HEALTH NET

A Better Decision

PRODUCER RESOURCE MANUAL

FOR HEALTH NET GENERAL AGENTS AND BROKERS WITH ALL SIZED EMPLOYER GROUPS

Health Net®

A BETTER DECISION

VISIT **WWW.HEALTHNET.COM/BROKER** FOR THE MOST CURRENT PRODUCER RESOURCE MANUAL

HEALTH NET

A Better Decision

Connecticut Office
(Northeast Headquarters)
Health Net of the Northeast, Inc.
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484

New Jersey Office
Health Net of the Northeast, Inc.
90 Matawan Road
Matawan, NJ 07747

New York Office
Health Net of the Northeast, Inc.
150 East 42nd Street, 26th Floor
New York, NY 10017

Please visit us online at
www.healthnet.com/broker
for the most up-to-date tools
and resources.

Table of Contents

Health Net is a Better Decision℠

Health Net's mission is to help people be healthy, secure and comfortable. This mission, embraced by more than 1,750 Northeast Associates and helps more than 500,000 members in the Tri-State area get the health care they need.

Health Net of the Northeast, Inc. is a subsidiary of Health Net, Inc., one of the nation's largest publicly traded managed health care companies, serving New York, New Jersey, Connecticut, and select counties in Pennsylvania. When choosing a health plan, employers need to know that the company they choose is financially strong and reliable. In addition, it should offer an array of competitive plans, give members access to a robust provider network, and provide the highest level of service and performance.

Here are highlights of our recent achievements:

- Ranked 179 on Fortune 500 List.[1]
- National Committee for Quality Assurance (NCQA) rating of "Excellent" for commercial lines of business in Connecticut, New Jersey and New York.[2]
- U.S. News and World Report recognized Health Net of the Northeast among the top 20 commercial plans in the nation.[3]
- Health Net of Connecticut ranks No. 11 nationally and No. 2 as the best Medicare health plan in the state.
- Health Net of New York ranks No. 6 for the state.
- Health Net of New Jersey ranks No. 2 in the state and No. 1 as the best Medicaid health plan in New Jersey.
- Partnered with the Department of Defense to provide health care services (TRICARE) for military personal and their families for over 20 years. TRICARE is in 23 states and has over 2.9 million members.[4]

About Health Net

Health Net provides the total solution for all sized employer groups in the Northeast by offering competitive and flexible plans, access to quality care and programs, as well as the tools and resources that empower consumer decision-making, through our Decision Power® program. Read more and you'll understand why Health Net is **A Better Decision℠**.

[1] *Fortune Magazine*, May 5, 2008

[2] Accredited July 5, 2006, and valid until July 5, 2009

[3] Listed in November 17, 2008 edition of *US News and World Report*

[4] TRICARE numbers are accurate as of December 2008.



Producer Resource Manual

Our goal is to provide you with the tools you need to conduct business with Health Net. To do this, we have provided a simple, streamlined, and easy way to obtain the information. Ranging from product offerings and new business administration to billing and payment, this producer manual provides a comprehensive overview of what you want – and need – to know.

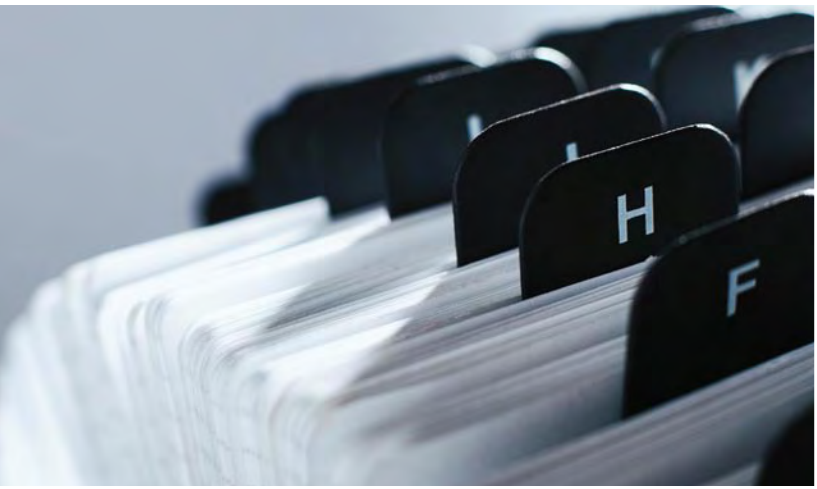
This producer resource manual places helpful information at your fingertips, including:

- Frequently used phone numbers and addresses
- Product information
- Online tools/resources for producers, employers and members
- Wellness and disease management programs
- Product information
- Group and member eligibility information

FOR MORE INFORMATION, CONTACT YOUR HEALTH NET REPRESENTATIVE WITH ANY QUESTIONS YOU MAY HAVE.

SECTION ONE

HOW TO REACH US



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IMPORTANT HEALTH NET PHONE NUMBERS

SUBJECT	PHONE	FAX	EMAIL
Account Services Unit *(Benefits, claims, commissions, eligibility, enrollment, pharmacy coverage & plan information)*	1-800-384-1878 *(groups 2-50 lives)* 1-800-321-5469 *(groups 51+ lives)*	1-203-402-7075 *(groups 2-50 lives)* 1-866-604-0541 *(groups 51+ lives)*	smallbusinessgroup@healthnet.com *(groups 2-50 lives)* asu@healthnet.com *(groups 51+ lives)*
Customer Contact Center *(Member Inquiries)*	1-800-441-5741 1-888-747-2424 (TDD)	1-203-402-7057	member@healthnet.com
Account Installation & Renewal Team *(New case installation/ processing & renewal plan changes for SBG groups with under 50 lives)*	1-888-595-6454	1-203-225-3274	SBGNewBusiness@healthnet.com SBGRenewalBusiness@healthnet.com
Appeals and Grievances	1-888-747-8494	Grievances: 1-203-225-9874 Appeals: 1-203-225-9870	
Authorization and Provider Services	1-800-438-7886	1-800-916-9029	
Broker Commissions	1-800-848-4747 (ext. 8685 or 8953)	1-203-225-4023	broker.comm-sgb@healthnet.com *(groups 2-50 lives)* *broker.comm-ne@healthnet.com (groups 51+ lives)*
Broker Licensing and Compliance	1-800-848-4747 (ext. 8600)	1-203-225-3204	brokerappointment@healthnet.com
CareCore National *(Prior authorization for diagnostic imaging services)*	1-800-420-3471	1-845-298-1490	
CVS Caremark	1-888-624-1139 1-866-236-1069 (TTY)		
Decision Power℠ Program	1-800-893-5597 1-800-276-3821(TTD)		
Finance *(Billing Concerns and Questions)*	1-877-701-8067	1-800-208-6962	smallgroupbillingar@healthnet.com
Landmark Healthcare *(Acupuncture and Chiropractic Care)*	1-800-638-4557	Claims: 1-888-565-4237 Treatment Plan: 1-800-599-8350	
Managed Health Network *(Mental Health & Behavioral Health Services)*	Benefits and Eligibility: 1-800-728-9899 Claims: 1-800-444-4281		
OrthoNet *(Physical Therapy & Occupational Therapy)*	1-800-413-8695	Authorization Requests: 1-800-450-4189	
Predetermination of Fees		1-203-402-7056	
Quest Diagnostics *(Diagnostic Laboratory Testing Services)*	Billing: 1-800-631-1388 Locations: 1-800-225-7483		
Pharmacy Department		1-203-225-3232	
Regional Sales Offices	1-203-402-4200 (CT) 1-212-856-4664 (NY) 1-732-353-7358 (NJ)	1-203-225-3320 (CT) 1-212-856-4560 (NY) 1-732-353-7501 (NJ)	

IMPORTANT HEALTH NET ADDRESSES

ADDRESSES FOR CASE SUBMISSIONS (2-50 Lives)

New Business Office	Account Management Office
Health Net of the Northeast, Inc. ATTN: New Business Office One Far Mill Crossing P.O. Box 904 CT-900-03-61 Shelton, CT 06484	Health Net of the Northeast, Inc. ATTN: Account Management Office One Far Mill Crossing P.O. Box 904 CT-900-03-61 Shelton, CT 06484

ADDRESSES FOR ENROLLMENT CHANGES (FOR EXISTING BUSINESS)

Health Net of the Northeast, Inc.
ATTN: Enrollment Services
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484

ADDRESSES FOR BILLING AND PAYMENT

DIRECT ADDRESSES	OVERNIGHT ADDRESSES
Bank of America **Health Net of Connecticut, Inc.** P.O. Box 30626 Hartford, CT 06150-0626	**Bank of America** **Health Net of Connecticut, Inc.** Lock Box # 30626 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108
Bank of America **Health Net of New York, Inc.** P.O. Box 19017 Hartford, CT 06150-9017 (For NY Charter plans) **Bank of America** **Health Net Insurance of New York, Inc.** P.O. Box 31965 Hartford, CT 06150-1965 (For NY Outlook POS, NY Outlook EPO, and NY Outlook HSA plans)	**Bank of America** **Health Net of New York, Inc.** Lock Box #19017 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108 (For NY Charter plans) **Bank of America** **Health Net Insurance of New York, Inc.** Lock Box #31965 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108 (For NY Outlook POS, NY Outlook EPO, and NY Outlook HSA plans)
Bank of America **Health Net of New Jersey, Inc.** P.O. Box 30599 Hartford, CT 06150-0599	**Bank of America** **Health Net of New Jersey, Inc.** Lock Box #30599 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108

Note: Be sure to include your group plan number on all correspondence that is sent to our office. This provides prompt identification and processing.

ADDRESSES FOR CLAIMS SUBMISSIONS	
MEDICAL CLAIMS **ACS/Health Net** P.O. Box 14700 Lexington, KY 40512	**BEHAVIORAL HEALTH CLAIMS** **MHN/HMC Claims** P.O. Box 14621 Lexington, Kentucky 40512-4621
CHIROPRACTIC CLAIMS **Landmark** 1750 Howe Ave., Suite 400 Sacramento, CA 95825	**CLAIMS RESUBMISSION** **ACS/Health Net** P.O. Box 14700 Lexington, KY 40512

Note: Questions about claims can be directed to the Customer Contact Center number on the back of the member's ID card.

MISCELLANEOUS ADDRESSES	
PREDETERMINATION OF FEES **Health Net - Provider Services Unit** ATTN: Predetermination of Fees P.O. Box 904 Shelton, CT 06484	**COB QUESTIONNAIRE** **Health Net of the Northeast, Inc.** ATTN: COB P.O. Box 904 Shelton, CT 06484
MAIL ORDER PHARMACY SERVICES **CVS CAREMARK** P.O. Box 94467 Palatine, IL 60094-4467	**APPEALS AND GRIEVANCES** **Health Net of the Northeast, Inc.** ATTN: Appeal and Grievance Unit One Far Mill Crossing P.O. Box 860, FMC B224 Shelton, CT 06484 *(For Hand Delivered Requests)* **Health Net of the Northeast, Inc.** Karen A. Coughlin Building, Second Floor 100 Beard Saw Mill Road Shelton, CT 06484

SECTION TWO

PRODUCT PORTFOLIO

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HEALTH NET PRODUCT PORTFOLIOS

Health Net offers two comprehensive portfolios of medical products that include POS, EPO, HMO, PPO and HSA plan options. Our Outlook and Charter portfolios were created to meet the needs and budgets of today's employer. We offer a comprehensive array of preventive care services and wellness initiatives that are covered as in-network benefits.

PRODUCT OFFERING BY STATE				
Product Line	**Plan Type**	**New York**	**New Jersey**	**Connecticut**
Outlook Product Portfolio	POS	•	•	•
	EPO	•		
	HMO		•	•
	PPO	•	•	•
	HSA	•	•	•
Charter Product Portfolio	POS	•	•	•
	EPO	•		
	HMO	•	•	•
	PPO	•	•	•

OUTLOOK℠ PORTFOLIO HIGHLIGHTS (HMO, EPO*, POS, PPO, HSA)

Health Net's Outlook Portfolio consists of plans that offer long term cost control and benefit planning strategies to employers.

- Available in New York, New Jersey and Connecticut.
- Greater rating flexibility for both new and renewing groups.
- Flexibility to choose from various pharmacy riders, including options that incorporate a deductible.
- Increased product flexibility with in-network deductibles and coinsurance, or higher copayment options.
- Open access — no referrals necessary to see a contracted specialist.
- Access to our broad and seamless Tri-State Advantage Platinum Network with over 140,000 provider locations.
- Flexibility to offer dual and triple options within the same group.
- Pre-existing conditions provision for qualified Outlook POS and EPO plans.

*EPO not available in New Jersey and Connecticut.

OUTLOOK℠ PLAN OPTIONS

We offer the following plan options in our Outlook Product Portfolio:

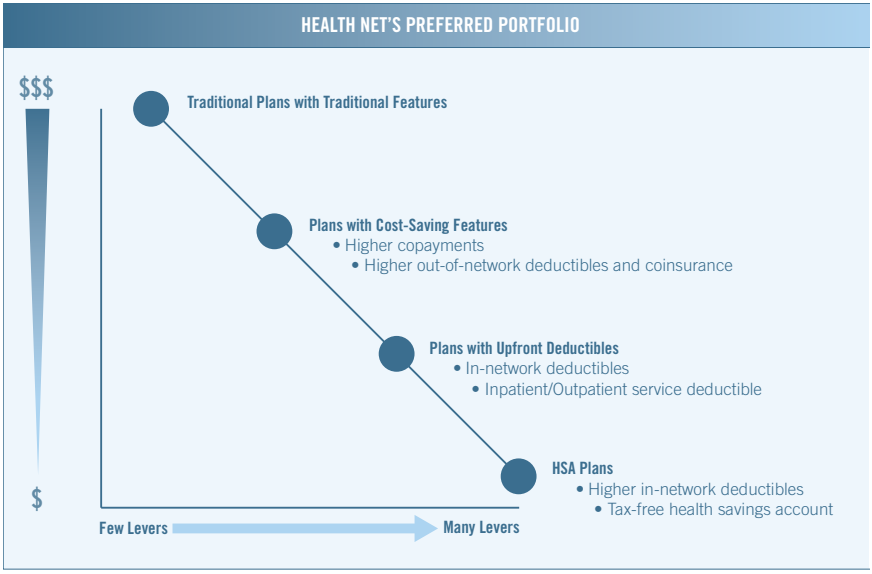
Outlook POS: Same as a traditional POS but with flexible cost-saving features, such as higher copayments and in-network deductibles and coinsurance.

Outlook EPO: An in-network product with flexible, cost-saving features, such as in–network deductibles and coinsurance.

Outlook HMO: An in-network product with cost-saving options, such as higher copayments, split copayments, and in–network deductibles.

Outlook PPO: Option for employees residing outside of the Health Net tri-state coverage area*. Open access with no referral necessary and access to our regional proprietary Advantage Platinum Insurance Network as well as access to our National PPO network through First Health.

Outlook Health Savings Account (HSA): A tax-advantaged health savings account with a high-deductible health plan. Plans are differentiated by deductibles and coinsurance. Bank of America is our preferred partner for HSA plans.



We provide the "levers" that allow employers to select the best plans and costs for their companies.

CHARTER PORTFOLIO HIGHLIGHTS

Health Net's Charter Portfolio encompasses our more traditional plan designs, which include richer benefits without cost sharing. We offer the following plan options in our Charter Product Portfolio:

Charter POS

- Freedom to visit any licensed provider and be eligible for benefit coverage, with higher out-of-pocket expenses for services from non-network providers.
- Out-of-network coverage is subject to deductible and coinsurance.

Charter HMO

- High level of coverage and convenience for covered services with access to our broad and seamless Tri-State Advantage Platinum Network, with no claim forms and no deductibles.
- Offered in some states with unique features, such as a hospital services deductible or an up-front deductible (applies to all services except preventive care) intended to provide the benefits expected from an HMO with innovative cost-saving features.

