Health Net of California, Inc. and Health Net Life Insurance Company (Health Net)
For groups of 101–500

Health Net's *Exclusive* ID Card Express

Employer Guide

Geoffrey Gomez, Health Net
We put the pieces together for sustainable affordability.

Health Net®

You Have Our Word, Backed *by* $5,000!

We're delivering on our promise of value-added performance solutions designed for your business. As a new Health Net employer group, you get more than a promise. You get a $5,000 guarantee – something no other California health care company offers!

ID cards mailed in 10 days or we pay you!

The Health Net guarantee

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

Group eligibility[1]

- New California groups only;
- With 101 to 500 employees; and
- That select plans from our Health Net Enhanced Choice or Starting Line-Up (SLU) portfolios.

Here's how it works

1. Once your application and enrollment package is approved by our Underwriting Department, you'll receive a letter from your Health Net sales consultant welcoming you to Health Net and letting you know you qualify for the **ID Card Express**.
2. We'll then *guarantee* that Health Net ID cards will be mailed to your employees **within 10 business days** from the date of the letter. It couldn't be easier!
3. And if we don't live up to our promise, **we'll pay you $5,000!** That's right.

Keeping you informed

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

Guarantee tips

There are a few things you can do (and probably do already) that will help you meet the guarantee criteria. The following information outlines tips for submitting your group enrollment via paper enrollment forms or electronic spreadsheet. Your broker or Health Net sales consultant will provide you with the required enrollment spreadsheet, called the Census Robotech Member Enrollment Template or Generic 349 Layouts Medical Dental Vision Life. (Depending on your enrollment type, you will need to fill out one of these spreadsheets.)

[1]Health Net's ID Card Express guarantee applies only to new group paper enrollment form and approved electronic spreadsheet enrollment types. The approved spreadsheets are Health Net's Census Robotech Member Enrollment Template for medical plan enrollments, or the Generic 349 Layouts Medical Dental Vision Life for medical and ancillary plan enrollments. The approved spreadsheets are provided by your broker or Health Net sales consultant. The guarantee does not apply to any other type of enrollment (for example, tape groups, custom ID cards/mailings, renewing groups, dental, vision, or Medicare COB).

- Provide ***all*** of your employee enrollment forms or the required spreadsheet **to Health Net as soon as possible** so they can be processed with the **initial submission**.
  - Late or incomplete spreadsheets or enrollment forms may cause disqualification of the guarantee.
- Review your spreadsheet or each and every enrollment form.
  - Your spreadsheet or enrollment forms must be filled out **completely and accurately with no more than 30 percent discrepancies** to qualify for the guarantee. Inaccurate or incomplete spreadsheets or enrollment forms will delay ID cards and will not be included in this guarantee.

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To be completed by employer
Employer name:
Requested effective date: | Employer group number *(medical)*:
Employee eligibility date *(new hire only)*: ☐ Same as hire date ☐ Other: ______

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.)

HMO
☐ HMO ☐ SmartCare HMO[1] ☐ ExcelCare HMO[2] ☐ Salud HMO y Más[3] ☐ EOA ☐ ExcelCare EOA[2] ☐ Select POS ☐ EPO ☐ Other: ______

PPO
☐ PPO ☐ OOS PPO ☐ HSA-compatible PPO ☐ OOS HSA-compatible PPO ☐ Integrated HSA-compatible PPO ☐ Integrated HSA-compatible PPO (opt out) ☐ Integrated HRA-compatible PPO

Dental and Vision
☐ Dental (DHMO) ☐ Dental (DPPO) ☐ Vision (PPO)

2. Reason for application
☐ Plan change ☐ Change address/name ☐ Delete dependent ☐ Other: ______
☐ New hire ☐ Open Enrollment
Special Enrollment Period
Qualifying event date: ___/___/___
Add dependent: ______
COBRA
☐ Effective date: ___/___/___
Qualifying event: ______
Qualifying event date: ___/___/___
☐ Marriage
☐ Newborn/Adoption/Legal Guardianship/Court Order/Assumption of parent-child relationship
☐ Loss of prior coverage: ___/___/___
☐ Other (specify): ______

