items such as thoracic and lumbar supports, cervical collars and pillows, heel lifts, ice packs, lumbar cushions, orthotics, rib belts, and home traction units.
- Chiropractic and acupuncture services may be subject to verification of medical necessity.

All Health Net SmartCare plans include acupuncture and chiropractic services as value-added benefits. For all other plans, chiropractic and acupuncture coverage may be added in conjunction with a purchase of a 51–100 Choice medical plan. This coverage does not come standalone.



Benefit description	*Member responsibility*
Office visit copay	$10 per visit/20 visits per calendar year (maximum visits are combined for chiropractic and acupuncture services).
Annual chiropractic appliance allowance	$50 toward the purchase of items necessary for chiropractic appliances such as cervical collars, cervical pillows, heel lifts, non-electric heat pads, cushions, rib belts, and home traction-lumbar units.

Life and AD&D

From group and supplemental term life to Accidental Death and Dismemberment (AD&D) benefits, Health Net has a range of coverage options for additional security. These products are underwritten by Health Net Life Insurance Company, a subsidiary of Health Net, Inc.

Health Net Group Term Life

Our Group Term Life Insurance is available in flat amounts of:

- $15,000
- $25,000
- $50,000

AD&D

AD&D benefits are included with a group life policy. The benefit is payable as a result of an accident, loss of life or any of the physical losses specified in the group policy. The benefit payable depends on the loss:

- The maximum benefit amount is equal to the basic life amount shown in the policy and is payable for the loss of life, loss of sight in both eyes, loss of both hands or both feet, or any two or more of these physical losses in the same accident.
- One-half of the maximum benefit amount is payable for the loss of sight in one eye, loss of one hand or loss of one foot.

Each policy type comes standard with:

- **Waiver of premium provisions.**
- **Accelerated death benefit** – This can be paid to an insured when the physician certifies a terminal illness. The accelerated benefit is a portion of the basic life insurance amount and is payable in a lump sum. The remaining portion is paid upon death to the insured's beneficiary.
- **Conversion privilege** – A conversion privilege to whole life insurance is available to certain individuals whose coverage terminates due to reasons specified in the group policy.

Dental *and* Vision Underwriting Guidelines

Group eligibility:
- 51–100 eligible employees with over 50% of the total group located in California, subject to out-of-area requirements below.
- Out-of-Area requirements
  - A maximum of 49% of the total eligible population may be out of California's service area, subject to the following rules.
  - Those employees who are out of the California service area may be written on a PPO plan.
- Dental and Vision must be written in conjunction with Medical only.
- Carve-out groups are not eligible for coverage.

Employee eligibility:
- Probationary period for new hires can be first of the month following date of hire, first of the month following 30 days, or first of the month following 1 month. **Note:** The probationary period must match Medical.
- Eligible employees can be defined as employees working at least 20 or 30 hours per week. **Note:** The hours per week must match Medical.
- With the exception of owners, all employees must be covered by workers' compensation.

Enrollment details:
- Groups enrolling in Health Net's Medical with Dental and/or Vision products or standalone Dental and/or Vision:
  - Employee eligibility is based on the entire group.
  - Minimum participation for the products must be met.
  - Standard paperwork requirements must be met.
- Existing Health Net Medical groups adding a Dental and/or Vision product:
  - If the Dental and/or Vision enrollment is below that of the current Medical, paperwork will be required to verify participation on the DPPO and employer rates on DHMO and Vision.

Rate information:
- 12-month rate guarantee for cases sold/renewed in conjunction with Medical or if sold as a standalone product.
- Cases sold off cycle from the Medical will have their first renewal in conjunction with the Medical.

Submission:
- First of the month effective dates are available.
- All cases must be submitted by the 1st of the month for which coverage is to be effective.

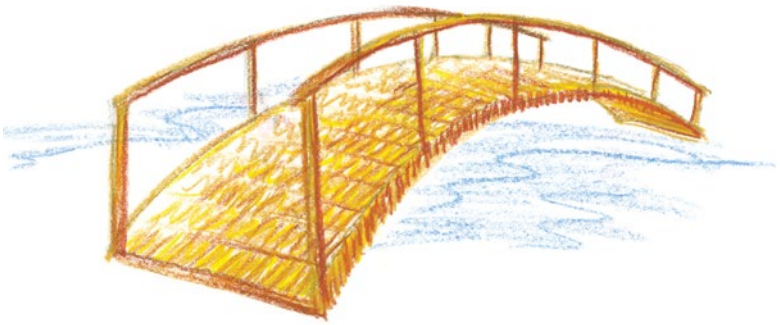
Vision details:
- A minimum participation of 75% of the eligible employees is required for employer paid rates. **Note:** Unlike Medical, waiving for other coverage will count against participation.
- A minimum employer contribution of 50% of the employee premium is required for employer paid rates.
- Voluntary rates apply to those cases with less than 75% participation and/or 50% contribution.
- A minimum of 10 enrolled employees is required.
- Dual Choice Vision is not available.

DHMO details:
- Employer paid rates:
  - A minimum participation of 50% is required. **Note:** Employees waiving coverage due to group coverage through another employer (i.e. spousal coverage) will not count against participation.
  - A minimum of 50% contribution is required.
  - Proof of immediately prior group dental coverage is required.
- Voluntary rates:
  - No minimum participation is required.
  - No minimum contribution is required.
  - No prior group dental coverage is required.
- A minimum of 10 enrolled employees is required.
- Orthodontia is available in all DHMO plans.

DPPO details:
- Employer paid rates:
  - A minimum participation of 75% is required. **Note:** Employees waiving coverage due to group coverage through another employer (i.e. spousal coverage) will not count against participation.
  - A minimum of 50% contribution is required.
  - Proof of immediately prior group dental coverage is required.
- Voluntary rates:
  - No minimum participation is required.
  - No minimum contribution is required.
  - No prior group dental coverage is required.
- A minimum of 10 enrolled employees is required.
- Orthodontia is available.
- Implant coverage is available in Classic Plus 1 only.