Charter Out-of-Area PPO

- Option for employees residing outside of the Health Net tri-state coverage area.*
- Access to our regional proprietary Advantage Platinum Insurance Network as well as access to our National PPO network through First Health.
- Open access – no referral necessary.
- Well-suited for multi-site employers and designed to allow for single plan administrator.
- One rate for all out-of-area PPO employees based on group's headquarter location.

AVAILABLE RIDERS FOR OUTOOK AND CHARTER PORTFOLIOS

We offer a variety of riders for our employers to choose from. Rider availability differs by product offering, state and group size.

- Domestic Partner coverage
- HIAA Buy-Up
- Pharmacy
- Increase Dependent Age rider
- Unlimited DME
- Additional 10 or 20 Outpatient Mental Health Visits
- Vision
- Unlimited Mental Health Services to treat biologically-based conditions
- Maximum Charge Limit

* Tri-state coverage area includes all of CT, NJ and selects counties in downstate NY. The only exception would be for qualified dependents of a divorce decree.

SECTION THREE

NETWORK

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NETWORK

With a physician network comprised of over 161,000 provider locations, Health Net is one of the largest networks in the Northeast.

Health Net's Advantage Platinum Provider Network

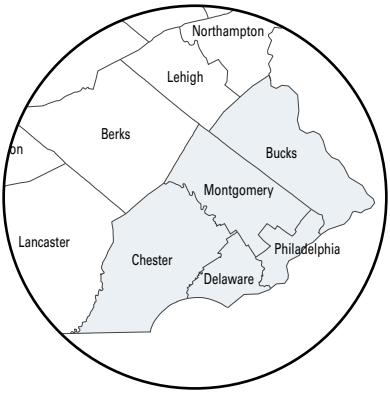
Our HMO and POS members in the Northeast enjoy access to our seamless Tri-State Advantage Platinum Network, encompassing 161,000 physician locations and 245 hospitals.*

NEW YORK

Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester Counties

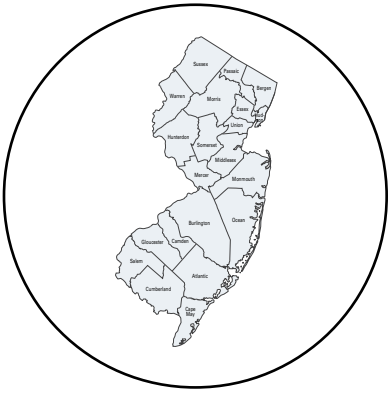
PENNSYLVANIA

Bucks, Chester, Delaware, Montgomery and Philadelphia Counties



NEW JERSEY

All Counties



CONNECTICUT

All Counties

*As of January 2009

ADVANTAGE PLATINUM NETWORK		
	Provider Locations	Hospitals
NY	72,801	102
NJ	40,068	80
CT	31,559	32
PA	17,289	32
TOTAL	161,717	246

Health Net's Advantage Platinum Insurance Provider Network

- Available to PPO members seeking services within our service area and New Jersey Outlook members enrolled in Outlook POS plans.
- Over 159,900 provider locations
- 244 hospitals
- Health Net proprietary network

First Health National PPO Provider Network

- Network for out-of-area PPO members
- Approximately 527,375 doctors and health care professionals in all 50 states plus Puerto Rico.
- 4,545 hospitals
- Emergency services are covered worldwide.
- First Health is available for groups with PPO members residing outside of the New Jersey, Connecticut or New York service area.

Laboratory Network Through Quest Diagnostics

Access to an extensive network of laboratories selected for quality of care, accessibility, administrative capabilities and cost effectiveness.

Pharmacy Through Caremark, Inc.

58,000 pharmacy locations nationwide, including most local, independent pharmacies as well as all nationally known chains. Mail-order prescriptions are available through CVS Caremark.

Mental Health / Substance Abuse Network Through Our Subsidiary MHN, Inc.

Comprehensive inpatient and outpatient network with almost 45,000 practitioners, including physicians, licensed therapists, social workers, psychologists, and various facility-based providers, as well as 1,400 hospitals and facilities. Comprehensive services available as standard and non-standard benefits, including an EAP program with various options.

All Network Counts are valid as of January 2008.

Holistic Health Care Network Through Landmark Healthcare, Inc.

Quality, affordable coverage for holistic treatments, including acupuncture, chiropractic and a discount program for massage therapy.*

Health Net Transplant Network

Expert facilities for complex transplant procedures, including heart, liver, and lung, both in our service area and throughout the country when medically necessary and otherwise covered.

* Massage therapy discount program is subject to change or termination without notice.

SECTION FOUR

CUSTOMER SERVICE

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CUSTOMER SERVICE

At Health Net, customer service is at the heart of everything we do. Read below to learn more about the services we provide to our brokers, employers and members.

Customer Service for Producers and Employers

Health Net employs a team approach to implementing new business and servicing accounts.

The New Business Team includes Account Executives, Broker Advisors and Account Service Representatives who support General Agents and Brokers with all new business needs. The Account Management Team includes Account Managers and Account Service Representatives that provide assistance with all account management needs.

MONDAY TO FRIDAY, 9:00 AM TO 4:30 PM	
MAIN OFFICE	**REGIONAL OFFICES**
PHONE: 1-888-595-6454 **FAX:** 1-203-225-3274	**CT PHONE:** 1-203-402-4200 **CT FAX:** 1-203-225-3320 **NY PHONE:** 1-212-856-4664 **NY FAX:** 1-212-856-4560 **NJ PHONE:** 1-732-353-7358 **NJ FAX:** 1-732-353-7501
• Case Installation • Case Processing	• Marketing materials • Enrollment packets • Plan information • Enrollment meetings • Assistance with quotes

Account Services Unit (ASU) for Producers and Employers

An additional resource available to you and your clients is our Account Services Unit. This is a specialized unit within our Customer Contact Center that is comprised of specially trained, seasoned customer service professionals. It is designed to assist our employer groups, their brokers/consultants and/or benefits staff. Their primary goal is to provide our clients and brokers with one-call resolution for the day-to-day administrative issues (e.g., claims questions, enrollment issues, eligibility inquiries, etc.) that may arise. Each Account Service Coordinator on this team is cross-trained in claims and customer service and is empowered to adjudicate claims for immediate response.

Contact the Account Services Unit for the following:

- Responses to general inquiries on member benefits and claims
- Commissions, Broker of Record (BOR) changes, tax ID changes
- Billing inquiries
- Claim inquiries
- Enrollment and eligibility information
- Plan administration
- Plan information and materials
- Pharmacy coverage – prior-authorization, Health Net Preferred Drug List (PDL)
- Information on policies and procedures

ACCOUNT SERVICES UNIT MONDAY TO FRIDAY, 8:00 A.M. TO 5:00 P.M.	
GROUPS 2-50 LIVES	GROUPS 50+ LIVES
Phone: 1-800-384-1878 Fax: 1-203-402-7075 Email: smallbusinessgroup@healthnet.com	Phone: 1-800-321-5469 Fax: 1-866-604-0541 Email: asu@healthnet.com

Customer Service for Members

Customer service at Health Net begins with carefully selected, experienced, courteous and knowledgeable staff. Customer Contact Representatives receive extensive classroom and on-the-job training for a superior understanding of our products and services, but also to reinforce excellent customer service skills. Once on the job, continued coaching and call monitoring ensures prompt, accurate and friendly service. A higher level of quality service is achieved through:

- "One-stop shopping" approach to customer service. Representatives are extensively trained to ensure that they can handle all types of customer issues, thus eliminating confusion over whom to call, as well as reducing inconveniences related to call-transfers and call-holding times.
- State-of-the-art Call Center technology.
- Automated call-tracking software that allows us to report on recurring issues and trends, on a plan-wide basis or for a specific employer group. Such information is invaluable for developing benefit plans, customer materials, and educational programs.
- 24-hour access via the Interactive Voice Response (IVR) unit and **www.healthnet.com**. Callers can check eligibility/plan information, check copayment information, order ID cards, order an EOC (for terminated members), request materials, primary care physician changes and name and address changes, and check claims status.
- Tele-Interpreters to assist non-English-speaking members, with the advantage of being able to speak to a representative in a specific language.
- Formal member appeal process to provide quick solutions.
- Prospective member call unit.
- Outbound calls for issue resolution follow through.

Health Net's Customer Contact Center
Monday to Friday, 8:00 a.m. – 6:00 p.m.
1-800-441-5741
1-888-747-2424 (TDD)

Health Net is partnered with AT&T's USA Direct® Service, which provides toll-free, country-specific access numbers, connecting callers to a special number dedicated to serving Health Net members. Availability of this benefit is in sync with the call center hours of operation in their home region. To find your country specific number, please visit **http://www.usa.att.com/traveler/index.jsp.**

SECTION FIVE

HEALTH AND WELLNESS PROGRAMS

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DECISION POWER℠: HEALTH IN BALANCE

Decision Power℠ is our Whole Person Strategy that unifies programs from wellness to disease management to complex care. Our approach breaks down the traditional disease and condition focused silos to address the needs of the whole person and the entire spectrum of health. Decision Power includes:

- **Health Coaches** are specially trained healthcare professionals such as nurses, dietitians and respiratory therapists who provide unbiased, evidence-based health information and coaching support. Health Coaches rely on standard-setting, proprietary methods of risk identification and predictive modeling to provide outreach and support where it can have the greatest impact.

- **Support videos** that contain testimonials from others who have faced similar treatment decisions and have chosen different treatment courses. Videos are made available to members based on need and appropriateness.

- **Information Resources** provide recommendations on the latest fact-based medicine and include an encyclopedia of health information that is easy to understand. These information resources include:

  - **Shared Decision-Making®:** programs contain unbiased information organized around Preference-Sensitive Decisions.
  - **Healthwise® Knowledgebase:** a health information database available in English and Spanish
  - **Health Crossroads® Web Modules:** an online decision support tool to help members understand and think through the pros and cons of their treatment options supported by streaming videos and decision quality tools.
  - **HEAR® Audio Library:** up-to-date recorded information on hundreds of health topics.

- **Online Tools** allow members to compare hospitals, research medications and track their symptoms. These online tools include:

  - **Hospital Comparison Report:** a hospital comparison tool that provides easy-to-read reports based on select criteria
  - **Medical Group Comparison Report:** a comparison report based on the quality of care and service.
  - **Drug Pricing Tool:** allow members to determine drug coverage and affordable alternatives approved by their physician.
  - **Health Risk Questionnaire:** online survey that identifies potential conditions early and includes recommendations about preventing health problems; members are encouraged to share results with their physician
  - **Symptom Diaries:** enables members to track and monitor conditions over time. Diary can be shared with a Health Coach and physician.
  - **Medication Record:** helps track medications

Decision Power℠ includes initiatives in the following areas:

- Wellness and Health Promotion
- 24/7 Urgent Needs Support
- Chronic Condition Management
- Complex Care Support

WELLNESS AND HEALTH PROMOTION

Health Net understands that change is difficult, and unless someone is willing to modify behaviors — eat healthier food, exercise regularly, quit smoking — no approach will be effective. That's why evaluating each individual's readiness to change is an essential component of our enhanced Health Risk Questionnaire (HRQ). The HRQ serves as the gateway to health promotion — offering relevant resources online, by phone, by secure messaging — to meet the members where they are.

Enhanced HRQ – Since 2006, members have used the first generation HRQ, powered by WebMD®. Beginning April 2008, members have access to an enhanced HRQ. New features and benefits include:

- Interactive, personalized summary that allows members to see instantly how lifestyle changes can reduce risk for future health problems.
- Enhanced, personalized reports for modifiable risk factors such as weight, nutrition, and stress — with relevant links to resources.
- More sophisticated, personalized reports on conditions such as cancer, depression, heart disease.
- An extensive reporting package for employers (minimum thresholds may apply).

Personal Health Record – This member health record is populated with HRQ results, imported lab and claims data, and member self-reported information. The tool translates all data into consumer-friendly terms. Powered by WebMD®, the tool is secure and consumer-controlled.

Wellness Programs – Decision Power℠ can help its members become more active participants in making healthy decisions with programs addressing smoking cessation, weight management, fitness, nutrition, stress management, cholesterol management, blood pressure management, and healthy pregnancy. New features and benefits include:

- Personalized calls from a Health Coach, who is a trained health professional, such as a nurse or dietitian. Members have unlimited access to our health coaching line, 24 hours a day, seven days a week.
- Online, secure, and private message exchange with a Health Coach.
- Comprehensive online programs and tracking tools.

To reach a Health Coach or for more details about the Decision Power Program please call:
1-800-893-5597 or 1-800-276-3821(TTD)

Member Discounts – Health Net offers an extensive array of "Well Rewards" discounts on products and services that are not covered medical benefits. Discounts are offered for:

- Acupuncture
- Children's Health Products and Services
- Chiropractic
- Emergency Medical Information Service
- Eye Exams, Glasses, Contacts and LASIK
- Fitness Clubs
- Fitness Equipment and Apparel
- Hearing Aids and Screenings
- Healthy Living Books, Magazines and Videos
- Pregnancy and Childbirth
- Relaxation and Massage Therapy
- Relaxation Products
- Senior Health
- Vitamins, Herbs and Supplements
- Weight Management

24/7 SUPPORT

Health Coaches, specially trained professionals such as a nurses, respiratory therapists or dietitians, are available 24 hours a day, 7 days a week, to help members understand their treatment options and provide useful information and decision-making support.

CHRONIC CONDITION MANAGEMENT

Health Coaches, specially trained professionals such as a nurses, respiratory therapists or dietitians, are available 24 hours a day, 7 days a week, to help members understand their treatment options and provide useful information and decision-making support. Decision Power℠ can help members address chronic conditions including:

- Asthma
- Diabetes
- Heart failure
- Chronic obstructive pulmonary disease
- Coronary heart disease
- Other conditions including back pain, osteoarthritis, uterine fibroids and prostate and uterine cancers.

The results of our 2007 Health Net of the Northeast Decision Power℠ Member Satisfaction Survey indicate 91 percent of all Decision Power℠ users would recommend Health Net to family and friends and 84 percent of users stated that speaking with Decision Power℠ Health coaches made the quality of care they received from their providers better or much better.

COMPLEX CARE SUPPORT

Members with care needs that require an intensive level of service are referred to the Complex Case Management (CCM) Program. Patients may have multiple co-morbidities, terminal diagnoses, several providers of care, and be experiencing psychological, social, and financial upheaval.

The CCM Program's collaborative approach facilitates communication among patients, their families, treating physicians, and other providers of care. The goal is to support the treating physician's care plan and complement case management.

The program provides consistent, regular, psychosocial and environmental support to patients and their families through a single community-based nurse care manager who is supported by a clinical team of nurses and physicians.

Patients indicate significantly better pain and symptom management compared to usual care, and a significantly higher percent of patients die at home (patient preference). Survey results also indicate 95 percent patients (and families) satisfied with the program and would recommend it to others and 80 percent report improved quality of life.

SECTION SIX

PHARMACY PROGRAM

6

THE HEALTH NET PHARMACY PLAN

This section will help to explain the Health Net pharmacy benefits, including some important elements, such as our preferred drug list and prior authorization.

Health Net pharmacy plan benefits are divided into three tiers. These tiers are designed to give member maximum flexibility in choosing the drug that fits their personal needs and budget, particularly when alternatives are available.

MEMBERS WITH A THREE TIER PHARMACY BENEFIT	
THEIR PRESCRIPTION IS FOR A:	**MEMBER PAYS:**
Generic drug	The lowest copayment (Tier 1)
Brand name drug on the Preferred Drug List with no generic equivalent	The moderate copayment (Tier 2)
Brand name drug on the Preferred Drug List with a generic equivalent or a drug not on the Preferred Drug List	The highest copayment (Tier 3)

Some prescription drug benefits include a Maximum Allowable Cost (MAC). With MAC A, if a member chooses a brand name drug when it has a generic equivalent, they may be required to pay the highest tier copayment plus the difference in cost between the generic and the brand name drug. (Member should check their benefits for details.)