3. Employee personal information
Last name: | First name: | MI: | ☐ Male ☐ Female
Residence address: | City: | State: | ZIP:
Date of birth *(mm/dd/yyyy)*: | Social Security #/Matricular ID # (required for all applicants): | Job title:
Telephone #: ( ) | Work phone #: ( ) | Email address:
Date of hire: / / | Dept. #: | Marital status: ☐ Single ☐ Married ☐ Domestic partner
I would prefer to receive communication and plan information in: ☐ English ☐ Spanish ☐ Chinese ☐ Korean
Participating physician group: | Primary care physician:
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*: | Is this your current PCP? ☐ Yes ☐ No
Dental HMO provider name: | Dental HMO provider ID #:

[1]Available in all or parts of Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.
[2]Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Ventura counties.
[3]Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

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Employee name: ______ Last 4 digits of Social Security #: __ __ __ __

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

Spouse/Domestic partner ☐ M ☐ 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 # (required for all applicants):
Participating physician group: | Primary care physician:
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*: | Is this your current PCP? ☐ Yes ☐ No
Dental HMO provider name: | Dental HMO provider ID #:

☐ Son ☐ Daughter | Disabled: ☐ Yes ☐ No | 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 # (required for all applicants):
Participating physician group: | Primary care physician:
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*: | Is this your current PCP? ☐ Yes ☐ No
Dental HMO provider name: | Dental HMO provider ID #:

☐ Son ☐ Daughter | Disabled: ☐ Yes ☐ No | 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 # (required for all applicants):
Participating physician group: | Primary care physician:
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*: | Is this your current PCP? ☐ Yes ☐ No
Dental HMO provider name: | Dental HMO provider ID #:

☐ Son ☐ Daughter | Disabled: ☐ Yes ☐ No | 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 # (required for all applicants):
Participating physician group: | Primary care physician:
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*: | Is this your current PCP? ☐ Yes ☐ No
Dental HMO provider name: | Dental HMO provider ID #:

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Double check all of the highlighted critical fields – just like the sample shown here.

Employee name: ______ Last 4 digits of Social Security #: __ __ __ __

5. Do you or your dependents have other health care coverage?
☐ No ☐ Yes If "Yes," please complete this section including 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:	%

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Employee name: ______ Last 4 digits of Social Security #: __ __ __ __

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

Employee personal information
Last name: | First name: | MI: | Social Security #/Matricular ID #:

Declining medical coverage for: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s) Name(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) Name(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) Name(s): ______
Reason: ☐ Other group coverage through this employer ☐ Individual coverage ☐ Other group coverage by another group *(i.e., spouse's employer)* ☐ Other: ______

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY
I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer and I have been given the chance to apply for the available coverages. 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.)*

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

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, DBP and/or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy.[4] 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.)

[4]"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Life Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

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Section 7, Declination of coverage, is only critical if subscribers decide to **decline coverage** for themselves or their eligible dependent(s).

Next steps

There's no further action required. Just leave the rest to us. We'll stick to our promise by making sure your employees receive their ID cards in a timely manner. And isn't that what it's really all about!

As Health Net members and insureds, you and your employees can access benefits right away, as well as find helpful services at **www.healthnet.com**, such as:

- **For you** – easy-to-use online billing and enrollment that gives you the flexibility to manage your account when it's convenient for you.
- **For your employees** – a wide array of useful online tools and resources to help them view their benefits and claims history, find doctors, and access wellness programs.

Health Net – your trusted partner for better health

At Health Net, we offer simple, smart and sustainable benefit solutions, making it easy for you to offer low-cost, quality plan choices that give your employees peace of mind and help them live well and work well. By providing affordable health coverage in concert with a profound commitment to the people and communities we serve, we do what it takes to make health care work for you and your employees.

Call your broker or Health Net sales consultant today for more information about our **ID Card Express**. It's just another way Health Net is leading the way forward.

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