Dual choice dental:
- Employer paid rates:
  - A minimum participation of 75% is required. **Note:** Employees waiving coverage due to group coverage through another employer (i.e. spousal coverage) will not count against participation.
  - A minimum of 50% contribution is required.
  - Proof of immediately prior group dental coverage is required.
- Voluntary rates:
  - A minimum participation of 75% is required. **Note:** Employees waiving coverage due to group coverage through another employer (i.e. spousal coverage) will not count against participation.
  - No minimum contribution is required.
  - No prior group dental coverage is required.
- A minimum of 10 enrolled employees is required.
- Groups may select 1 DHMO and 1 DPPO, 2 DHMO, or 2DPPO with a minimum of 10 enrolled employees and 2 on a given plan.
- Orthodontia is available for employer paid DPPO groups of 10 or more enrolled employees OR for groups of 2–9 enrollees with proof of immediately prior indemnity orthodontic coverage.
- Orthodontia is available for voluntary DPPO groups of 10 or more enrolled employees.
- Classic Plus 1 is available only to groups enrolling 10 or more employees on that plan, whether employer-paid or voluntary.

Employees waiving coverage due to group coverage through another employer (i.e., spousal coverage) will not count against participation.



Health Net

Member Extras

Health Net Member Extras

At Health Net, we're about more than just health care coverage. Sure, comprehensive benefits are essential, but so is making it easy for people to get the most from their health plan.

Decision Power®: Health & Wellness

Decision Power is an integrated program created to engage people in their health. With personalized tools and achievable goals, employees can feel confident in their ability to make positive and lasting behavioral changes. Here are just a few of the ways we help employees achieve improved wellness:

- Get help with a specific health goal.
- Learn about treatment options.
- Try an online improvement program.
- Assess health risks.
- Track diet, exercise and cholesterol.
- Better manage chronic illness.

Self-service at www.healthnet.com

Connecting you and your clients with Health Net

We're committed to bringing you and your clients the information and tools that make your lives easier – what you need, when you need it. With helpful resources like HealthNet.com and our Health Net Mobile app, we make it easy to navigate from "what you see" to "what you need."

Fast, easy and just what you're looking for!

HealthNet.com guides you to the information you need with intuitive navigation and useful links, including:

- MyAlerts – Shows Book of Business alerts, such as delinquent payments and rate changes.
- View Member Coverage – Allows you to look up eligibility for your clients.
- Quick Links – Provides access to commonly used features on the website.

Our dynamic website is a valuable tool for your clients as well, giving employers and employees just what they're looking for, with simple navigation and easy-to-find information for an interactive and satisfying health plan experience. For fast and easy access to the information you and your clients need, visit **www.healthnet.com.**

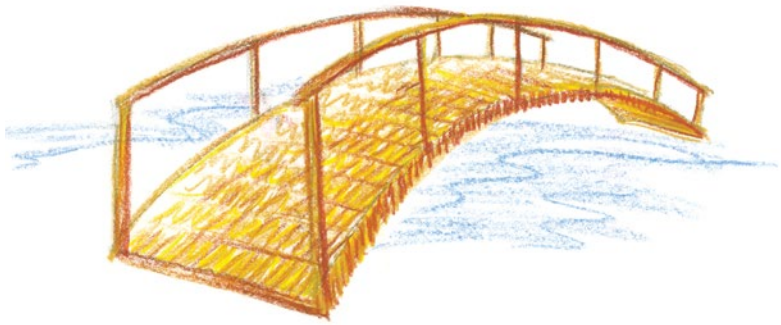
On the go with Health Net Mobile

Your clients and their employees lead busy lives, always on the go. Keeping track of the details – even critical details like health care information – can be daunting. How can you help them? Make sure they know how our Health Net Mobile app can make their hectic lives run more smoothly.

All it takes is an iPhone, Android or other web-enabled smartphone, and Health Net members have everything they need to track their health plan details – no matter where they are or how busy they get. Here is an example of how it works:

- A member uses her lunch break to take her son to a doctor's appointment. She's forgotten her son's Health Net ID, but she's got her phone. Our My ID Card feature lets her view the card, a list of her plan dependents – and their ID cards, too – all on Health Net Mobile.

Through Decision Power, we deliver a personalized and accessible approach to wellness.



Group Administration

Group Administration

This quick reference section provides tips for applications, handling group changes and using our convenient online billing and enrollment tools. Your kit includes member materials and forms for your reference and use.

Application tips

For group employee applications, group administrators will need to confirm that the following items are complete:

- Date of hire
- Date of birth
- Signatures – Employees must sign both the acceptance and declination sections

Handling group changes

Adding employees or dependents

Groups can add employees at the following times:

- New hire (after meeting the company's probationary period) – Applications must be received within 30 days of member effective date.

  Example: The probationary period is the first of the month following date of hire. An employee hired January 15 would have a February 1 effective date.
- Open Enrollment – During the annual renewal period, groups can enroll employees and dependents that had previously declined coverage.
- Loss of coverage – Application must be signed by the subscriber and received by Health Net within 30 days of the event.

Outside of Open Enrollment, dependents can only be added if there is a qualifying event:

- Birth
- Marriage
- Court order
- Adoption
- Loss of coverage

All applications for adding new dependents due to a qualifying event must be signed by the subscriber and received by Health Net within 30 days of the event.

Billing contacts

Our Membership Accounting is available to answer any billing or eligibility questions. The number for you to call is 1-800-224-8808, option 3, or send a fax to (916) 935-4420.

California Assembly Bill 2470 (2010) requires us to provide notice of termination in the event of nonpayment of premium within specific time frames. We will be including the required notice with each of our monthly bills. Please note that if you have paid timely in the past and have not received a risk of termination notice for nonpayment of premium, this notice will likely not impact your current payment practices.