MAC A – Available in Connecticut (except for HSA plans which include an integrated pharmacy benefit as part of the medical plan)

- If the member receives a brand name drug and there is a generic drug equivalent available, the member pays the prescription copayment (Tier 3) plus the difference in cost between the brand name and generic drug, regardless of whether the participating physician specifies "Dispense as Written" (DAW) on the prescription order.
- If the member's physician and Health Net agree that a brandname drug with a generic equivalent is medically necessary and appropriate and Health Net prior authorizes the use of the brand name drug instead of the generic drug equivalent, the member will pay only the Tier 3 copayment.

MAC C – Available in New York and New Jersey

- Plan does not discipline covered individuals for choosing a brand name drug when a generic equivalent is available. Covered individuals pay the appropriate copayment for the prescription with no additional charges.

What Members Should Do To Ensure Prescription Coverage

- Work with their doctor to determine if the drug requires prior authorization or has other limitations or restrictions in accordance with their prescription drug benefit.
- View their prescription coverage online by logging in to **www.healthnet.com**, or call the Pharmacy Information number on their Health Net ID card. In addition, a staff member in the doctor's office may be willing to verify coverage for the member.

Factors that May Affect Costs

- Some prescription drug benefits include a deductible that must be paid before the plan begins to cover prescriptions.

The Health Net Preferred Drug List

The Health Net Preferred Drug List (PDL) is a comprehensive list of prescription drugs approved for use by Health Net members. It is regularly reviewed and updated by our Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is a panel of clinicians and practicing doctors, representing a broad spectrum of medical specialties, including Cardiology, Infectious Disease, Internal Medicine, Behavioral Health, and Pediatrics. The committee considers questions like: *How well does the medicine treat the illness? How many people have used the medicine? How safe is it? Compared to similar, less expensive medicines, does it work better, the same, or worse?*

To find out what medications are on the PDL, log in to **www.healthnet.com** and go to the *Pharmacy Info* section.

Health Net Pharmacy Network

We contract with pharmacies throughout the Northeast to ensure that when a member needs medication, they won't have far to go. Pharmacies that belong to our network include local and national chains, such as CVS, Walgreens, Wal-Mart, Target, Rite Aid, Pathmark, Stop and Shop and Duane Reade. To find a Health Net pharmacy, members can log in to **www.healthnet.com** for the names of 63,000 participating pharmacies throughout the United States or reference a Health Net Directory of Physicians and Providers.

Prior Authorization

Prior authorization is the process of obtaining approval from Health Net for certain prescriptions before they are eligible for coverage. As part of this process, members may be required to try one or more prerequisite medicines first before another medication will be covered. Prerequisite and prior authorization drugs are FDA approved to treat the same condition. Prior authorization helps ensure the appropriate use of medications and may even lower a member's copayment.

Drugs That Require Prior Authorization

Our P&T Committee determines which drugs are subject to our prior authorization program. To obtain the most up-to-date listing, members can log in at **www.healthnet.com** > View Prescription Coverage >Northeast > View our Drug Lists > Individual, Family and Group (non-Medicare). The web site contains the most current version of the prior authorization list.

There Are Reasons a Prescription May Require Prior Authorization:

- Drug Utilization Review may occur at the pharmacy. This is a safety alert that is intended to warn the pharmacist and doctor about potential problems posed by select medications.
- Certain injectable drugs require prior authorization and need to be obtained through a Specialty Injectable Pharmacy.
- The member may not currently have coverage for non-preferred drugs in their outpatient prescription drug benefit.
- The quantity of the prescription may be outside normally accepted doses and/or directions.
- Medical policy guidelines may recommend alternatives for certain drugs.

Approval Process for a Drug Requiring Prior Authorization

In order to be approved, members should do the following:

1. Contact the prescribing physician.
2. Doctor must provide medical evidence, via a fax form, that the requested drug is medically necessary for the member's condition, or that a preferred drug has failed to be an effective treatment for the member, that the member has experienced adverse effects from the preferred drug, that changing therapy to a covered medication would be medically inappropriate. The prescribing physician will forward a completed Prior Authorization Request Form, along with any relevant documentation, to Health Net Pharmaceutical Services for review at 1-800-977-8226. Physicians can obtain prior authorization forms by contacting the Prior Authorization Unit or through Health Net's Provider web site.
3. After comparing the information given in the request to the established prior authorization criteria, a decision is made. Decisions will be made once all information required has been submitted with the request. If the request is urgent, the review can be completed quicker depending upon the information provided in the fax.
   Turn around times vary by state:
   CT - 48 hours for routine requests and 24 hours for urgent requests
   NJ - 24 hours for routine requests and 24 hours for urgent requests
   NY - 72 hours for routine requests and 24 hours for urgent requests
4. New members may complete a Prior Authorization Override Form for some medications in order to obtain a 30-day override while their provider submits the necessary requests to Health Net.
5. If the prior authorization request is approved, the pharmacy will be able to bill Health Net directly and the member will be required to pay the applicable copayment based on their specific plan as defined in their Evidence of Coverage.
6. If the prior authorization request is denied, the member and the prescribing physician will be notified in writing of the decision and informed of the appeal process.
7. If the member obtains a drug that requires prior authorization without getting one first, he or she may be responsible for the entire cost of the drug.

Determination of Medical Necessity During the Prior Authorization Process

Medical necessity is determined based on the physician's chart records, previous drug therapy, and other pertinent data, such as laboratory results.

To Check the Status of a Prior Authorization Request

Members can call the doctor's office or the Customer Contact Center at the number on the back of their Health Net ID card.

How Members Can Save Money

How can members save money, and still get the medication they need? They should ask their doctor or pharmacist if the prescribed medication is on our Preferred Drug List. If it isn't, they should ask if there's a preferred alternative. If the prescription is for a brand name drug, members should ask if there is a generic alternative available. When it comes to affordability in a pharmacy benefit, nothing can help more than the substitution of generic for brand name drugs. The brand name is the name under which the drug is marketed and sold. If there is an existing patent, the drug will not be available as a generic. But once a patent expires, any drug manufacturer obtaining FDA approval can sell the drug, usually at a much lower price, under its generic name. All generics are FDA-approved and equivalent to their brand name counterparts in safety, strength, quality and performance. And finally, another cost-saving option our members have is our Prescription Mail Order Program (CVS Caremark) for a member's maintenance medications, depending on their prescription drug benefit.[1]

How Mail Order Saves Money

For most plans, members pay only two retail copayments for each three-month supply. For example, if a medication requires a $15 copayment per month under the retail prescription drug benefits, a three-month mail order supply would require $30, rather than $45 at retail. (Members should check their benefits for details.)[1]

HEALTH NET'S PRESCRIPTION BY MAIL DRUG PROGRAM

Health Net's prescription mail order program offers:

- **Convenience**: home delivery for most of maintenance prescription needs. "Maintenance medications" are drugs needed for chronic or long-term conditions, such as high blood pressure or high cholesterol.
- **Savings**: for most plans[1], this means a three-month supply of a drug for the copayment of only two months.

Who Is Eligible

Most members with prescription drug benefits are eligible. Members should check their plan documents to see if they are eligible.

What is Covered

Most maintenance medications that by law require a doctor's prescription, and are covered under the member's prescription drug benefit, are covered. Certain controlled substances and all drugs that require prior authorization may be subject to dispensing limitations according to the pharmacy prescription plan and/or the professional judgment of the pharmacist and/or state laws/regulations. Certain injectable drugs require prior authorization and need to be obtained through a Specialty Injectable Pharmacy. If members have any questions, they should call the toll-free Customer

[1] Members should refer to their Evidence of Coverage (EOC) for benefit plan terms and conditions.

Contact Center number listed on their Health Net ID card, or go to **www.healthnet.com**. Note, the mail order prescription service is designed to complement, not replace, the existing Health Net pharmacy network.

How To Use The Prescription Mail Order Program

Members should:

1. Ask their doctor for a prescription. By law, CVS Caremark can only fill a prescription with the quantity indicated. Generally, the maximum mail order benefit is a ninety day supply at a time.

EXAMPLE
1 tablet/capsule a day = 90 tablets/capsule
2 tablets/capsules a day = 180 tablets/capsules
3 tablets/capsules a day = 270 tablets/capsules

2. Examine the prescription for the proper dosage, as well as the doctor's signature, state license number and DEA number. Members need to make sure that their full name is on the prescription.
3. Complete an order form and patient profile questionnaire, and be sure to include their Health Net identification number on the order form. Members can obtain an order form by calling Customer Contact at 1-800-441-5741 or directly on the Internet at **www.healthnet.com.** The patient profile will only need to be completed with the first order. List all allergies, drug sensitivities and health conditions. Members should answer "none" if none applies.
4. Mail the completed order forms, original prescriptions (no photocopies) and their copayment(s) to CVS Caremark.
5. Allow at least 14 days from the day they mail their order for their prescription. Prescriptions will be delivered at no charge to the member, most by first-class mail directly to their home. There is a charge, however, if overnight mail service is selected. Medication(s) will arrive in a plain, weather-resistant package, ensuring its safety, security, and privacy.
6. Place their refill order at least 14 days prior to the time their current supply of medication runs out. This can be done via Internet, phone, or mail-in refill form included with their first order. Only the refills authorized by their physician can be filled. Members can also determine when their prescription is refillable from their prescription bottle, which displays the date that they can order their next refill, or at **www.healthnet.com** > View Prescription Coverage > Manage Your Prescriptions > Get prescriptions by mail. Mail order gives members access to a pharmacist 24 hours a day for any questions they may have. They can also check on the status of a prescription 24 hours a day via Internet, or by speaking to a mail order representative.

Members can contact CVS Caremark customer service at:
1-888-624-1139
1-866-236-1069 (TTY)

Health Net's Informed Choice Program

Our Informed Choice Program offers periodic member mailings which highlight simple tips and alternatives that could potentially result in lower out-of-pocket pharmacy costs. The Informed Choice program includes:

- Member mailings regarding our new tablet-splitting program where a member can split a higher dose tablet in half to equal their prescribed daily dose (for Connecticut and New Jersey groups only).
- Member mailings regarding generic alternatives versus more expensive brand-name drugs (for groups in all three states).

Member Online Tools

Members have access to our industry-leading tools for confident decision-making by logging in to **www.healthnet.com**. They can:

- Instantly locate any of over 63,000 participating pharmacies throughout the United States.
- Compare drugs according to drug price, and plan-related copayments.
- Enroll in the mail order program, as well as refill orders and check on an order status.
- Research drugs for uses, side effects and potential drug-to-drug interactions.
- Download forms or complete copies of the Health Net Preferred Drug List and Prior Authorization List.
- Access a host of health and wellness resources.
- Get up-to-date information about prescription drugs, over-the-counter medications, and supplements, as well as prescription history monitoring, drug interactions and more from the Medication Center.

Our prescription drug benefits and pharmacy programs allow our members to make the final decisions that affect their health and finances. Should members have questions about side effects, proper usage and alternative drugs for a prescription, they should ask their doctor or pharmacist. For additional questions about their prescription drug benefits, members should call the Pharmacy Information number on their Health Net ID card.

SECTION SEVEN

WEBSITE: WWW.HEALTHNET.COM

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WEBSITE: WWW.HEALTHNET.COM

The portals on **www.healthnet.com** provide reference information and online tools that offer producers, employers and members the ability to access different resources pre- and post-login.

Register Now

Producers who do not have a user name and password can register online at Health Net's home page, **www.healthnet.com**, and follow these simple steps:

1. Go to **www.healthnet.com**.
2. Click on the Broker portal.
3. Click on the "Register Now" button.
4. Fill in the requested information.
5. Begin to navigate the Health Net website.

Note: In the case of affiliated partnerships between GAs and Brokers, a GA should register prior to the broker in order to view all account information. Once a brokerage firm (and GA if applicable) is registered, all staff may then register and have full access to information.

Producers can also call the Customer Contact Center for assistance in obtaining a user name and password instantly.

WHAT PRODUCERS CAN DO ONLINE

PRE-LOGIN

Visit Home page by Region
Access Plan Information
Download Forms and Brochures
Conduct Doctor Search
Get Appointed
Compare Plan Costs
Secure Messaging
View Pharmacy Information

POST-LOGIN

Access Broker Tools
- Become Appointed
- View/Download/Print Forms, brochures and logos
- Read Newsletters and Communications
- Learn About Incentive Program
- Update Account
- Access Commissions and Compensation Statements (SBG only)
- Access Renewal Information (SBG only)

Access Employer Tools
- Verify Member Eligibility
- View Online Billing and Enrollment Demo
- View Bill

Access Member Tools
- Decision Power - Wellness Programs
- Compare Plan Costs
- Decision Power Information

See Our Plans
- Employer Sponsored Plans Descriptions
- Medicare Plan Descriptions
- Pharmacy Information

WHAT EMPLOYERS CAN DO ONLINE

PRE-LOGIN

Chose the Right Plan - See Our Plans
Conduct Doctor Search
Compare Plan Costs
Secure Messaging

POST-LOGIN

Answer Employee Questions
- Doctor and Hospital Search
- Eligibility and Copayments
- Preferred Drug List
- Contact Us
- Compare Plan Costs

Access Member Tools
- Information on Member Programs
- Decision Power – Wellness Programs
- Hospital Comparison Report

Get Things Done
- Add a New Member
- Terminate a Member
- Change Employee Information
- View and Pay Bill
- Reconciliation
- Email Account Management
- Access eNewsletter Archive
- View/Download Employer Group Manual
- Download Forms

Doctor Search
- Advanced Search, Express Search and More
- Alternative Care
- Dental & Vision
- Behavioral Health

WHAT MEMBERS CAN DO ONLINE

PRE-LOGIN

View Our Drug List and Generics FAQ
Doctor Search
Secure Messaging
Medical Policies
Compare Plan Costs

POST-LOGIN

See My Plan
- Copayments for Family
- Links to HSA Accounts
- PCP Details and Change PCP for Family
- Prior Authorization Lists

View Prescription Coverage
- Prescription Management and History
- Drug Pricer/Pharmacy Copayments
- Prescriptions by Mail Information
- Preferred Drug List

WHAT MEMBERS CAN DO ONLINE

POST-LOGIN (CON'T)

It's Your Life-Wellsite (powered by WebMD®)
- Talk To a Health Coach
- Health Risk Questionnaire
- Medical Encyclopedia
- Preventive Care Guidelines
- Treatment Cost Estimator
- Hospital Comparison Report
- Member Discounts
- Wellness Programs

Get Things Done
- Access Online Forms
- File a Complaint or Grievance
- Email Customer Service
- Inquire About a Claim
- Order ID Cards

Doctor Search
- Advanced Search, Express Search and More

Streamlined access to important administrative functions.

Our website features are designed to provide you quick access to information, tools, and transactions to help support your business.

Our enhanced navigation menu, located on the left side of the page, makes it easy to search the information you need:

Broker Tools provides essential information to help you sell and manage your Health Net book business. This section includes broker appointment information, forms and brochures, incentives programs, an archive of communications, training modules regarding our plans and selling points, Health Net logos and an account management center.

Employer Tools gives you a guest view of key features used by our employers which allows them to add a new member, terminate a member, change employee information, and pay bills online.

There are two ways to access your clients information online. Both require the Employer to grant you access in advance.

- **Read Only Access** – Employers can grant a broker read only access to their Enrollment and Billing information through the Broker Portal.
- **Limited or Full Transaction Access** – Employers can customize a broker's access to perform transactions online through the Employer Portal.

Member Tools gives you access to member tools such as Decision Power and Hospital Comparison Report, and a provides a demo of our brand new It's Your Life℠ – Wellsite
(powered by WebMD®). With It's Your Life-Wellsite, we have partnered with WebMD® to offer our members a robust suite of online tools to help them manage their health care and lifestyle choices. The new site creates a user experience that combines Health Net's proprietary branding with WebMD's industry leading name recognition and quality features, including the following:

- Health Risk Questionnaire (HRQ)
- My Health Personal Health Record (PHR)
- Medication Center
- Disease and Condition Centers
- Wellness Programs
- News and Features
- Treatment Cost Estimator
- Hospital Comparison Report
- Member Discounts (Healthy Discounts)

Doctor Search allows you to search for participating providers and facilities by various criteria, such as type of plan, provider, specialty, physician gender and radius within a specified zip code. Search can be conducted via Express or Advanced Search. It also provides information on participating alternative care, dental, vision, and behavioral health providers.