If you intend to cancel or change insurance coverage, Health Net must receive notice on or before the first of the month prior to the effective date of the replacement coverage. Failure to do so may result in continued billing and additional premiums owed.

Canceling employee/dependent coverage

When should Health Net be notified of a cancellation?
Health Net must be notified as soon as possible prior to the last day that the member is eligible for coverage, but no later than 30 days[1] after the effective date of the cancellation. Premium credit cannot be issued for more than 30 days[1] retroactively.

Why is timely notification important?
Members who are no longer eligible, but who have not, in fact, been cancelled by their employer, may incur substantial medical expenses between the time they cease to meet eligibility requirements and the time they are actually removed from the plan. According to the eligibility rules of your Health Net plan, if you notify us of a cancellation more than 30 days after what should have been the last day of coverage, Health Net will require that you pay subscription charges/premiums for the affected member up to the time that you provided us with proper notification.

How does cancellation of the subscriber's coverage affect the coverage of his or her dependents?
When the subscriber's coverage is cancelled, all covered dependents also lose eligibility and are cancelled automatically.

How is employee coverage cancelled?
The group administrator must indicate the cancellation and effective date on the Current Membership and Membership Changes pages of the monthly billing statement (membership invoice). If the billing statement has already been sent, written notification of the cancellation on the group's letterhead may be mailed to Health Net at:

PO Box 9103
Van Nuys, CA 91409-9103
Or faxed to (916) 935-4420

Any written request from a group or broker will be accepted.

How can a dependent's coverage be cancelled if the subscriber continues to be covered?
Follow the same procedure as when canceling an employee; or, to cancel a dependent's coverage when the subscriber continues to be covered, you must submit the following form.

Enrollment and Change Form

The "Delete Dependent" change option should be indicated below "Reason for Change." A completed, signed and dated Enrollment and Change Form must be submitted for each subscriber who is canceling a dependent's coverage.

[1]Permitted days are subject to contract agreement.

Online billing and enrollment

Convenience and control 24/7

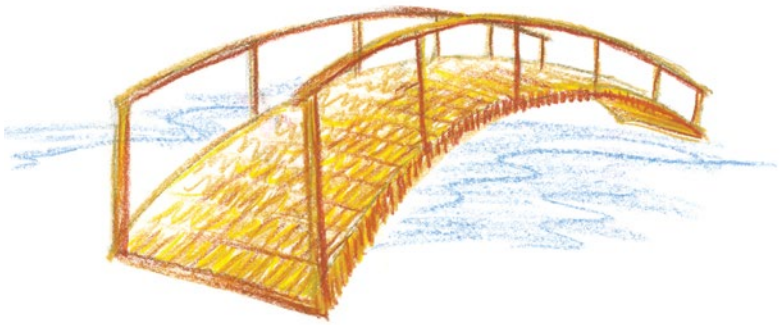
Health Net makes it easy for your clients to simplify health plan administration with Online Billing and Enrollment, our free, user-friendly web portal for enrolled employer groups. Visit our website at www.healthnet.com. With Online Billing and Enrollment, groups can:

- View and print billing statements.
- Retain up to 18 months of billing and payment history.
- View, add and update enrollment information anytime.
- Get helpful reports:
  - The Roster Report lists all active employees and their dependents, the plans they're enrolled in and effective dates.
  - The Daily Transaction Report lists all the daily transactions the group administrator has processed online.

Both reports are easily downloaded into spreadsheet format.

Online Billing and Enrollment is fully integrated to work with the rest of Health Net's systems, so the updates that you make will always be reflected online.

Andre Hamil,
Health Net
We partner with you to promote workforce health.



Appendix/
Forms

Health Net®

51–100 Application

for Group Enrollment and Change

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the "Health Net Entities"). Dental HMO plans are provided by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans are underwritten by Unimerica Life Insurance Company (together, the "DBP Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, the "Fidelity Entities").

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.
2. Carefully review and select the plan option(s) that are best for you and your covered family members.
3. If you choose to enroll in the HMO, HMO ExcelCare Network, HMO SmartCare Network, HMO Salud con Health Net®, POS, Elect Open Access℠ (EOA), EOA ExcelCare Network, or Dental HMO (DHMO), you must select your provider, physician group, primary care physician, and dental provider. Be sure to fill in the names and numbers as they appear in the HMO Health Net Directory of Providers, or call the Customer Contact Center from 8:00 a.m. to 6:00 p.m., Monday through Friday for assistance.

   51–100 Business Group: 1-800-522-0088 (*English*)
   1-877-891-9050 (*Cantonese*)
   1-877-339-8596 *(Korean*)
   1-877-891-9053 (*Mandarin*)
   1-800-331-1777 (*Spanish*)
   1-877-891-9051 (*Tagalog*)
   1-877-339-8621 (*Vietnamese*)

   Health Net Life: 1-800-865-6288

   Health Net Dental: 1-866-249-2382

   Health Net Vision: 1-866-392-6058

4. If you choose to enroll in a PPO, HSA-compatible or HRA-compatible insurance plan, you are not required to select a primary care physician or physician group to enroll.
5. Make a copy of the completed application for your records.

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.

Health Net®

(For enrollment, sections 1, 3 and 8 are required. For waivers, only section 7 is required.)

Employer name:	
Effective date:	Employer group number *(medical)*:
Social Security #:	

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (Select coverage.)