SECTION EIGHT

HOW TO GET A QUOTE / SUBMIT NEW BUSINESS / RENEW

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HOW TO GET A QUOTE

The following section explains the process you should follow when you obtain quotes for submitting new business cases to Health Net.

Large Business Group (groups of 51 or more employees) new business quotes should submit their quotes to their assigned Account Executive via email.

Small Business Groups (brokers with groups of 2-50 employees) can easily access rates for both new and renewing business by using one of our three online quoting vendors.

ONLINE QUOTING VENDORS

Proposal Generator – Health Net's Proprietary Quoting Tool

Use this valuable tool to create Small Business proposals and benefit summaries for clients in New York, Connecticut and New Jersey. You can access this link by logging in to **www.healthnet.com**:

1. Go to the Broker web site.
2. Select Northeast.
3. Select Broker Tools (left hand navigation).
4. Select Proposal Generator (Note: You can access the tool pre-login.).
5. Follow instructions on page to download Proposal Generator.

HealthConnect Systems – Provides rates for Small Business plans in New York, New Jersey and Connecticut. To access HealthConnect Systems, log in to www.healthconnectsystems.com. You will be required to provide a username and password to log in to the site.

Benefit Central / Insurix – Provides rates for Small Business plans in Connecticut and New York. To access Benefit Central / Insurix, log in to www.benefitcentral.com. You will be required to provide a username and password to log in to the site.

INFORMATION NEEDED TO OBTAIN QUOTES

Please have the following information on hand when requesting a quote:

1. Company name and/or DBA, Address, City, State, Zip
2. Requested effective date
3. Current and/or renewal dates
4. Current Plan Summary (optional)
5. Current Bill and/or renewal letter (consensus information)
6. Carrier history for past 5 years (LBG 51+ lives only)
7. Industry and SIC code (LBG 51+ lives only)
8. Employer contribution for employee and dependant (LBG 51+ lives only)
9. 12-24 months of claims experience (Will be requested when applicable)

10. Census data on all eligible employees (in Excel format if possible)
    - Full name
    - Date of birth
    - Gender
    - Coverage status (single, family, etc.)
    - Home zip code
    - COBRA participants
    - Waivers (including spousal)
    - Part-time employees
    - Retirees
    - Non-Eligible employees

HOW TO SUBMIT A NEW BUSINESS CASE

Case Submission

Large Business Group (groups of 51 or more employees) should submit new cases to your assigned Account Executive.
Small Business Groups (groups of 2-50 employees) should submit new cases to the New Business Office at:

Health Net of the Northeast, Inc.
ATTN: New Business Office
One Far Mill Crossing
P.O. Box 904
CT-900-03-61
Shelton, CT 06484

Fax: 203-225-3274
Email: sbgnewbusiness@healthnet.com

Submission Deadline

Large Business Group (groups of 51+ employees) we recommend that you submit new business cases 45 days prior to the effective date.
Small Business Group (groups of 2-50 employees) should submit new business cases 15 business days prior to the effective date.

Enrollment Processing Reminders

Please note the following for a smooth enrollment for all size groups:

1. Master applications must be completed with all necessary information.
   This includes:
   - Group Name and Mailing address
   - Group Billing Contact
   - Group VIP Contact
   - Group Benefit Contact
   - Billing Method
   - Coverage Effective Date
   - Current Carrier (Prior Carrier #1 & #2)
   - Employer Contribution Amount Toward Employees & Dependents
   - Dependent Age Limit
   - Number of Total Employees
   - Domestic Partner Coverage
   - Number of Covered Employees
   - Number of Eligible Employees
   - Number of Waivers
   - Number of Employees on Cobra

2. No discrepancies with the deposit check. This includes:
   - Make check payable to Health Net, Inc.
   - Amount of Binder Check should equal One Month's Premium

3. Enrollments completed in full
   - Member must print clearly
   - Anyone covering a full time student dependent needs to include the name of the college/university in the student information section.
   - Member and employer signatures are needed on every form
   - Black ink is preferred

4. Quotes:
   - Plan and rate information on the master application must mirror the quote.
   - Include the Health Net Submission Report (2-50 lives only).

5. Miscellaneous Forms:
   - Creditable Coverage Attestation Form and bill from prior carrier for plans with pre-existing condition clauses
   - Transition of Care Form (refer to *Transition of Care* section)
   - Prescription Prior Authorization Form (refer to *Pharmacy* Section)

6. New Jersey SBG cases (2-50 lives) must be submitted with a completed certification form.
   This includes:
   - Listing of all employees on the original effective date of the plan including the dates of hire, job title, number of hours worked and work location
   - Completion of the back of the certification form
   - Signing the certification form in the locations where indicated, in the section stating whether they are non-reform or reform

New Business Case Checklist (for groups of 2-50 employees)
You will need to complete the New Business Case Checklist when submitting a new Small Business (2-50 lives) case to Health Net. Please contact your representative to obtain a copy of the form (one for New York, New Jersey and Connecticut). In addition, you can log in to the Broker Portal on **www.healthnet.com** to download a copy.

NEW BUSINESS CASE CHECKLISTS (for groups of 2-50 employees)

NEW BUSINESS CASE SUBMISSION – CONNECTICUT, NEW JERSEY AND NEW YORK

You will be required to provide the following information for each new case submission.

- Client Name
- Client Email Address
- Date Submitted
- Plan coverage(s) that apply
- Effective date of coverage (1st or 15th)

Agent Information
- Agent / Agency
- Contact
- Phone
- Address
- Email
- Fax
- State(s) where licensed

Policy Holder Information
- Fully completed Master Application
- Quoted Plans and census use, include Health Net Submission Report
- Fully completed Member Enrollment Forms
- Waivers for each employee waiving coverage (Waivers should include employee Name, Social Security Number, Date of Birth, Signature and Reason for Waiving Coverage). Note: Waiver forms are not required for Charter HMO products.

HSA Forms (if enrolling in an Outlook HSA plan)
- HSA Employer Enrollment Form
- HSA Employee Enrollment Form
- HSA HIPAA Release Form
- NJ Declaration of Understanding *(NJ groups only)*

Other Documents
- Deposit check (Make checks payable to Health Net, Inc.)
- Copy of prior Carrier Invoice and/or Attestation Forms for plans with Pre-Existing Condition Clause
- Full-time Student Verification Form (if applicable)
- Most recent CT State Quarterly Wage & Tax Statement (UC5) (If not available you may submit payroll records or W-4 with a letter from the accountant. K-1 or Schedule C Earnings for partners and proprietors along with copies of Incorporation papers will be accepted.)
- For NY – Current NYS45 (If not available. You may submit payroll records or W-4 with a letter from the accountant. In addition, K-1 or Schedule C Earnings for partners and proprietors, along with copies of Incorporation papers, will be accepted.)
- For NJ – For groups with 6-50 employees, a NJ State Certification document is required. (If not available, you may submit payroll records or W-4 with a letter from the accountant. In addition, K-1 or Schedule C Earnings for partners and proprietors along with copies of Incorporation papers will be accepted.)
- For NJ – For over-age dependents, a Health Net Supplemental Enrollment form is required.

OFFICIAL GROUP FILING AND REQUIRED DOCUMENTS – CONNECTICUT

Below is a list of accepted tax forms to verify a group's eligibility for group health care coverage in Connecticut.

- New Corporation: UC-5A (Quarterly Wage and Tax Report), 941 or UC2B with a copy of current payroll listing at least two employees.
- Federal and State of Connecticut documents confirming registration of the business, with copies of current payroll listing at least two eligible employees.
- Existing Corporation: A copy of the current year's Form 1120 or 1120S with current payroll listing at least two eligible employees.
- Partnership or LLC: A copy of the current year's 1065 and K-1s, with current payroll listing at least two eligible employees.
- Existing Proprietorship: A copy of the current year Schedule C.
- Non-profit Organization: A copy of the UC1NP Form, with current payroll listing at least two eligible employees.
- "S" Corporation: A copy of current year's Form 1120 or 1120S with copies of current payroll listing at least two eligible employees.

OFFICIAL GROUP FILING AND REQUIRED DOCUMENTS – NEW JERSEY GROUPS WITH 5 OR FEWER FULL TIME EMPLOYEES

Below is a list of accepted tax forms to verify a group's eligibility for group health care coverage in New Jersey. Please note that this is required for groups with 5 or less full-time employees. Tax forms are not required for New Jersey group enrollment on all other group sizes.

New requirement:
- Most recent Quarterly Tax and Wage Statement (WR30) must be submitted with new case submission.
- Terminated employees and/or part-time employees should be noted accordingly on the WR30.

Exceptions:
- Submit a W4 with the WR30 for those employees (i.e., new hires) not listed on the WR30.
- Spousal Business Statement for Husband and Wife Groups may be submitted only if the WR30 has not been filed. (A copy of the WR30 must be provided when filed.)

If not required to file a WR30 or if it is not available, two of the following must be submitted instead:

One of the following IRS forms:
- IRS 1040 Schedule C (Sole Proprietorship) or F (Farm)
- IRS 1065 (Partnership)
- IRS 1120 ("C" Corporation or "S" Corporation)
- IRS 941 (Church or Not-for-Profit Organization)
- IRS 1099 (Independent Contractor)
- IRS 990 (Tax Exempt Organization)

For companies in business less than three months, the following will be accepted:
- NJ-REG (Business Registration application)
- SS-4 (application for Employer Identification Number)

OFFICIAL GROUP FILING AND REQUIRED DOCUMENTS – NEW JERSEY (continued)

AND, one of the following:

- Articles of Incorporation
- Partnership Agreement
- Letter from the group's accountant or attorney containing the list of employees by name and indicating they are compensated

OFFICIAL GROUP FILING AND REQUIRED DOCUMENTS – NEW YORK

Below is a list of accepted tax forms to verify a group's eligibility for group health care coverage in New York.

- New Corporation: Articles of Incorporation and W4 for at least two employees
- Existing Corporation: NYS-45 (indicating all eligible employees)
- New Partnership: Partnership Agreement indicating all eligible partners and W4 for at least two employees
- Existing Partnership: K1 indicating at least two eligible partners and NYS-45 (indicating all eligible nonpartner employees)
- NYSHIPP-Approved Organization: NYSHIPP Certificate
- New Proprietorship: W4 for at least 2 employees
- Existing Proprietorship: Schedule C and NYS-45 (indicating all eligible employees)
- New Subchapter S Corporation: CT6 and W4 for each employee
- Existing Subchapter S Corporation: 1120S and NYS-45 (indicating all eligible employees)
- New Limited Liability Corporation: Articles of Incorporation and W4 for at least two employees
- Existing Limited Liability Corporation: NYS-45 (indicating all eligible employees)

SUBMISSION INSTRUCTIONS – CONNECTICUT, NEW JERSEY AND NEW YORK

Completed paperwork should be sent to Health Net by either email, fax or US Postal Service.

Deposits checks should be made payable to Health Net, Inc. and sent to Health Net using the mailing address below:

Mail: Health Net of the Northeast, Inc.
ATTN: Small Business New Business Office
One Far Mill Crossing
P.O. Box 904
CT-900-03-61
Shelton, CT 06484

Email: sbgnewbusiness@healthnet.com

Fax: 1-203-225-3274

SUBMISSION DEADLINE – CONNECTICUT, NEW JERSEY AND NEW YORK

Effective Dates may be the first or fifteenth of the month only. All required paperwork must be received by Health Net at least 15 days prior to requested effective date to ensure timely group installation and member enrollment. For submissions after the 15th of the month, please include a Late Case Submission Form which can be found on our forms and brochures page at www.healthnet.com/broker.

RENEWALS

The following section explains our renewal and recertification process as well as our policy for modifying benefit/plan designs for renewing groups.

Contract Renewal

SBG (2-50 lives)

Two months prior to the group's policy anniversary, Health Net will send employer groups and their broker/consultant (if applicable) a letter reminding them of their renewal date. During this time, groups can make changes to their policy including the following:

- Modifications to deductible and coinsurance levels for plans
- Changing waiting periods and eligibility requirements (subject to state laws)
- Revisions to rider selections

Please note that the renewal period should be the only time during the year that modifications to the group's plan should occur. New Jersey allows for policy changes off cycle if no other changes were made in the preceding 12 months.

LBG (51+ lives)

Three months prior to the group's policy anniversary, the Health Net Account Manager will contact the broker of authorization (if applicable) notifying them of a group's renewal date and discuss any modifications a group may want to make to their plan.

Health Net Renewal Process

SBG (2-50 lives)

- Renewal letters are sent to brokers 75 days prior to renewal.
- Renewal letters are sent to employer groups 65 days prior to renewal.
- Health Net systems are updated with group's requested benefit changes, if applicable, 15-45 days prior to renewal. Please note that we require 7 business days to update the systems from receipt of paperwork.

LBG (51+ lives)

- Renewal letters and rates are sent to brokers 60 days prior to renewal. Upon request, renewals can be delivered earlier, however, a minimum of 30 days notice is required to obtain rates.

Modifications to Benefits/Plan Designs

SBG (2-50 lives)

We reserve the right to deny requests for plan changes. However, New Jersey allows for policy changes off cycle if no other changes were made in the preceding 12 months. Health Net members may only change their benefits on an annual basis.

LBG (51+ lives)

Health Net requires 30 day notice of plan design changes or termination. In the event notice is not given, groups will be automatically renewed with existing plans at renewal increase.

Recertification

Our recertification policy is to send out all timely recertification notices to all clients and their brokers.

SECTION NINE

UNDERWRITING GUIDELINES: GROUPS WITH 2-50 LIVES

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UNDERWRITING GUIDELINES: GROUPS WITH 2-50 LIVES – NEW YORK

Planholder Responsibilities: The employer is responsible for handling administrative details including enrollment/termination of participating members. The employer is also responsible for payment of all premiums.

Age/Rate Calculations: Issued to employers situsedin New York:

Community rated: No age calculation

Employees included: Only employees covered for medical benefits with Health Net.

Independent Contractors / Consultants (1099 individuals): Independent contractors and/or consultants (1099 individuals) are not eligible for coverage. Independent contractors and/or consultants (1099 individuals) are not considered employees and are therefore excluded from the definition of those eligible for coverage under Health Net.

Participation Requirements: The goal for Health Net Small Business is total case replacement. This means that Health Net is the sole carrier for a group.

Charter Portfolio: Health Net of the Northeast, Inc. requires 60 percent participation for the POS product; there is no minimum participation for the HMO product. Employees with spousal waivers, Medicare waivers and waivers due to other group coverage plus those enrolled in Health Net all count as participating. A signed waiver must be supplied for any employee choosing to waive the offer of coverage, except for groups offering the HMO only.

MINIMUM PARTICIPATION ENROLLMENT EXAMPLE FOR CHARTER POS:	
Total eligible employees*	50
Times the required participation percent	.60
Minimum prior to valid (qualified) waivers	30
Less valid (qualified) waivers	5
Equals the minimum enrollment	25

*INCLUDES WAIVERS

Outlook Portfolio[1]: Health Net of the Northeast, Inc. requires 60 percent participation for the Outlook products. Participation is calculated after spousal and Medicare waivers.

[1] A new product portfolio providing lower cost options and limited rider coverage selections. For some plans the coverage for pre-existing conditions is limited.

MINIMUM PARTICIPATION ENROLLMENT EXAMPLE FOR OUTLOOK:	
Total eligible employees*	50
Less valid (qualified) waivers	5
Equals net eligible employees	45
Times the required participation percent	.60
Equals the minimum enrollment	27

*INCLUDES WAIVERS

Small Employer Defined (Case Size 2 – 50): "Small Employer" means a person, firm, corporation, partnership or association actively engaged in business that, on the application date, employed at least two, but not more than 50, eligible employees. Eligible employees include all employees appearing on the employer's Quarterly Wage and Tax Statement (Form NYS-45); proprietors; and shareholders and partners in sub-chapter S corporations and Limited Liability Partnerships and Limited Liability Corporations (LLP and LLC) regardless of state.

Retirees, independent contractors and other employees whose compensation is reported on IRS Form 1099 are not eligible for coverage and, therefore, are not counted as eligible. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for state taxation purposes are considered to be a single employer. Any employer headquartered in the State of New York who meets the definition of "Small Employer" (as defined above) is a Small Employer.

Union Employees: Union employees are included in the count when determining small employer status if the employer either (a) includes the union employees for coverage under the same plan as the non-union employees; or (b) provides a separate plan for their coverage. In cases where the employer contributes toward union employees coverage under a health and welfare plan, they will not be included in the count. (Only the non-union employees then determine Small Employer status.)

Majority State: There is no requirement for the majority of the employees to be employed within the State of New York to meet the definition of a Small Employer.

Certification: The determination of Small Employer status is made on the date of application and will be recertified on subsequent plan anniversaries. Once a determination has been made, the plan will be administered in accordance with that determination until the next certification. The following forms may be required with the application for coverage: NYS-45, payroll records, W-4, K-1, as well as documents of incorporation.

ELIGIBILITY

Employee: An eligible employee is one who works a minimum of 20 hours per week. Health Net will cover employees who are not actively at work due to a disability and will not apply the dependent non-confined provision, per the Health Insurance Portability and Accountability Act (HIPAA). However, we reserve the right to postpone the effective date of an employee not actively at work due to a non-disability related leave of absence.

Dependent Children: Dependent children can be included under the base plan to age 19 or to age 23 if a full-time student. A rider can be purchased to continue coverage for dependent children to age 20 or to age 26 if a full-time student.

Domestic Partner: Coverage for domestic partners is available as requested.

Pre-existing Conditions Limitation: The pre-existing Conditions Limitation cannot be more restrictive than 6/12 (treatment was recommended or received in the 6 months preceding the effective date/waiting period may not exceed 12 months) and specifically excludes any "prudent person" limitation. No pre-existing conditions limitation may be imposed on newborns, adoptees or newly married spouses who enroll within 30 days of eligibility. In addition, pregnancy or genetic information may not be considered pre-existing conditions. (However, a genetic condition may be subject to a pre-existing conditions limitation).

Continuity of Coverage – Pre-existing Conditions: In determining whether a pre-existing condition provision applies, HIPAA requires insurers to credit the time an individual was insured under prior insurance plans. Prior creditable coverage includes another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare Parts A & B, Tricare (p/k/a CHAMPUS), the Federal Employees Health Benefit Plan, a medical health care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, any public health plan, or a health plan issued under the Peace Corps Act. For continuity to exist, there must not be a break in coverage longer than 63 days, exclusive of any service waiting period.

Certificates of Creditable Coverage: To facilitate the administration of continuity of coverage, HIPAA requires insurers to deliver Certificates of Creditable Coverage to all insured employees upon termination of their group coverage. These certificates must show the beginning and end dates of coverage.

Late Entrant: A Late Entrant is an eligible employee or a dependent who does not enroll during the initial eligibility period or during a Special Enrollment period. Late Entrants will not have coverage until the next Special Enrollment period.

However, a Late Entrant does not include an individual who does not enroll when initially eligible due to being covered under another health benefit plan at that time, provided that the individual's prior coverage was either COBRA coverage or state continuation that has been exhausted, or other coverage that has been lost or terminated due to loss

of eligibility as a result of legal separation, divorce or death of a spouse, termination of employment or reduction in work hours, or the termination of the other plan or of the employer's contributions towards the plan, provided enrollment is requested within 30 days of the termination of the other health benefit plan.

A Late Entrant also does not include court ordered coverage for a spouse or minor child(ren) if applied for within 30 days of the court order. Finally, an individual who selected another employer-sponsored health plan during an open enrollment period is not considered a Late Entrant.

Special Enrollments: An insurer is required to have a special 30-day enrollment period during which individuals who previously waived coverage are allowed to enroll without having to wait for the plan's next regular open enrollment period. Special enrollees are not considered Late Entrants. A special enrollment can occur when a person with other health coverage loses that coverage or when a dependent is acquired through marriage, birth, adoption or placement for adoption. The employee or dependent must otherwise be eligible for coverage under the terms of the plan.

Unlike our standard procedures, the special enrollment provisions allow all family members to enroll with a newly acquired dependent. An employee can enroll when he or she marries or has a new child. A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can also be enrolled with the employee when they marry or when a child is born, adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee can be enrolled if the employee enrolls at the time of the marriage, birth, adoption or placement for adoption.

A person who enrolls during a special enrollment period cannot be treated as a late enrollee. Accordingly, the plan may not impose a pre-existing condition exclusion that is longer than the exclusion for timely new entrants under the plan. Please note, no pre-existing condition exclusion can be applied to newborns, newly adopted children or children newly placed for adoption if coverage is requested within 30 days of the birth, adoption or placement for adoption. In addition, pregnancy can never be subject to a pre-existing condition limitation, even if the mother is a late enrollee under the plan.

Premium Rating: All groups and each employee are charged the same community rate for the same plan. The only factors affecting group rates are plan design and geographic location.

Minimum Employer Contribution: The minimum employer contribution is either 75 percent of the single premium or 50 percent of the total premium.

One-Life Groups: Coverage is not currently offered to one-life groups.

Guaranteed Issue/Acceptance: We will not refuse coverage for any applicant due to any health related condition.

Open Enrollment: Insurers are required to establish at least one period of at least 30 days per year in which individuals who have previously refused coverage may enroll without penalty.

Dual/Triple Option: Two life groups may offer two options as long as one employee is enrolled in each plan. Groups with three or more lives may offer three options. If one of the options is the HMO, and the group does not meet the minimum participation, the group may select the HMO product as a single option.

Plan Design: All plans are sold with prescription plans (no carve out). Medical plans must be distinguishable; the prescription plan cannot be the only differentiation between the plan offerings. There are no restrictions on the approved plan combinations that can be offered under either a dual or triple option. The Outlook portfolio products may be offered alongside the Carter portfolio products if the Outlook-based participation requirements are met.

Out-of-Area PPO (percentages are based on eligible employees, not enrolled): For products with in-network benefits only (HMO/EPO), the out-of-area employees must be covered by an out-of-area PPO plan.

For the Charter portfolio POS products, it is recommended that out-of-area employees be covered under an out-of-area PPO. Any group where 20 percent or more employees are outside of Health Net's service area must be issued an out-of-area PPO product. Out-of-area employees cannot exceed 50 percent of the group.

For the Outlook portfolio POS products, out-of-area employees must be covered by an out-of-area PPO. Out-of-area employees cannot exceed 30 percent of the group.

State Continuation: Employers with fewer than 20 employees are required to offer the New York Six-Month Extension program. For more information about state continuation requirements, contact New York's Department of Insurance at 212-480-5242 or www.ins.state.ny.us/nyins.htm.

Federal Continuation: Employers with 20 or more employees are required to offer the coverage outlined in the Consolidated Omnibus Budget Reduction Act (COBRA).

Direct Pay Conversion: Direct-pay options are available to members whose Health Net group coverage is terminating (usually after COBRA continuation ends). Health Net members terminating from group coverage in New York will receive automated letters that refer them to Group Health Benefits Administrators (GHBA). Two conversion plans are available.

UNDERWRITING GUIDELINES: GROUPS WITH 2-50 LIVES – NEW JERSEY

Planholder Responsibilities: The employer is responsible for handling administrative details including enrollment/termination of participating members. The employer is also responsible for payment of all premiums.

Age/Rate Calculations: Issued to employers situsedin New Jersey:

Reform: Rates are based on the actual age of employees on the effective or renewal date.

Employees included: Only employees covered for medical benefits with Health Net

Independent Contractors/Consultants (1099 individuals): Independent contractors and/or consultants (1099 individuals) are eligible for coverage as required by New Jersey Small Group Reform.

Participation Requirements: New Jersey Small Group Reform prohibits carriers from requiring total case replacement. However, the following participation requirements apply:

Charter Portfolio: Health Net of the Northeast, Inc. requires the state mandated 75 percent participation of eligible employees. Employees with spousal (or civil union partner), Medicare, Medicaid, New Jersey Family Care waivers, waivers due to other group coverage, plus those enrolled in Health Net, all count as participating. There is no participation requirement for dependent coverage. A valid signed waiver must be supplied for any employee choosing to waive our offer of coverage, unless selecting coverage from another carrier.

Outlook Portfolio[1]: Health Net of the Northeast, Inc. requires the state mandated 75 percent participation and the same criteria as indicated for the Charter Portfolio.

MINIMUM PARTICIPATION ENROLLMENT EXAMPLE:	
Total eligible employees*	34
Times the required participation percent	.75
Minimum prior to valid (qualified) waivers	26
Less valid (qualified) waivers	14
Equals the minimum enrollment	12

*INCLUDES WAIVERS

Small Employer Defined (Case Size 2 – 50): "Small Employer" means any person, firm, corporation, partnership or association that is actively engaged in business who employed an average of at least two, but not more than 50 eligible employees, during

[1] A new product portfolio providing lower cost options and limited rider coverage selections.

the preceding calendar year and with at least two employees on the first day of the plan year, the majority of whom are employed within the state of New Jersey. Affiliated companies, or those treated as a single employer under the Internal Revenue Code, are considered to be a single employer.

The New Jersey Joint Advisory Bulletin Number 97-01 changed the way a two person group is handled administratively. If the two persons are married (or civil union partners) and persons are the only 2 employees of the company, the spouse (or civil union partner) may waive coverage under a spousal (or civil union partner) waiver instead of having to each enroll for coverage as single employees.

Union Employees: A union employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement (e.g., selecting insurance through the Union plan) is not considered an eligible employee.

Majority State: The majority of the employees must be employed within the situs state of New Jersey.

Certification: New business cases insuring less than 51 lives are required to complete a New Jersey Certification Form at inception to determine their status. The determination of Small Employer status is made on the date of application and on subsequent certification at plan anniversaries and is based on the group's enrollment in the preceding calendar year. Once a determination has been made, the plan will be administered in accordance with that determination until the next certification.

The following forms may be required with the application for coverage: WR-30, payroll records, W-4, K-1, as well as documents of incorporation. Starting with April 4, 2004 effective dates, all employers with five or fewer employees must also submit a WR-30 at inception. WR-30 documents will also be required at time of recertification for all size groups. Please refer to the new case submission checklist for a sample Spousal (or civil union partner) Business Statement.

ELIGIBILITY

Employee: An eligible employee is one who works 25 or more hours per week on a regular basis, including a sole proprietor or partner if included as an employee under the small employer's health plan. Health Net will cover employees who are not actively at work due to a disability and will not apply the dependent non-confined provision, per the Health Insurance Portability and Accountability Act (HIPAA). However, we reserve the right to postpone the effective date of an employee not actively at work due to a non-disability related leave of absence.

Independent contractors and/or consultants (1099 individuals) may qualify as employees if they:

a. Work under written contract for money or other legal consideration
b. Work exclusively for the employer

c. Work 25 hours or more weekly
d. Work on other than a temporary basis, and
e. Meet a substantial business need of the employer

Note: The employer decides whether independent contractors may qualify as employees for that group. However, if they elect to insure one 1099 employee, they must insure all 1099 employees.

Part-time, temporary or substitute employees are not considered eligible, as defined by the employer as required by New Jersey Small Group Reform. A union employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement (selecting insurance through the Union plan) is also not considered an eligible employee.

Dependent Children: Dependent children can be included under the base plan to age 30.

Domestic Partner: Coverage for domestic partners is available as requested. Civil unions are also recognized as eligible in New Jersey effective 02/19/07. A civil union member is enrolled with the same administrative procedure as a spouse.

Pre-existing Conditions Limitation: A 6/6 (condition manifested itself within 6 months of the enrollment date/waiting period may not exceed six months) Pre-existing Condition Limitation applies to groups with 2 to 5 employees and to late entrants. Please note, the pre-existing conditions limitation does not apply to a Late Entrant if 10 or more late entrants request enrollment within any 30-day period.

Continuity of Coverage - Pre-existing Conditions: In determining whether a pre-existing condition provision applies, HIPAA requires insurers to credit the time an individual was insured under prior insurance plans. Prior creditable coverage includes another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare Parts A & B, Tricare (p/k/a CHAMPUS), a medical health care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, any public health plan, a health plan issued under the Peace Corps Act or a foreign private health plan. For continuity to exist there must not be a break in coverage longer than 90 days exclusive of any service waiting period.

Certificates of Creditable Coverage: To facilitate the administration of continuity of coverage, HIPAA requires insurers to deliver Certificates of Creditable Coverage to all insured employees upon termination of their group coverage. These certificates must show the beginning and end dates of coverage.

Late Entrant: A Late Entrant is an eligible employee or a dependent who does not enroll during the initial eligibility period or during a Special Enrollment period.

However, a Late Entrant does not include an individual who does not enroll when initially eligible due to being covered under another health benefit plan at that time, provided that the individual's prior coverage was either COBRA coverage or state continuation that has been exhausted, or other coverage that has been lost or terminated due to loss of eligibility as a result of legal separation, divorce or death of a spouse, termination of employment or reduction in work hours, or the termination of the other plan or of the employer's contributions towards the plan, provided enrollment is requested within 90 days of the termination of the other health benefit plan.

A Late Entrant also does not include court ordered coverage for a spouse or minor child(ren), if applied for within 30 days of the court order. Finally, an individual who selected another employer-sponsored health plan during an open enrollment period is not considered a Late Entrant.

Special Enrollments: An insurer is required to have a special 30-day enrollment period during which individuals who previously waived coverage are allowed to enroll without having to wait for the plan's next regular open enrollment period. Special enrollees are not considered Late Entrants. A special enrollment can occur when a person with other health coverage loses that coverage or when a dependent is acquired through marriage, birth, adoption or placement for adoption. The employee or dependent must otherwise be eligible for coverage under the terms of the plan. Unlike our standard procedures, the special enrollment provisions allow all family members to enroll with a newly acquired dependent. An employee can enroll when he or she marries or has a new child. A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can also be enrolled with the employee when they marry or when a child is born, adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee can be enrolled if the employee enrolls at the time of the marriage, birth, adoption or placement for adoption.

A person who enrolls during a special enrollment period cannot be treated as a late enrollee. Accordingly, the plan may not impose a pre-existing condition exclusion that is longer than the exclusion for timely new entrants under the plan. Please note, no pre-existing conditions exclusion can be applied to newborns, newly adopted children or children *newly* placed for adoption if coverage is requested within 30 days of the birth, adoption or placement for adoption. In addition, pregnancy can never be subjected to a pre-existing conditions limitation, even if the mother is a late enrollee under the plan.

Premium Rating: Premium rates are based on the benefits plan, the distribution of age and gender, and the group's location based on their zip code and the primary/secondary status of Medicare. Rates cannot be higher or lower than the minimum and maximum rates filed by Health Net of the Northeast, Inc.

Health Net of the Northeast, Inc. reserves the right to adjust the rates if employees transfer coverage from another employer sponsored plan into our Health Net Small Business plan, and this addition of employees results in a change in the covered population's demographic rating factors below or above 15 percent.

If premium rates are increased due to this addition of employees, the planholder can request plan changes to reduce the rate. We will not make off-anniversary plan changes due to the normal addition of new hires or the deletion of terminated employees. Renewal rates will reflect the current census at the time the renewal rates are calculated and will remain in effect until the plan's next renewal anniversary. Rates may be adjusted whenever an affiliate or branch is added to the plan. However, off-anniversary reductions are allowed on an exception basis. Please contact the Health Net New Business or Account Management Office.

Minimum Employer Contribution: The employer is required to contribute a minimum of 10 percent of the cost of the total premium per New Jersey Small Group Reform.