SmartCare HMO[1]

SmartCare Standard ☐10 ☐20 ☐30 ☐40 ☐50	**SmartCare Value** ☐50

Other plan options

HMO Standard ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐50	**HMO Value** ☐10 ☐20 ☐30 ☐40 ☐50	**HMO Advantage** ☐25 ☐35 ☐45
HMO Standard Dual Network[2] ☐20 ☐30	**HMO Value Dual Network**[2] ☐30 ☐40	
EOA Standard ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐50	**EOA Value** ☐10 ☐20 ☐30 ☐40 ☐50	**EOA Advantage** ☐25 ☐35 ☐45
PPO Standard ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45	**PPO Value** ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45	**PPO Advantage** ☐45
HSA[3] **Value PPO** ☐4500 ☐Integrated ☐Opt out	**HRA PPO** ☐3000 ☐5000 ☐Integrated	**POS** ☐10 ☐20

Salud con Health Net
☐HMO y Más 15[4] ☐HMO y Más 25[4] ☐HMO y Más 35[4] ☐Salud EPO[5] ☐Salud Mexico[6]

Dental (DHMO)	Dental (DPPO)	Vision (PPO)
☐HN Plus Plan #: _____	☐Classic ☐Classic Plus ☐Basic ☐Essential ☐Essential Value	☐Preferred 1025-2 ☐Preferred 1025-3 ☐Preferred Value 10-2

2. Reason for change

Reason for change:
☐Plan change
☐Change address/name
☐Delete dependent *(list names below)*
☐Other: _____

Reason for application:
☐New hire Date of hire: ____/____/_____
☐Open Enrollment ☐Loss of prior coverage date: ____/____/_____
☐COBRA[7] effective date: ____/____/_____ Qualifying event date: ____/____/_____
☐Add dependent: _____
Qualifying event: _____ Qualifying event date: ____/____/_____

3. Employee personal information

Last name:	First name:	MI:	☐Male ☐Female
Residence address:	City:	State:	ZIP:
Date of birth: *(mm/dd/yy)*	Social Security #/Matricular ID #:	Job title:	
Telephone #: ( )	Work phone #: ( )	Email address:	
Date of hire: / /	Class:	Dept. #:	Employment status: ☐Salaried ☐Hourly
Marital status: ☐Single ☐Married ☐Domestic partner			
If available, I would prefer to receive communication and plan information in Spanish: ☐Yes ☐No			
Participating physician group/PPG #:	Health Net primary care physician/PCP #:		
Physician name *(first, last)*:	Is this your current MD? ☐Yes ☐No	Dental HMO provider ID #:	

Social Security #:

4. *Family information, please list all eligible family members to be enrolled.*
(Attach additional sheets if necessary.)

☐ Spouse ☐ M ☐ Domestic partner ☐ F	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth: *(mm/dd/yyyy)*	Social Security #/Matricular ID #:		
Health Net primary care physician/PCP #	Participating physician group/PPG #:		
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth: *(mm/dd/yyyy)*	Social Security #/Matricular ID #:	Disabled: ☐ Yes ☐ No	
Health Net primary care physician/PCP #	Participating physician group/PPG #:		
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth: *(mm/dd/yyyy)*	Social Security #/Matricular ID #:	Disabled: ☐ Yes ☐ No	
Health Net primary care physician/PCP #:	Participating physician group/PPG #:		
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth: *(mm/dd/yyyy)*	Social Security #/Matricular ID #:	Disabled: ☐ Yes ☐ No	
Health Net primary care physician/PCP #	Participating physician group/PPG #:		
Physician name *(first, last)*:	Is this your current MD? ☐ Yes ☐ No	Dental HMO provider ID #:	

[1]Available in all or parts of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.
[2]Groups may only select one tailored network offering alongside the full network Dual Plans. ExcelCare and SmartCare may not be offered together.
[3]HSA-compatible.
[4]Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.
[5]Available in Los Angeles, Orange and Ventura counties.
[6]Available in select ZIP codes of San Diego and Imperial counties.
[7]Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA.

Social Security #:	

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

If "Yes," please complete this section including Medicare.

☐ Self	Name:	Name of other insurance carrier:	Prior coverage start date: *(mm/dd/yy)*	
Prior coverage end date: *(mm/dd/yy)*	Reason for ending coverage:	Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Spouse ☐ Domestic partner	Name:	Name of other insurance carrier:	Prior coverage start date: *(mm/dd/yy)*		
Prior coverage end date: *(mm/dd/yy)*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:	Name of other insurance carrier:	Prior coverage start date: *(mm/dd/yy)*		
Prior coverage end date: *(mm/dd/yy)*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:	Name of other insurance carrier:	Prior coverage start date: *(mm/dd/yy)*		
Prior coverage end date: *(mm/dd/yy)*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:	Name of other insurance carrier:	Prior coverage start date: *(mm/dd/yy)*		
Prior coverage end date: *(mm/dd/yy)*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

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

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit 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's Group Policy and Certificate of Insurance.

Social Security #:

7. Declination of coverage *(Complete this section if any coverage is being declined by you or your eligible dependents.)*

☐ Declining medical coverage for:

_____

☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

☐ Declining dental coverage for:

_____

☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

☐ Declining vision coverage for:

_____

☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Stop and read carefully.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____

(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage *(Signature required.)*

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. The Health Net Entities, the DBP Entities and/or the Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Evidence of Coverage or Certificate of Insurance for coverage underwritten by the Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net 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 or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes 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.)

Please contact the Health Net Customer Contact Center at the toll-free numbers below if you need assistance in completing this form or if you have questions about your coverage:

English	1-800-522-0088
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

If you have questions about your dental or vision coverage, please call:

Dental	1-866-249-2382
Vision	1-866-392-6058

If you have questions about your physician or physician group, call your physician group directly, or contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

HMO, HMO ExcelCare Network, HMO SmartCare Network, Salud con Health Net HMO, Select (POS), Elect Open Access (EOA), EOA ExcelCare Network, EPO, Dental HMO enrollees:

Participating physician group (PPG), primary care physician (PCP) and dental provider selection.

Please note, if you do not select a participating physician group, primary care physician or dental provider for yourself and each of your eligible dependents, a participating physician group, primary care physician and/or dental provider will be selected for you.

Emergency and urgently needed care:

- If your situation is life-threatening or an emergency: Call 911 or go to the nearest hospital.
- If your situation is not so severe: If you cannot call your primary care physician or physician group, or you need medical care right away, go to the nearest hospital or medical center.
- If you are outside your physician group's service area: Go to the nearest hospital, medical center or call 911. In all cases, contact your primary care physician or participating physician group as soon as possible to inform them about your condition.