One-Life Groups: Coverage is not currently offered to one-life groups.

Guaranteed Issue/Acceptance: We will not refuse coverage for any applicant due to any health related condition.

Multi Option: Multi option is permitted however, one employee must be enrolled in each option.

Plan Design: Medical plans must be distinguishable; the prescription plan cannot be the only differentiation between the plan offerings. There are no restrictions on the approved plan combinations that can be offered under a multi option. The Outlook portfolio plans can be offered alongside the Charter portfolio products if the overall participation requirements are met.

Out-of-Area PPO (percentages are based on eligible employees, not enrolled): For products with in-network benefits only, the out-of-area employees must be covered by an out-of-area PPO plan.

For the Charter portfolio POS products, it is recommended that out-of-area employees be covered under an out-of-area PPO. Groups with 20 percent or more of their employees residing and working outside Health Net's service area must be issued an out-of-area PPO product for their out-of-area employees.

For the Outlook portfolio POS products, any out-of-area employees must be covered by an out-of-area PPO or a Charter POS portfolio product. Groups with less than 20 percent of their employees residing and working outside the Health Net service area may offer their out-of-area employees a Charter POS. Groups with 20 percent or more of their employees residing and working outside of Health Net's service area must be issued an out-of-area PPO product for their out-of-area employees.

Employee Waiting Periods: Employee waiting periods may not exceed six months per New Jersey Small Group Reform.

State Continuation and State Disability Continuation: Employers with fewer than 20 employees (not COBRA eligible), the State has instituted a coverage continuation policy similar to COBRA, effective 03/07/2005 for new business. For in-force business, the new continuation policy is effective on their first renewal on or after 3/7/2005. The employer can require the employee to pay up to 102 percent of the premium for employee and dependent coverage. Qualifying events include the following: Loss of employment; reduction of work hours below 25 hours per week; death; divorce; and dependent child reaching the limiting age. Continuation period limits follow federal COBRA guidelines. Active employees who work beyond their Medicare Eligibility date (age 65) are entitled to 18 months of state continuation upon termination. Active employees who terminate prior to age 65 can remain on state continuation until their Medicare eligibility date (age 65) but not for more than 18 months, whichever occurs first.

Federal Continuation: Employers with 20 or more employees are required to offer the coverage outlined in the Consolidated Omnibus Budget Reduction Act (COBRA).

Direct Pay Conversion: Direct-pay options are available to members whose Health Net group coverage is terminating (usually after COBRA continuation ends). Individuals and terminated members eligible for NJ Direct Pay may call 1-800-838-0935 for enrollment and plan information. Several New Jersey HMO plans are available, some with prescription coverage.

UNDERWRITING GUIDELINES: GROUPS WITH 2-50 LIVES – CONNECTICUT

Planholder Responsibilities: The employer is responsible for handling administrative details including enrollment/termination of participating members. The employer is also responsible for payment of all premiums.

Age/Rate Calculations: Issued to employers situsedin Connecticut

Reform: Rates are based on the actual age of employees on the effective or renewal date.

Employees included: Only employees covered for medical benefits with Health Net.

Independent Contractors/Consultants (1099 individuals): Independent contractors and/or consultants (1099 individuals) are not eligible for coverage. Independent contractors and/or consultants (1099 individuals) are not considered employees and therefore are excluded from the definition of those eligible for coverage under the Small Business Group.

Participation Requirements: The goal for Health Net is total case replacement. This means that Health Net is the sole carrier for a group.

Charter Portfolio: Health Net of the Northeast, Inc. requires 75 percent participation. Participation is calculated after spousal (or civil union partner), Medicare and Husky waivers. A signed waiver must be supplied for any employee choosing to waive the offer of coverage. Health Net of the Northeast, Inc. will allow spousal (or civil union partner), Medicare and Husky waivers on non-contributory medical plans.

Outlook Portfolio[1]: Health Net of the Northeast, Inc. requires 75 percent participation and the same criteria as indicated for the Charter portfolio.

MINIMUM PARTICIPATION ENROLLMENT EXAMPLE:	
Total eligible employees*	50
Times the required participation percent	5
Equals net eligible employees	45
Times the required participation percent	.75
Equals the minimum enrollment	34

*INCLUDES WAIVERS

Small Employer Defined (Case Size 1 – 50): "Small Employer" means any person, firm, corporation, Limited Liability Company, partnership or association actively engaged in business which, on at least 50 percent of its business days during the preceding twelve months, employed no more than 50 eligible employees (the majority of whom

[1] A new product portfolio providing lower cost options and limited rider coverage selections. For some plans, the coverage for pre-existing conditions may be limited.

were employed within the state of Connecticut). In determining the number of eligible employees, companies which are affiliated or which are eligible to file a combined state tax return will be considered one employer.

Union Employees: Union employees are included in the count when determining small employer status if the employer either (a) includes the union employees for coverage under the same plan as the non-union employees; or (b) provides a separate plan for their coverage. In cases where the employer contributes toward union employees coverage under a health and welfare plan, they will not be included in the count. (Only the non-union employees then determine Small Employer status.)

Majority State: The majority of the employees must be employed within the situs state of Connecticut.

Certification: The determination of Small Employer status is made on the date of application will be recertified on subsequent plan anniversaries. Once a determination has been made, the plan will be administered in accordance with that determination until next certification. The following forms may be required with the application for coverage: Wage and tax report UC5, payroll records, W-4, K-1 as well as documents of incorporation.

ELIGIBILITY

Employee: An eligible employee is one who works a minimum of 30 hours per week on a full-time basis, including a sole proprietor or a partner, provided they are included as an employee under the small employer health plan. Health Net will cover employees who are not actively at work due to a disability and will not apply the dependent non-confined provision, per the Health Insurance Portability and Accountability Act (HIPAA). However, we reserve the right to postpone the effective date of an employee not actively at work due to a non-disability related leave of absence. An employee who works on a part-time, temporary or substitute basis is not considered an eligible employee.

Dependent Children: Dependent children can be included under the base plan to age 26.

Domestic Partner: Coverage for domestic partners is available as requested. Civil union partners are also recognized as eligible in Connecticut. A civil union member is enrolled with the same administrative procedure as a spouse.

Pre-Existing Conditions Limitation: The pre-existing condition limitation cannot be more restrictive than 6/12 (treatment was recommended or received in the 6 months preceding the effective date/waiting period may not exceed 12 months). The pre-existing condition limitation for a late enrollee may be extended to 18 months. No pre-existing condition limitation may be imposed on newborns, adoptees or newly married spouses who enroll within 30 days of eligibility. In addition, pregnancy or

genetic information may not be considered pre-existing conditions. (However, a genetic condition may be subject to a pre-existing conditions limitation.)

Continuity of Coverage – Pre-existing Conditions: In determining whether a pre-existing condition provision applies, HIPAA requires insurers to credit the time an individual was insured under prior insurance plans. Prior creditable coverage includes another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare Parts A & B, Tricare (p/k/a CHAMPUS), the Federal Employees Health Benefit Plan, a medical health care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, any public health plan, or a health plan issued under the Peace Corps Act. For continuity to exist there must not be a break in coverage longer than 63 days, exclusive of any service waiting period.

With respect to a newly insured group member whose previous coverage terminated due to an involuntary loss of employment, a 90-day maximum allowable break in prior creditable coverage is allowed. For example, the pre-existing condition provision will not apply to an employee who lost employment involuntarily on January 1st and was rehired on or before April 1st of the same year.

Certificates of Creditable Coverage: To facilitate the administration of continuity of coverage, HIPAA requires insurers to deliver Certificates of Creditable Coverage to all insured employees upon termination of their group coverage. These certificates must show the beginning and end dates of coverage.

Late Entrant: A Late Entrant is an eligible employee or a dependent who does not enroll during the initial eligibility period or during a Special Enrollment period. Late Entrants will not have coverage until the next Special Enrollment period.

However, a Late Entrant does not include an individual who does not enroll when initially eligible due to being covered under another health benefit plan at that time, provided that the individual's prior coverage was either COBRA coverage or state continuation that has been exhausted, or other coverage that has been lost or terminated due to loss of eligibility as a result of legal separation, divorce or death of a spouse, termination of employment or reduction in work hours, or the termination of the other plan or of the employer's contributions towards the plan, provided enrollment is requested within 30 days of the termination of the other health benefit plan.

A Late Entrant also does not include court ordered coverage for a spouse or minor child(ren), if applied for within 30 days of the court order. Finally, an individual who selected another employer-sponsored health plan during an open enrollment period is not considered a Late Entrant.

Special Enrollments: An insurer is required to have a special 30-day enrollment period during which individuals who previously waived coverage are allowed to enroll without having to wait for the plan's next regular open enrollment period. Special enrollees are not considered late entrants. A special enrollment can occur when a person with

other health coverage loses that coverage or when a dependent is acquired through marriage, birth, adoption or placement for adoption. The employee or dependent must otherwise be eligible for coverage under the terms of the plan.

Unlike our standard procedures, the special enrollment provisions allow all family members to enroll with a newly acquired dependent. An employee can enroll when he or she marries or has a new child. A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can also be enrolled with the employee when they marry or when a child is born, adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee can be enrolled if the employee enrolls at the time of the marriage, birth, adoption or placement for adoption.

A person who enrolls during a special enrollment period cannot be treated as a late enrollee. Accordingly, the plan may not impose a pre-existing condition exclusion that is longer than the exclusion for timely new entrants under the plan. Please note, no pre-existing conditions exclusion can be applied to newborns, newly adopted children or children newly placed for adoption if coverage is requested within 30 days of the birth, adoption or placement for adoption. In addition, pregnancy can never be subjected to a pre-existing conditions limitation, even if the mother is a late enrollee under the plan.

Premium Rating: All groups are charged modified community rates in five-year age bands adjusted for gender and county. Rates may not be increased due to health conditions. Medicare as the primary or secondary carrier may also impact rates.

Minimum Employer Contribution: The minimum employer contribution is either 75 percent of the single premium or 50 percent of the total premium.

Guaranteed Issue/Acceptance: We will not refuse coverage for any applicant due to any health related condition.

Dual/Triple Option: Two-life groups may have the choice of an HMO, POS or HSA plan. Groups with greater than two lives may have any three options. One employee must be enrolled in each option.

Plan Design: All plans are sold with prescription plans (no carve out). Medical plans must be distinguishable; the prescription plan cannot be the only differentiation between the plan offerings. There are no restrictions on the approved plan combinations that can be offered under either a dual or triple option. The Outlook portfolio products may be offered alongside the Charter portfolio products if the overall participation requirements are met.

Out-of-Area PPO (percentages are based on eligible employees, not enrolled): For products with in-network benefits only (HMO), the out-of-area employees must be covered by an out-of-area PPO.

For the Charter portfolio POS products, it is recommended that out-of-area employees be covered by an out-of-area PPO. Groups with 20 percent or more of their employees residing outside Health Net's service area must be issued an out-of-area PPO product.

For the Outlook portfolio POS products, any out-of-area employees must be covered by an out-of-area PPO to a maximum of 30 percent of the group.

State Continuation: Employers with fewer than 20 employees are required to offer the Connecticut State Continuation program. For more information about state continuation requirements, contact Connecticut's Department of Insurance at 1-860-297-3800 or www.ct.gov/cid/site/default.asp.

Federal Continuation: Employers with 20 or more employees are required to offer the coverage outlined in the Consolidated Omnibus Budget Reduction Act (COBRA).

Direct-Pay Conversion: Direct-pay options are available to members whose Health Net group coverage is terminating (usually after COBRA continuation ends). Members terminating from group coverage under Health Net will receive a letter, generated upon termination, advising them to contact their former employer for federal or state continuation options, or to contact Connecticut Health Reinsurance Association (HRA) at 1-800-842-0004 for further options. From that point, the HRA is the sole communicator of rates, benefits and eligibility for any conversion plans.

SECTION TEN

UNDERWRITING GUIDELINES: GROUPS WITH 51 OR MORE LIVES

10

UNDERWRITING GUIDELINES: GROUPS WITH 51 OR MORE LIVES – CONNECTICUT

Planholder Responsibilities: The employer is responsible for handling administrative details including enrollment/termination of participating members. The employer is also responsible for payment of all premiums.

Participation: Health Net of Connecticut, Inc. has a policy that at least 75 percent of a group's eligible employees needs to be enrolled for the group to have coverage. Eligible employees consist of all full time employees that have satisfied their waiting period and do not have coverage through a spouse's plan. For the latter, the employer needs to retain a waiver form for every excluded person from the eligible population. Health Net of Connecticut, Inc. will not accept participation of dependents at less than 50 percent.

MINIMUM QUOTE PARTICIPATION LEVEL:	
Enrolled less waived **(for spousal or other coverage)** employees >75 percent Eligible less **(qualified)** waived employees	**Calculation** 100 Eligibles – 20 waived (spousal coverage) 80 eligible x .75 percent 60 employees

Large Group Minimum Renewal Participation: 10 contracts or 10 percent of eligible less waived, whichever is greater. If the existing enrolled contracts are less than this minimum, Underwriting will decline to renew.

EMPLOYEE/DEPENDENT ELIGIBILITY:

Employee: Health Net of Connecticut, Inc. will insure full time employees and part time employees who work more than 30 hours. Documentation to verify employee status is the quarterly IRS form (W4-T) listing wage earners and their salaries. Health Net of Connecticut, Inc. does not cover 1099 employees or Board of Directors. Disabled employees are covered per contractual and legislative mandates.

All eligible employees must be actively at work or retired. Employer leave of absence plans will be honored, such as vacation weeks, maternity leave, etc.

Dependent Children: Dependent children can be included under the base plan to age 26.

Domestic Partner: Coverage for domestic partners is available as requested. Civil union partners are also recognized as eligible in Connecticut. A civil union member is enrolled with the same administrative procedure as a spouse.

Late Entrant: A Late Entrant is an eligible employee or a dependent who does not enroll during the initial eligibility period or during a Special Enrollment period. Late Entrants will not have coverage until the next Special Enrollment period.

However, a Late Entrant does not include an individual who does not enroll when initially eligible due to being covered under another health benefit plan at that time, provided that the individual's prior coverage was either COBRA coverage or state continuation that has been exhausted, or other coverage that has been lost or terminated due to loss of eligibility as a result of legal separation, divorce or death of a spouse, termination of employment or reduction in work hours, or the termination of the other plan or of the employer's contributions towards the plan, provided enrollment is requested within 30 days of the termination of the other health benefit plan.

A Late Entrant also does not include court ordered coverage for a spouse or minor child(ren), if applied for within 30 days of the court order. Finally, an individual who selected another employer-sponsored health plan during an open enrollment period is not considered a Late Entrant.

Special Enrollments: An insurer is required to have a special 30-day enrollment period
during which individuals who previously waived coverage are allowed to enroll without having to wait for the plan's next regular open enrollment period. Special enrollees are not considered late entrants. A special enrollment can occur when a person with other health coverage loses that coverage or when a dependent is acquired through marriage, birth, adoption or placement for adoption. The employee or dependent must otherwise be eligible for coverage under the terms of the plan.

Unlike our standard procedures, the special enrollment provisions allow all family members to enroll with a newly acquired dependent. An employee can enroll when he or she marries or has a new child. A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can also be enrolled with the employee when they marry or when a child is born, adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee can be enrolled if the employee enrolls at the time of the marriage, birth, adoption or placement for adoption.

A person who enrolls during a special enrollment period cannot be treated as a late enrollee. Accordingly, the plan may not impose a pre-existing condition exclusion that is longer than the exclusion for timely new entrants under the plan. Please note, no pre-existing conditions exclusion can be applied to newborns, newly adopted children or children newly placed for adoption if coverage is requested within 30 days of the birth, adoption or placement for adoption. In addition, pregnancy can never be subjected to a pre-existing conditions limitation, even if the mother is a late enrollee under the plan.

Out-of-Area PPO (percentages are based on eligible employees, not enrolled): For products with in-network benefits only (HMO), the out-of-area employees must be covered by an out-of-area PPO.

Health Net of Connecticut, Inc. can insure all members in other areas, limited at this time to less than or equal 25 percent of the total enrollees, with our PPO product.

Minimum Employer Contribution: The employer must pay a minimum of 75 percent of the single employee premium, or alternately, 50 percent of the total premium.

UNDERWRITING GUIDELINES: GROUPS WITH 51 OR MORE LIVES – NEW JERSEY

Planholder Responsibilities: The employer is responsible for handling administrative details including enrollment/termination of participating members. The employer is also responsible for payment of all premiums.

Participation: Health Net of New Jersey, Inc. has a policy that at least 75 percent of a group's eligible employees needs to be enrolled for the group to have coverage. Eligible employees consist of all full time employees that have satisfied their waiting period and do not have coverage through a spouse's plan. For the latter, the employer needs to retain a waiver form for every excluded person from the eligible population. Health Net of New Jersey, Inc. will not accept participation of dependents at less than 50 percent.

MINIMUM QUOTE PARTICIPATION LEVEL:	
Enrolled less waived **(for spousal or other coverage)** employees >75 percent Eligible less **(qualified)** waived employees	**Calculation** 100 Eligibles – 20 waived (spousal coverage) 80 eligible x .75 percent 60 employees

Large Group Minimum Renewal Participation: 10 contracts or 10 percent of eligible less waived, whichever is greater. If the existing enrolled contracts are less than this minimum, Underwriting will decline to renew.

EMPLOYEE/DEPENDENT ELIGIBILITY:

Employee: Health Net of New Jersey, Inc. will insure full time employees and part time employees who work more than 30 hours. Documentation to verify employee status is the quarterly IRS form (W4-T) listing wage earners and their salaries. Health Net of New Jersey, Inc. does not cover 1099 employees or Board of Directors. Disabled employees are covered per contractual and legislative mandates.

All eligible employees must be actively at work or retired. Employer leave of absence plans will be honored, such as vacation weeks, maternity leave, etc.

Dependent Children: Dependent children can be included under the base plan to age 30.

Domestic Partner: Coverage for domestic partners is available as requested. Civil unions are also recognized as eligible in New Jersey effective 02/19/07. A civil union member is enrolled with the same administrative procedure as a spouse.

Late Entrant: A Late Entrant is an eligible employee or a dependent who does not enroll during the initial eligibility period or during a Special Enrollment period.

However, a Late Entrant does not include an individual who does not enroll when initially eligible due to being covered under another health benefit plan at that time, provided that the individual's prior coverage was either COBRA coverage or state continuation that has been exhausted, or other coverage that has been lost or terminated due to loss of eligibility as a result of legal separation, divorce or death of a spouse, termination of employment or reduction in work hours, or the termination of the other plan or of the employer's contributions towards the plan, provided enrollment is requested within 90 days of the termination of the other health benefit plan.

A Late Entrant also does not include court ordered coverage for a spouse or minor child(ren), if applied for within 30 days of the court order. Finally, an individual who selected another employer-sponsored health plan during an open enrollment period is not considered a Late Entrant.

Special Enrollments: An insurer is required to have a special 30-day enrollment period during which individuals who previously waived coverage are allowed to enroll without having to wait for the plan's next regular open enrollment period. Special enrollees are not considered Late Entrants. A special enrollment can occur when a person with other health coverage loses that coverage or when a dependent is acquired through marriage, birth, adoption or placement for adoption. The employee or dependent must otherwise be eligible for coverage under the terms of the plan. Unlike our standard procedures, the special enrollment provisions allow all family members to enroll with a newly acquired dependent. An employee can enroll when he or she marries or has a new child. A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can also be enrolled with the employee when they marry or when a child is born, adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee can be enrolled if the employee enrolls at the time of the marriage, birth, adoption or placement for adoption.

A person who enrolls during a special enrollment period cannot be treated as a late enrollee. Accordingly, the plan may not impose a pre-existing condition exclusion that is longer than the exclusion for timely new entrants under the plan. Please note, no pre-existing conditions exclusion can be applied to newborns, newly adopted children or children newly placed for adoption if coverage is requested within 30 days of the birth, adoption or placement for adoption. In addition, pregnancy can never be subjected to a pre-existing conditions limitation, even if the mother is a late enrollee under the plan.

Out-of-Area PPO (percentages are based on eligible employees, not enrolled): For products with in-network benefits only (HMO), the out-of-area employees must be covered by an out-of-area PPO.

Health Net of New Jersey, Inc. can insure all members in other areas, limited at this time to less than or equal 25 percent of the total enrollees, with our PPO product.

Minimum Employer Contribution: The employer must pay a minimum of 75 percent of the single employee premium, or alternately, 50 percent of the total premium.

UNDERWRITING GUIDELINES: GROUPS WITH 51 OR MORE LIVES – NEW YORK

Planholder Responsibilities: The employer is responsible for handling administrative details including enrollment/termination of participating members. The employer is also responsible for payment of all premiums.

Participation: Health Net of New York, Inc. has a policy that at least 75 percent of a group's eligible employees needs to be enrolled for the group to have coverage. Eligible employees consist of all full time employees that have satisfied their waiting period and do not have coverage through a spouse's plan. For the latter, the employer needs to retain a waiver form for every excluded person from the eligible population. Health Net of New York, Inc. will not accept participation of dependents at less than 50 percent.

MINIMUM QUOTE PARTICIPATION LEVEL:	
Enrolled less waived **(for spousal or other coverage)** employees >75 percent Eligible less **(qualified)** waived employees	**Calculation** 100 Eligibles – 20 waived (spousal coverage) 80 eligible x .75 percent 60 employees

Large Group Minimum Renewal Participation: 10 contracts or 10 percent of eligible less waived, whichever is greater. If the existing enrolled contracts are less than this minimum, Underwriting will decline to renew.

EMPLOYEE/DEPENDENT ELIGIBILITY:

Employee: Health Net of New York, Inc. will insure full time employees and part time employees who work more than 30 hours. Documentation to verify employee status is the quarterly IRS form (W4-T) listing wage earners and their salaries. Health Net of New York, Inc. does not cover 1099 employees or Board of Directors. Disabled employees are covered per contractual and legislative mandates.

All eligible employees must be actively at work or retired. Employer leave of absence plans will be honored, such as vacation weeks, maternity leave, etc.

Dependent Children: Dependent children can be included under the base plan to age 30.

Domestic Partner: Coverage for domestic partners is available as requested.

Late Entrant: A Late Entrant is an eligible employee or a dependent who does not enroll during the initial eligibility period or during a Special Enrollment period. Late Entrants will not have coverage until the next Special Enrollment period.

However, a Late Entrant does not include an individual who does not enroll when initially eligible due to being covered under another health benefit plan at that time, provided that the individual's prior coverage was either COBRA coverage or state continuation that has been exhausted, or other coverage that has been lost or terminated due to loss of eligibility as a result of legal separation, divorce or death of a spouse, termination of employment or reduction in work hours, or the termination of the other plan or of the employer's contributions towards the plan, provided enrollment is requested within 30 days of the termination of the other health benefit plan.

A Late Entrant also does not include court ordered coverage for a spouse or minor child(ren) if applied for within 30 days of the court order. Finally, an individual who selected another employer-sponsored health plan during an open enrollment period is not considered a Late Entrant.

Special Enrollments: An insurer is required to have a special 30-day enrollment period during which individuals who previously waived coverage are allowed to enroll without having to wait for the plan's next regular open enrollment period. Special enrollees are not considered Late Entrants. A special enrollment can occur when a person with other health coverage loses that coverage or when a dependent is acquired through marriage, birth, adoption or placement for adoption. The employee or dependent must otherwise be eligible for coverage under the terms of the plan.

Unlike our standard procedures, the special enrollment provisions allow all family members to enroll with a newly acquired dependent. An employee can enroll when he or she marries or has a new child. A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can also be enrolled with the employee when they marry or when a child is born, adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee can be enrolled if the employee enrolls at the time of the marriage, birth, adoption or placement for adoption.

A person who enrolls during a special enrollment period cannot be treated as a late enrollee. Accordingly, the plan may not impose a pre-existing condition exclusion that is longer than the exclusion for timely new entrants under the plan. Please note, no pre-existing condition exclusion can be applied to newborns, newly adopted children or children newly placed for adoption if coverage is requested within 30 days of the birth, adoption or placement for adoption. In addition, pregnancy can never be subject to a pre-existing condition limitation, even if the mother is a late enrollee under the plan.

Out-of-Area PPO (percentages are based on eligible employees, not enrolled): For products with in-network benefits only (HMO), the out-of-area employees must be covered by an out-of-area PPO.

Health Net of New York, Inc. can insure all members in other areas, limited at this time to less than or equal 25 percent of the total enrollees, with our PPO product.

Minimum Employer Contribution: The employer must pay a minimum of 75 percent of the single employee premium, or alternately, 50 percent of the total premium.

SECTION ELEVEN

COMMISSIONS AND APPOINTMENT

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COMMISSIONS AND APPOINTMENT

The following section explains when we mail commissions, how to become appointed as a broker with Health Net and how to become a Broker of Record (BOR).

Commission Schedule

We mail commissions by the 15th of each month. In order to be eligible for commissions, a broker must be officially licensed and appointed as an agent of Health Net. No broker will be compensated and no compensation will be paid until they are licensed and appointed with Health Net. Please refer to the licensing and appointment section on the next page for more information.

HEALTH NET COMMISSION SCHEDULE			
	Connecticut	New Jersey	New York
SBG (2-50 lives)	5%	5%	4%
LBG (51+ lives)	4%	5%	4%

Once appointed, we generally issue commission statements and checks to brokers by the 15th of the month following the month in which we receive the group premium. Commissions will be issued on the month following the month in which the broker is appointed with Health Net. There will be no retroactive payments.

Questions regarding broker and commissions status should be directed to the following:

Health Net of the Northeast, Inc.
ATTN: Commissions
P.O. Box 904
Shelton, CT 06484
Phone: 1-800-384-1878
Fax: 1-203-225-4023
Email: Broker.Comm-NE@healthnet.com

New Jersey Producer Compensation Disclosure Mandate

Effective January 5, 2009, the New Jersey Department of Banking and Insurance (DOBI) requires all licensed New Jersey general agents and brokers to disclose compensation received from the sale of a health care policy or contract. This mandate applies to both small business (SBG) and large business (LBG) employer groups.

We have created forms you can use for your Health Net book of business. Simply refer to your clients' new business quote or renewal proposal to confirm the commission rate then complete the corresponding form that can be found on the Health Net website at *www/healthnet.com/broker > Northeast > Forms and Brochures*

Appointment

How a producer becomes licensed and appointed with Health Net

- Broker must be a licensed agent in the state in which the group is sitused.
- Broker submits a fully completed and executed Health Net Broker Agreement and W-9 Form to the Broker Licensing and Compliance Department. He/she must include copies of his or her current state health insurance license(s).
- The Broker Licensing and Compliance Department will set up the broker in our system and on the respective state Department of Insurance website or through Sircon (licensing vendor), and assign the broker a unique Health Net Broker Code.
- Health Net will mail to the broker a welcome letter that includes the assigned Health Net Broker Code. This code should be used on all correspondence to Health Net from the broker.

Questions regarding licensing and compliance should be directed to the following:

Health Net of the Northeast, Inc.
ATTN: Broker Licensing and Compliance
P.O. Box 904
Shelton, CT 06484
Phone: 1-800-848-4747 (ext. 8600)
Fax: 1-203-225-3204
Email: BrokerAppointment@healthnet.com

Broker of Record

Broker of Record is the broker assigned by the group as its current servicing broker. The Broker of Record must clearly specify his/her name and Health Net Broker Code on the Group Application for each new group.

How to become a Broker of Record (BOR):

- Broker of Record letters **MUST** be on company letterhead and signed by the president, officer, or other decision maker of the employer group. It should also include a fax number or email address, so we may confirm receipt of the letter.
- The Broker of Record letter must be SENT DIRECTLY via mail, email, or fax to the Broker Licensing and Compliance Department. If applicable, also submit a copy of the Broker of Record letter through your General Agent. We cannot guarantee your Broker of Record change unless it is sent directly to the Broker Licensing and Compliance Department.
- The Broker Licensing and Compliance Department must confirm the Broker of Record letter by the last business day of the month in order for the new Broker of Record to be eligible for commissions effective the first of the following month.
- Upon receipt of the Broker of Record letter, the Broker Licensing and Compliance Department will send confirmation of the effective date of assignment to both the new and the previous broker. Contact the Broker Licensing and Compliance Department at 1-800-848-4747 (ext. 8600) if you have not received your confirmation within five days of submission.

- The previous broker has 15 days from date of the confirmation notice to dispute the new assignment. Your Health Net account executive will resolve such disputes.
- The group for which you are being designated Broker of Record will receive a letter of notification and a copy of the letter that was sent to the previous broker.

Please note the following:

- Any change in Broker of Record on a renewing group requires a letter from the policyholder appointing the new broker.
- Broker of Record changes on existing Health Net business does not count toward new business and persistency bonuses.
- Broker of Record letters must be confirmed by the Broker Licensing and Compliance Department or they will not be honored.

Commissions will be payable on the first of the month following receipt and execution of the BOR letter by the Broker Licensing and Compliance Department. For direct cases, where there is no assigned broker of record, commissions are payable upon the group's next annual renewal.

Brokers requesting a transfer of their cases from one General Agent to another will be required to submit their request in writing and provide a list of their cases and include the following information: **group name, Health Net group number and effective date.**

For BOR and Tax ID changes, contact the Broker Licensing and Compliance department via phone at 1-800-848-4747, ext. 8600, via fax at 1-203-225-3204, or via email at **BrokerAppointment@healthnet.com**.

SECTION TWELVE

HOW TO ENROLL A MEMBER

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HOW TO ENROLL A MEMBER

The following section explains the member enrollment process for health care coverage through Health Net, including information on our new Online Billing and Enrollment functionality.

New Employee

- Employee should submit completed enrollment form to the benefit administrator.
- Employee should complete an enrollment form prior to or within 31 days after waiting period has been satisfied.
- If employee is waiving benefits, the refusal of group insurance section must be completed and submitted to the benefit administrator. (For New Jersey Reform, a waiver form must be completed.)

QUALIFYING EVENTS FOR LATE ENTRANTS

(NOTE: ALSO REFER TO QUALIFYING EVENTS AND COVERAGE LENGTH GRID ON PAGE 91)

Late Entrant

- Unless employee has a qualifying event, he/she must wait until next open enrollment period to enroll for HMO/POS benefits.
- To enroll for Indemnity or PPO benefits (if available), employee should submit completed enrollment form.

Late Enrollee

If there is loss of medical coverage elsewhere, employee should submit completed enrollment form within 31 days.

Employee Marriage

Employee should complete an enrollment form, which must be reported and received within 31 days of the date of marriage. Otherwise, the dependent is considered a late entrant.

Addition/Adoption of Newborn

Employee should complete an enrollment form, which must be reported and received within 31 days of the date of birth. Otherwise, the dependent is considered a late entrant.

Terminated Employee (Also refer to Continuation of Coverage section on pages 90 through 95).

- Report employee's exact last date of work within 31 days.
- Complete a COBRA Continuation Form to continue benefits under COBRA (if eligible).
- Complete a State Continuation Form to continue under Connecticut, New York or New Jersey continuation.
- For New Jersey Reform and Non-Reform: If employee is totally disabled, complete an Election of Continuation - Total Disability Form to continue under New Jersey Continuation.

Rehired Employee

- If rehired within 31 days after termination, reinstate employee as of date of rehire and report within 31 days.
- If rehired after 31 days, employee is considered a new employee. (See New Employee section above).

Withdraw from Coverage

To waive/delete benefits, report within 31 days of the date coverage is to be removed.