PPO enrollees:

Emergency and urgently needed care.

- If your situation is life-threatening or an emergency:

  Call 911 or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

Precertification:

You, the member, are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring precertification.

For precertification, please call 1-800-977-7282.

Disabling conditions:

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer, and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled, (b) the maximum benefits of the prior insurer's coverage are paid, or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

Products/Entities:

Health Net of California, Inc. offers the following products: Health Net Elect, HMO, Salud HMO y Más, and Select POS.

Health Net Life Insurance Company offers the following products: PPO, Salud con Health Net EPO, Life, and AD&D insurance.

Dental Benefit Providers of California, Inc. offers the following products: Dental HMO (DHMO).

Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of coverage:

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

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 Health Net's Commercial Contact Center at 1-800-522-0088. Individual and Family Plan (IFP) or Farm Bureau applicants please call 1-800-909-3447, option 2. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in an HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (IFP, por sus siglas en inglés) o de la Oficina Agrícola, deben llamar al 1-800-909-3447, opción 2. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥打您會員卡上所列的電話號碼，雇主團體申請人請致電 Health Net 的商業聯絡中心，電話 1-800-522-0088。個人和家庭計畫 (IFP) 或農業局申請人請撥打 1-800-909-3447，請按 2。若您投保 PPO 計畫，請致電 1-800-927-4357 與加州保險局聯絡，詢求額外協助。若您投保 HMO 計畫，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được cấp dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị và cũng có thể được cấp tài liệu phiên dịch sang ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm theo nhóm do hãng sở đài thọ xin gọi Trung Tâm Liên Lạc Thương Mại của Health Net tại số 1-800-522-0088. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP) hoặc Farm Bureau, xin gọi số 1-800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Bộ Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị đang tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net 의 상업(Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088 번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 혹은 Farm Bureau 가입 신청자님은 안내번호 1-800-909-3447번, 옵션 2를 이용해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC(보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa employer group applicants, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa Individual and Family Plan (IFP) o Farm Bureau applicants, mangyaring tumawag sa 1-800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-800-909-3447 համարով, ընտրանք 2: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в коммерческий контактный центр компании Health Net по телефону 1-800-522-0088. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP), а также планов страхования Фермерского бюро: пожалуйста, звоните по номеру 1-800-909-3447, добавочный 2. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.

Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体への加入申込の方は、Health Net 民間コンタクト・センター、1-800-522-0088 までご連絡ください。個人・家族プラン (IFP) またはファーム・ビューローへの加入申込の方は、1-800-909-3447（ダイアル後 2 を選択）までお問い合わせください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMOプランにご加入の方は、カリフォルニア州管理医療庁 (DMHC) の相談窓口、1-888-HMO-2219 までご連絡ください。

Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. و یا متقاضیان گروههای کارفرمایان لطفاً با مرکز جاری Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان «طرح افراد و خانواده ها» (IFP) یا «دفتر مزارع» لطفاً به شماره 1-800-909-3447 گزینه 2 تلفن کنند. برای دریافت کمک بیشتر به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.

Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ, ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-800-909-3447, ਔਪਸ਼ਨ ੨ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਫਫੋ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬអ្នកដាក់ពាក្យសុំជាក្រុមនៃក្រុមហ៊ុនការងារ សូមទូរស័ព្ទទៅ មណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088 ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) ឬអ្នកដាក់ពាក្យសុំ Farm Bureau សូមទូរស័ព្ទទៅលេខ 1-800-909-3447 ចុចជំរើសទី 2 ។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅ ខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។

Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj thov tau kom muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tom hauj lwm thov hu rau Health Net's Commercial Contact Center ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) los sis Farm Bureau thov hu rau 1-800-909-3447, xaiv nqe 2. Yog xav tau kev pab ntxiv hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.

Hmong

T'áá Hó Hasaad Bee 'Áka'e'eyeed Doo Bą́ą́h 'Ílíní Da. Haíshíį́ shá 'ata' hodoolnih nínízinígíí łá' ná choídoot'eeł. Ła' naaltsoos t'áá ni nizaad bee nich'į' yídóolta dóó naaltsoos bee hadadilyaago nich'į' 'ádadoolníił. Shiká'e'doowoł nínízingo, ninaaltsoos nitł'izí bine'dęę́' béésh bee hane'í biká'ígíí bich'į' holne' dooleeł, doodago nidaalnishí hada'diilaaígíí 'éí Na'iiłniihí 'Atsíís Bik'ih 'Adeest'íį́' 'Ihnáhane' Bił Haz'áníjį' kojį' béésh bee holne' dooleeł 1-800-522-0088. T'áá Ła' Jizį́ dóó Hooghan Haz'ánígi Bił Nahat'a' (IFP) doodago Dá'ák'eh Yá Dah Háaztánígíí bił náha'dit'éego kojį' béésh bee holne' dooleeł 1-800-909-3447, naaki góne'ígíí bił yaa 'adidíilchił. PPO bił náhadilnéédhdą́ą́' 'éí CA Béeso 'Ách'ą́ą́h Naa'nil Bił Haz'ánígííjį' shiká'e'doowoł diníigo béésh bee holne dooleeł 1-800-927-4357. HMO bił náhadilnéédhdą́ą́', DMHC 'Áka'aná'áwo'go Bił Haz'áníjį' béésh bee holne' dooleeł 1-888-HMO-2219.

Navajo

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID)، وبالنسبة لمجموعات المصالح التجارية رجاء الاتصال بمركز خدمات القطاع التجاري لمؤسسة Health Net على الرقم 1-800-522-0088. المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) أو Farm Bureau رجاء الاتصال بالرقم 1-800-909-3447. خيار 2. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. إذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.

Arabic

6029666 CA106603 (2/14)

Health Net®

Groups 51–100 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, the "Health Net Entities"). Dental HMO plans are provided by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans are underwritten by Unimerica Life Insurance Company (together, the "DBP Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, the "Fidelity Entities").

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Application is hereby made for a Group Service Agreement/Group Policy provided by the Health Net Entities, the DBP Entities and/or the Fidelity Entities, 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 data is being submitted to allow the Health Net Entities, the DBP Entities and/or the Fidelity Entities to determine the eligibility of employees seeking enrollment.

51–100 Business Group: 1-800-522-0088 (*English*)
1-877-891-9050 (*Cantonese*)
1-877-339-8596 (*Korean*)
1-877-891-9053 (*Mandarin*)
1-800-331-1777 (*Spanish*)
1-877-891-9051 (*Tagalog*)
1-877-339-8621 (*Vietnamese*)

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

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.

Health Net®

Groups 51–100 Application

for Group Service Agreement/Group Policy

1. Health plan information (Select one network option only.) *(Applicable to HMO and EOA plans only.)*

Groups taking multiple plans, select your package:

☐ Enhanced Choice ☐ ExcelCare Choice ☐ SmartCare Choice ☐ SmartCare

Groups with a single plan, select your network:

☐ Full network (HMO and EOA) ☐ ExcelCare Network[1] (HMO and EOA)

SmartCare HMO[2]

SmartCare Standard ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 | **SmartCare Value** ☐ 50

Other plan options

HMO Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50	**HMO Value** ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50	**HMO Advantage** ☐ 25 ☐ 35 ☐ 45
HMO Standard Dual Network[3] ☐ 20 ☐ 30	**HMO Value Dual Network[3]** ☐ 30 ☐ 40	
EOA Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50	**EOA Value** ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50	**EOA Advantage** ☐ 25 ☐ 35 ☐ 45
PPO Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45	**PPO Value** ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45	**PPO Advantage** ☐ 45
HSA[4] Value PPO ☐ 4500 Integrated ☐ Yes ☐ No		**POS** ☐ 10 ☐ 20

HRA PPO
☐ 3000 ☐ 5000 Integrated ☐ Yes ☐ No
If Yes, select one option: ☐ Plan A: HRA pays first ☐ Plan B: Member pays first ☐ Plan C: HRA with Debit Card

Salud con Health Net
☐ HMO y Más 15[5] ☐ HMO y Más 25[5] ☐ HMO y Más 35[5] ☐ Salud EPO[6] ☐ Salud Mexico[7]

Ancillary options

Dental (DHMO) ☐ HN Plus Plan #: _____	**Dental (DPPO)** ☐ Classic ☐ Classic Plus ☐ Basic ☐ Essential ☐ Essential Value Plan #:_____	**Vision (PPO)** ☐ Preferred 1025-2 ☐ Preferred 1025-3 ☐ Preferred Value 10-2

Optional Rider[8] ☐ Acupuncture ☐ Chiropractic ☐ Combined Acupuncture/Chiropractic[9]

2. Employer group information *(For changes to existing coverage, please complete only sections 2, 3, 4, and 13.)*

Corporate name or (DBA):	SIC:	Names of: ☐ Affiliates ☐ Subsidiaries to be included		
Location address:		City:	State:	ZIP code:
Billing address (if different than location):		City:	State:	ZIP code:
Tax ID number (TIN):		Total number of employees worldwide:		

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

3. Effective date information

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

4. Employer contribution *(Note: Employer contribution for health is a minimum of 50% or $175[10], and for life is 50%.)*

Employee Medical: _____% or, $_____ Employee Dental: _____% Employee Vision: _____% Employee Life: _____%
Dependent Medical: _____% 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."

5. Eligibility information

Employer data	Medical	Dental	Vision	Life and AD&D (see section 7)
A) Total number of eligible employees (all active, full-time, permanent employees working the minimum required number of hours per week who are eligible for benefits): **Note:** Do not include employees who have not satisfied the waiting 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):				
Total number of employees (A+B):				
C) Total number of Health Net enrollees (excluding COBRA enrollees):				
D) Number of Health Net COBRA enrollees (applying for health coverage):				
E) Number of waivers (Please include the Member Declination of Coverage Forms.):				

Domestic partners
All new group plans effective after January 2, 2005, must provide domestic partner coverage equivalent to the spouse coverage offered.
Standard ☐ All members – same sex partners qualify for coverage; opposite sex partners only qualify for members over the age of 62.
Extended ☐ All members qualify – same sex or opposite sex at any age can be enrolled.

1. Number of hours worked per week required to be eligible for medical insurance coverage:	☐ 20 ☐ 30
2. How would you like your COBRA enrollees to be billed:	☐ Group billed ☐ Member billed
3. Within the last 12 months, has the employer held a Health Net contract?	☐ Yes ☐ No
4. Do the eligible enrollees represent a carve-out either by class, location or union affiliation?	☐ Yes ☐ No

6. Probationary period *(Completed by employer.)*

Applicant shall inform each eligible employee that he or she may apply for benefits under the Group Policy provided by the Health Net Entities, the DBP Entities and/or the Fidelity Entities after the probationary period (specified below) during which a person must be continuously employed full time by applicant.

1. Probationary period for new hires/rehires – First of the month following:	☐ Date of hire ☐ 1 mo. ☐ 30 days
2. Do you want to waive the probationary period for all enrollees at initial enrollment?	☐ Yes ☐ No

7. Life and AD&D benefit selection *(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.

☐ **Option C** – $50,000 flat amount for all employees.

(Continue here from Section 5)

Life Insurance

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

Does this policy replace an existing policy? ☐ Yes ☐ No *If "Yes," list carrier:*

8. 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

Health and/or Life: _____ Workers' compensation: _____

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

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

Plan(s) offered: _____

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.)

9. Health questionnaire (For new groups only.)

All employer groups must answer "Yes" or "No" to the following questions.

Genetic Information Nondiscrimination Act of 2008 (GINA) compliance statement: This is not a request for genetic information. In answering this Health Questionnaire on behalf of your employees, employees' dependents and/or persons to be covered, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe your employees, employees' dependents or other persons to be covered may be at risk.

1. To your knowledge, is there any employee, dependent of an employee, or person to be covered who has received more than $5,000 of medical care in the past two (2) years? ☐ Yes ☐ No
2. To your knowledge, is any employee, dependent of an employee, or person to be covered unable to work due to injury or illness? ☐ Yes ☐ No
3. To your knowledge, are there any current pregnancies or recent hospitalizations for any employee, dependent of an employee, or person to be covered? ☐ Yes ☐ No
4. To your knowledge, has any employee, dependent of an employee, or person to be covered ever had, consulted for, had treatment rendered, been advised to have treatment or received treatment, or been hospitalized, for any of the following conditions: cardiovascular disease or heart attack; disorder of the kidney, stomach, intestines or liver; mental or nervous condition; central nervous system disorders; diabetes; respiratory disorders; or cancer? ☐ Yes ☐ No
5. To your knowledge, has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or AIDS-related complex (ARC) by a medical professional? ☐ Yes ☐ No

For each "Yes" answer, please provide the person's name and submit their completed employee "Health Questionnaire."

10. 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.

☐ Policy renewal date to coincide with medical plan. Effective: _____

11. Mailing methods

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

12. Underwriting criteria

General conditions

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

   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% or $175 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 38 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 19 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.

13. 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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities and receipt of the first month's premium.

The undersigned, on behalf of Group Applicant, understands and agrees that the employer Group Policy(s) applied for, except for the HRA 3000 and HRA 5000 HRA-compatible plans outlined in the "Health plan information" section of this Application for Group Service Agreement/Group Policy, is intended to be issued as a standalone plan(s) only or in conjunction with a Health Savings Account (HSA) banking arrangement, where applicable. Such plan(s), except for the HRA 3000 and HRA 5000 HRA-compatible plans specified above, may not be combined with any form of partial self-funding or otherwise insuring of the deductible, whether in a wraparound, addition or companion capacity, including a partially self-funded Section 105 wraparound, at any time during which the Group Policy(s) is in force. Failure to comply is a breach of the Group Policy(s) and Underwriting Assumptions, and it will result in Health Net Life Insurance Company canceling the health insurance plan coverage initially issued, and replacing it with the most similar plan from the HRA 3000 and HRA 5000 HRA-compatible plan suite offered by Health Net Life Insurance Company and available for purchase at the time of the breach. The replacement health insurance plan will be issued at the applicable premium rates in effect at that time.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. Should it be determined at the time of enrollment and/or at a future date that there are misstatements in this application, the Health Net Entities, the DBP Entities and/or the Fidelity Entities may at their respective sole options either rescind the quote or initiate termination of the respective group contract(s).

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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities, 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 of California, Inc. and/or Health Net Life Insurance Company Account Executive or Broker as specified.

Applicant, in the event this application is accepted, agrees to cooperate with Health Net Entities 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 Entities, "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 Entities, the DBP Entities and/or the Fidelity Entities Group Policies (as referenced herein), and the employee enrollment forms form the entire agreement between the parties.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

13. Arbitration agreement and other important terms (cont.)

BINDING ARBITRATION AGREEMENT: On behalf of Group Applicant, I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, 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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities, 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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities 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. A more detailed arbitration provision is included in the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by the Health Net Entities, the DBP Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by the Health Net Entities, the DBP Entities and/or the Fidelity Entities to deny, reduce, terminate, or not pay for all or a part of a benefit. However, members and the Health Net Entities, the DBP Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Officer of the company signature:	Officer title:	Date:

Applicant's signature above confirms: 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.

14. 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:	

15. For Health Net use only

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

Health Net of California, Inc. offers the following products: Elect Open Access, HMO, POS, Salud con Health Net® HMO y Más.℠

Health Net Life Insurance Company offers the following products: PPO, Salud con Health Net EPO and PPO, 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.

[1] Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Ventura counties.

[2] Available in all or parts of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.

[3] Groups may only select one tailored network offering alongside the full network Dual Plans. ExcelCare and SmartCare may not be offered together.

[4] HSA-compatible.

[5] Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

[6] Available in Los Angeles, Orange and Ventura counties.

[7] Available in select ZIP codes of San Diego and Imperial counties.

[8] All riders for HMO, Salud HMO y Más, EOA, and POS only.

[9] SmartCare HMO plans have combined Chiropractic/Acupuncture that is not optional.

[10] Multi-plan packages require a minimum of 50% of the lowest cost plan (excluding Salud) or $100 per employee. Single plan option requires a minimum of 50% or $100 per employee.

CA106607 (1/14)

51-100 GSA 10/13

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

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Open Enrollment Medical Plan Change Request *Form*

Please use this form to indicate plan changes for your employees and their dependents during your renewal. Please call your authorized Health Net broker or Health Net Account Manager, or refer to the Group Policy and Procedures Guide, for acceptable plan changes and guidelines.

Group contact information			
Group number:	Group name:		Renewal effective date:
Group contact:	Contact phone:	Contact fax:	Contact email address:

NOTE: You must provide the Summary of Benefits and Coverage (SBC) to each individual listed on this form before the individual makes the plan choice and PRIOR TO SUBMITTING THIS FORM TO HEALTH NET. If you need an SBC for any plan(s) offered, please contact your Health Net Account Manager to obtain a copy. Please indicate with a check, using blue or black ink, the plan each member wishes to move into.
Please list all **currently enrolled** members making plan changes during Open Enrollment on this form. New enrollees will need to submit separate enrollment applications. Please photocopy this form if more space is required.

Please fax completed forms to the Health Net Account Management Department. For groups located in Southern California, please fax to (818) 676-6297, and for Northern California, please fax to 1-800-303-3110.

				SmartCare HMO					
				Standard					Value
Member's name	Member's SSN or reference ID	Primary care physician ID	Group #	10	20	30	40	50	50

(continued)

Member's name	Member's SSN or reference ID	Primary care physician ID	Group #	EOA or HMO plans		HMO 10	HMO 15	HMO 20	HMO 25	HMO 30	HMO 35	HMO 40	HMO 45	HMO 50	EOA 10	EOA 15	EOA 20	EOA 25	EOA 30	EOA 35	EOA 40	EOA 45	EOA 50	Salud y Más 15	Salud y Más 25	Salud y Más 35	POS 10	POS 20
				ExcelCare Network	Indicate option																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
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				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							

Member's name	Member's SSN or reference ID	Group #	HSA or PPO plans	Salud EPO	Salud Mexico	PPO 10	PPO 15	PPO 20	PPO 25	PPO 30	PPO 35	PPO 40	PPO 45	HSA 4500	HRA 3000	HRA 5000
			Indicate option													
			☐ Standard ☐ Value ☐ Advantage													
			☐ Standard ☐ Value ☐ Advantage													
			☐ Standard ☐ Value ☐ Advantage													
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			☐ Standard ☐ Value ☐ Advantage													
			☐ Standard ☐ Value ☐ Advantage													
			☐ Standard ☐ Value ☐ Advantage													

As an owner or officer of stated company, I hereby authorize the above changes to our Health Net Group medical coverage. I have informed the employees listed above that the enrollment terms of the Health Net form they completed previously at enrollment are still in force and a copy is available upon request. Employees enrolling in PPO coverage from HMO coverage have been informed that their PPO coverage may be subject to the pre-existing condition limitation if insufficient creditable coverage was accumulated to offset the pre-existing limitation.

Printed name	Signature	Date

Health Net®

Dual Network[1] Open Enrollment Medical Plan
Change Request *Form*

Please use this form to indicate plan changes for your employees and their dependents during your renewal. Please call your authorized Health Net broker or Health Net Account Manager, or refer to the Group Policy and Procedures Guide, for acceptable plan changes and guidelines.

Group contact information			
Group number:	Group name:		Renewal effective date:
Group contact:	Contact phone:	Contact fax:	Contact email address:

Please indicate with a check, using blue or black ink, the plan each member wishes to move into. Please list all **currently enrolled** members making plan changes during Open Enrollment on this form. New enrollees will need to submit separate enrollment applications. Please photocopy this form if more space is required.

Please fax completed forms to the Health Net Account Management department. For groups located in Southern California, please fax to (818) 676-6297, and for Northern California, please fax to 1-800-303-3110.

				SmartCare HMO						Full network HMO			
				Standard					Value	Standard		Value	
Member's name	Member's SSN or Reference ID	Primary care physician ID	Group #	10	20	30	40	50	50	20	30	30	40

[1]Groups may only select one tailored network offering alongside the full network Dual Plans. SmartCare and Silver may not be offered together.

(continued)

Member's name	Member's SSN or Reference ID	Primary care physician ID	Group #	EOA or HMO plans		HMO 10	HMO 15	HMO 20	HMO 25	HMO 30	HMO 35	HMO 40	HMO 45	HMO 50	EOA 10	EOA 15	EOA 20	EOA 25	EOA 30	EOA 35	EOA 40	EOA 45	EOA 50	Salud y Más 15	Salud y Más 25	Salud y Más 35	POS 10	POS 20
				Silver Network	Indicate option																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							
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				☐	☐ Standard ☐ Value ☐ Advantage																							
				☐	☐ Standard ☐ Value ☐ Advantage																							

Member's name	Member's SSN or Reference ID	Group #	HSA or PPO plans	Salud EPO	Salud PPO	Salud Mexico	PPO 15	PPO 20	PPO 25	PPO 30	PPO 35	PPO 40	PPO 45	HSA 1500	HSA 2500	HSA 3500	HSA 4000	HSA 4500	HRA 3000	HRA 5000
			Indicate option																	
			☐ Standard ☐ Value ☐ Advantage																	
			☐ Standard ☐ Value ☐ Advantage																	
			☐ Standard ☐ Value ☐ Advantage																	
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			☐ Standard ☐ Value ☐ Advantage																	
			☐ Standard ☐ Value ☐ Advantage																	

As an owner or officer of stated company, I hereby authorize the above changes to our Health Net Group medical coverage. I have informed the employees listed above that the enrollment terms of the Health Net form they completed previously at enrollment are still in force and a copy is available upon request. Employees enrolling in PPO coverage from HMO coverage have been informed that their PPO coverage may be subject to the pre-existing condition limitation if insufficient creditable coverage was accumulated to offset the pre-existing limitation.

Printed name	Signature	Date

Taxpayer Identification

and Worldwide Employee Count Verification Form

Please provide your TIN and/or your total number of employees.

Health Net must collect this information to comply with many different regulations, including the Medicare Secondary Payer Act and Health Care Reform. If the information Health Net has on file for you is correct, you do not need to complete this form.

Policyholder (or company) name:
Group/Parent ID or policyholder number:
Taxpayer identification number (TIN):
Total worldwide employees (includes full-time, part-time, leased, seasonal, etc. Refer to 42 C.F.R. 411.101 for more information):
As of effective date:

Signature of representative:	Print name of representative:	Date:

You, the employer, are responsible for notifying Health Net of any changes occurring during the course of a calendar year that could impact your employer size determination related to Medicare Secondary Payer or Health Care Reform.

Please fax this form back to (818) 676-7411.

CA98022 (7/13)

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Mark Rivera,
Health Net
We communicate your way –
phone, online and mobile.

Health Net

51–100 Choice

Health coverage that works harder for your business

With Health Net, employer groups have more budget-friendly options to choose from, which means that more clients can buy. And when more clients are buying, you can do more selling. It's another way we're working hard to make health care work for you!

Need answers? Find them here:

- Call your Health Net account executive or account manager.
- Visit us online at www.healthnet.com/broker.
- See ACA-related information at www.healthnet.com/broker reform guide
- Call your Broker Services team at 1-800-448-4411, option 4.

Save time online.

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