Where to Send Enrollment Forms

Employers should send enrollment forms to:

Health Net of the Northeast, Inc.
ATTN: Enrollment Services
Mail Stop: CT-900-02-52
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484

Online Billing and Enrollment

Billing and Enrollment can be conducted online at **www.healthnet.com**. Eligible employers are able to:

- View and pay bills online
- Research up to two years of billing and payment history
- Enroll, terminate and modify employee and dependent enrollment
- Communicate with billing and enrollment specialists through a secure online message center

Access to all these tools are managed by the respective employer group's client administrator, ensuring security and administrative ease in the management of delegated users.

SECTION THIRTEEN

MEMBER ELIGIBILITY AND CONTINUATION OF COVERAGE

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MEMBER ELIGIBILITY AND CONTINUATION OF COVERAGE

MEMBER ELIGIBILITY

There are member eligibility requirements, which vary by state, that must be satisfied when enrolling a group for health care coverage through Health Net. Please refer to the *Underwriting Guidelines* chapters to see the member eligibility requirements in New York, New Jersey and Connecticut. This section also includes detailed information on pre-existing conditions limitation, certificates of creditable coverage, late entrant, and special enrollments.

CONTINUATION OF COVERAGE

Depending on the size and location of a company, an employer must offer one of a number of continuation of coverage options to terminating employees. Each option provides coverage for varying periods of time, depending on the event that qualified the employee for continuation of coverage. In addition, there are various administrative and premium billing guidelines associated with each option.

State Continuation Programs

Employers with fewer than 20 employees are required to offer the state continuation programs in their respective state.

COBRA

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated. COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. In addition, a two percent administration charge may be added. It is ordinarily less expensive, though, than individual health coverage.

COBRA must be offered by employers with 20 or more employees (Federal Government agencies and churches are exempt) when group insurance coverage terminates for an employee.

CONTINUATION OF COVERAGE: QUALIFYING EVENTS AND COVERAGE LENGTHS				
Qualifying Events & Coverage Lengths	COBRA	NY STATE CONTINUATION	NJ GROUP CONTINUATION RIGHTS	CT STATE CONTINUATION
Worker whose employment terminates for any reason except gross misconduct	18 months	18 months	18 months	18 months
Reduction in the worker's number of hours of employment	18 months	18 months	18 months	18 months
Spouse & children of divorced worker	36 months	36 months	36 months	36 months
Spouse & children of deceased worker	36 months	36 months	36 months	36 months
Spouse & children of Medicare eligible	36 months	36 months	None	36 months
Children who no longer meet the criteria for eligible dependents	36 months	36 months	36 months	36 months

CONTINUATION OF COVERAGE: ADMINISTRATION AND PREMIUM BILLING				
Administration & Premium Billing	COBRA	NY SIX-MONTH EXTENSION	NJ GROUP CONTINUATION RIGHTS	CT STATE CONTINUATION
Time from termination date that employer must offer continuation	14 days	15 days	Employee must contact employer within 30 days	14 days
Election period from date of notification	60 days	60 days	30 days	60 days
Payment period from date of election	45 days	45 days	30 days	45 days
Administrative fee (employer option)	up to 2 percent	Not Applicable	up to 2 percent	up to 2 percent
Monthly payment to employer	Yes	Yes	Yes	Yes
Retain same benefits as employer-sponsored plan	Yes	Yes	Yes	Yes
Eligible for "open enrollment" changes	Yes	Yes	Yes	Yes
Notification of continuation option to dependents Health Net terminates because of age	Yes	Yes	Yes	Yes

New Jersey Dependents to Age 30

The State of New Jersey has enacted legislation that gives eligible dependents who have reached the standard limiting age of their medical policy the option to continue coverage until age 30. This change in dependent eligibility is effective for group medical plans issued or renewed on or after May 12, 2006.

In order to qualify for this extended coverage the dependent must:

- Be an insured's child by blood or by law;
- Be less than 30 years of age *(Effective January 1, 2009, coverage will extend through the age 30);*
- Be unmarried;
- Have no dependents;
- Reside in New Jersey or be enrolled as a full-time student at an accredited institution;
- Not be covered under an individual/group plan, church plan, health benefits plan or Title XVIII of Social Security (or entitled to coverage under Title XVIII).

An eligible dependent may elect, in writing to the employer, coverage to age 30:

- During an open enrollment period for the group;
- Within 30 days prior to the plan's standard limiting age;
- Within 30 days of meeting the definition of dependent described above if coverage had already terminated.

Connecticut Dependents to Age 26

Effective January 1, 2009, the State of Connecticut is enacting legislation that gives dependents of health plan members the option to continue coverage until the age of 26, if the following eligibility requirements are met:

- Under 26 years of age;
- A resident of the state of Connecticut;
- Not married;
- Not covered as a subscriber under another group plan

An eligible dependent may elect, in writing to the employer, coverage to age 26:

- During an open enrollment period for the group;
- Within 30 days prior to the plan's standard limiting age;
- Within 30 days of meeting the definition of dependent described above if coverage had already terminated.

Employer Sanctions for Failure to Follow Continuation of Coverage Regulations

For Employers: An employer with 20 or more employees who does not provide continuation under all plans cannot take a business income tax deduction for costs of a medical plan.

For State and Local Government Agencies: State and local government agencies that do not provide continuation options lose federal funds.

For Employees: A highly compensated employee would be subject to imputed income on employer contributions for the costs of medical plans, for tax purposes, including special medical plans (MERPS), if any plan maintained by the employer does not comply.

Terminating Continuation of Coverage

When an employer no longer has to offer continuation coverage either through COBRA or a state extension program, employers do not need to provide coverage after any one of the following occurs:

- The continuation period expires; beneficiaries may be covered under multiple qualifying events, but in no case can the coverage period exceed 36 months.
- The employee fails to pay on a timely basis (including a 30-day grace period)
- The employee or beneficiary is covered under another group health plan after making his or her continuation coverage selection.
- The employee or beneficiary becomes eligible for Medicare.

Enrolling in Continuation of Coverage through Health Net

To terminate a subscriber/member's Health Net group coverage:

- Employer should complete a Health Net Change/Cancellation Form to terminate the subscriber/member from the company's bill at the time of the qualifying event. (Form should include the group number and plan code.)

To reinstate a subscriber/member under any option

- Employer should complete a Health Net Enrollment Form (if the member was not the original subscriber) to reflect all persons to be covered by the continuation option. The employer should clearly mark the form with the option under which they are enrolling the member(s).
- Reinstating the member will add him or her back onto the company's premium invoice. The company can elect to have a separate group set up to easily identify this population. The employer should contact their Health Net representative for more information.
- If the member accepts a continuation option, is reinstated and then fails to pay within the allowed limit, the company must terminate the member using a Health Net Change/Cancellation Form.

Effective Date: The effective date will be the day after the coverage was terminated. Therefore, there will be no lapse in Health Net coverage.

Retroactivity Policy: An exception to Health Net's 30-day retroactivity policy may be granted to accommodate the federal regulations allowing additional days for election and payment of the continuation option. But, Health Net must agree to this arrangement in advance.

Administration and Billing: Health Net will send the company an invoice for this population. The company is responsible for collecting premiums directly from the members. However, Health Net must receive the premium by the 1st of the month for that month's coverage, except for the initial payment, which is due 45 days from the date COBRA was selected.

Direct-Pay Conversion Plans

Eligibility: Direct-pay options are available to members whose Health Net group coverage is terminating (usually after COBRA continuation ends).

Coverage: This option will provide different coverage than the member had under the company's current group plan and will vary based on several factors (e.g., the state in which the member's group plan was issued and the state in which the member resides).

Connecticut Plan Members: Members terminating from group coverage under Health Net will receive a letter, generated upon termination, advising them to contact their former employer for federal or state continuation options, or to contact Connecticut Health Reinsurance Association (HRA) at 1-800-842-0004 for further options. From that point, the HRA is the sole communicator of rates, benefits and eligibility for any conversion plans.

New York Plan Members: Health Net members terminating from group coverage will receive automated letters that refer them to Group Health Benefits Administrators (GHBA). Two conversion plans are available.

New Jersey Plan Members: Individuals and terminated members eligible for New Jersey Direct Pay may call 1-800-838-0935 for enrollment and plan information. Several New Jersey HMO plans are available, some with prescription coverage.

When Network Changes Occur

In instances in which a primary care physician (PCP) terminates from the network, the Network Management staff facilitates assignment of a new PCP. For other practitioners that terminate, Network Management staff advises the practitioner in writing that members currently in an active course of treatment must be allowed to continue their course of treatment 90 days in New York and Connecticut and 120 days in New Jersey. The provider must agree to accept participating rates and must coordinate all services through the Health Net prior authorization process.

1. When prior authorized, a member receiving medically necessary care from a provider who is leaving the Health Net network may be able to continue receiving

care from that provider during a transitional period.

2. Continued care for covered services during either transitional period will only be prior authorized if the provider leaving the network agrees to the following:

   - Comply with Health Net's quality assurance requirements, policies and procedures.
   - Provide Health Net with medical information related to the member's care.
   - Accept payment for services at the same rates in effect before the transitional period.

Network Management generates a list of members who have received services from the terminating provider within the prior six (6) month period. This list is forwarded to Member Services where a letter is sent to the member thirty (30) days prior to the effective termination date informing them of the network change, description of applicable coverage available to the member and guidelines for receiving care during the transitional period.

When prior authorized, medically necessary services rendered during the transitional period may continue for up to 90 days in New York and Connecticut and 120 days in New Jersey following the date Health Net notifies the member that the provider is leaving the network. If the member has entered the second trimester of pregnancy, the transitional period will include postpartum care directly related to the delivery.

New York Only: Continued care for covered services during the transition period will only be covered if the non-participating provider agrees to accept Health Net's fees as payment in full. If the non-participating provider refuses to accept Health Net's fees and the member has a POS plan, covered services will be reimbursed as out-of-network benefits.

To join Health Net and take full advantage of its benefits, some of our members and/or their dependents that are enrolling in a plan may need to begin seeing physicians and other providers whom they have not visited before. Some of these members may be in an ongoing treatment plan for a complex condition (e.g., pregnancy, cancer treatment, dialysis, etc.) and may be apprehensive about "starting over" with a new physician who is not familiar with them. Therefore, Health Net will, at times, allow a member to continue receiving services from a non-participating provider at an in-network level of benefits for a specified period of time. During that time, our Medical Management staff will work with the member and his or her attending physician to transfer the member's care to a participating provider.

This process is called Transition of Care. The next chapter goes into details of this program.

SECTION FOURTEEN

TRANSITION OF CARE / CARE MANAGEMENT PROGRAMS / CLINICAL ACCOUNT MANAGEMENT

14

TRANSITION OF CARE

This section is included to help you understand the Health Net Transition of Care Program. Transition of care is when a new member is allowed to continue seeing a non-participating provider at an in-network level of benefits. Health Net covers health care services provided under transition of care with the same terms and conditions as applicable for participating health care providers. To be eligible for payment by the Plan, providers must agree to Health Net terms and conditions prior to providing service under the transition of care provisions.

Policy Statement

Health Net ensures continuity of care and integration of services for members.

Purpose

The purpose of this policy is to describe the process to ensure the seamless transition of care for members newly enrolled in Health Net.

Transitional Period

- If the member has entered the second trimester of pregnancy, the transitional period will include postpartum care directly related to the delivery.
- For new members, the transitional period is the 60-day period immediately following the effective date of coverage.

Procedure

Who is Eligible for the Transition of Care Program?

Health Net facilitates timely communication of information to support continuity of care. Health Net must prior authorize all covered services in order for continuation of care to be covered during the transitional period.

Members newly enrolled in Health Net will be evaluated for the Transition of Care Program.

1. Receiving treatment from a non-participating provider for a degenerative or disabling condition for a transitional period of not more than 60 days from the effective date of enrollment.
2. Receiving chemotherapy or radiation therapy.
3. Actively engaged in therapy from a mental health provider, in a hospice setting, acute care facility, acute rehabilitation, or skilled nursing facility.
4. Receiving home-care services.
5. For members who are pregnant and have entered the second trimester of pregnancy on the effective date of enrollment, the transitional period will include postpartum care directly related to the delivery.

6. Receiving treatment for an exacerbation of a chronic illness including, but not limited to:

Cancer	Kidney Dialysis
ALS	Lupus
Asthma	Multiple Sclerosis
CIDP	Myasthenia Gravis
Cystic Fibrosis	Parkinson's Disease
Dermatomyositis	Polymyosistis
Diabetes	Rheumatoid Arthritis
Gaucher's Disease	Scleroderma
Hemophilia	Sickle Cell Anemia
	Transplants

If the member does not meet the above criteria, the transitions of care guidelines do not apply. The services the member receives must be consistent with the requirements found in their Evidence of Coverage (EOC).

Who Can Initiate the Transition of Care Process?

1. A members may initiate the process by contacting the Customer Contact Center. The Customer Contact Center representative will refer the member to the Case Management Department. The Case Manager will then contact the member to assess his or her needs.

2. Health Net Account Manager can initiate the process by providing the member with a Transition of Care Form in his or her member packet. The member would complete the form and either mail it to the Case Management Department or Health Net Account Manager can give the form to the Case Management Department.

3. A Provider can initiate the process by contacting the Provider Call Unit. The Call Unit will send a request to the Case Management Department, which in turn will contact the provider to get the information.

CARE MANAGEMENT PROGRAMS

Health Net's Care Management Program targets members at risk for or who are experiencing a significant medical event. The program serves as a means for achieving wellness and autonomy through support, coordination of services, communication, education, and identification of health care resources.

Comprehensive Case Management Program

Targets members with care needs that require an intensive level of service. The Case Manager arranges for the delivery of care and monitors the member's condition on an ongoing basis.

Complex Case Management

Targets members with a significant, life-limiting condition with multiple co-morbidities, significant psychological & social issues and with multiple physicians involved in the member's care.

High Risk OB Program
Primary focus is to reduce the occurrence of preterm births utilizing a three-tier approach.

Oncology Case Management Program
Targets members with newly diagnosed or recurrent disease to educate the member and coordinate necessary referral services.

Post Discharge Program
Outreach call after hospital discharge to assure member has an understanding of discharge instructions, medication knowledge and adherence, and confirm ordered home care services initiated.

Renal Care Program
Targets members who have been diagnosed with End Stage Renal Disease and are currently being treated with dialysis to provide ongoing health status monitoring and interventions.

Transplant Case Management Program
Supports members through the evaluation, transplant and recovery processes.

CLINICAL ACCOUNT MANAGEMENT
In an effort to expand the services provided to our clients and enhance methods for achieving cost/quality outcomes, Health Net has established Clinical Account Management to enhance delivery of our current Medical Management Programs for designated employer groups. The Clinical Account Management Program provides dedicated medical management support and oversight to these employer groups to offer solutions and implementation strategies to meet unique client needs.

Goal
The Clinical Account Manager is a medical management "account manager" and serves as a proactive partner with the employer group to improve the overall health care experience and provide direct assistance with all aspects of the identification, coordination and management of health services for specific employer groups.

The Clinical Account Manager works with the Sr. Account Consultant, designated Plan Medical Director and the employer group in a collaborative manner to achieve the program objectives:

- Provide the employer group with customized assistance and support to promote quality and mitigate medical cost trend
- Provide a customized approach to understanding the medical benefit plan and delivery system

- Integrate knowledge and group capabilities to coordinate activities to promote group wellness
- Provide education, advice, and identification of the health status of the group and resources for information, services and analysis
- Targeted actions related to the overall health, health promotion and disease prevention

SECTION FIFTEEN

BILLING AND PAYMENTS

15

BILLING AND PAYMENTS

The following section explains the billing and payment method we utilize and includes information on our online Interactive Billing Services (Billing).

Billing Method: Members Added or Terminated Within a Specific Month

SBG (Employers with 1-50 lives)
For groups with up to 50 employees, billing is prorated by the number of days in the month that the member is active. Premium charged will be calculated by using the number of days effective divided by the number of actual days in the month.

For example, if the member is effective on the first day of a 31-day month, the premium charged to the employer will be for the full month:
31 effective days / 31 days in the month = 100 percent premium charged to employer.

However, if a member becomes effective on the 10th day a 31-day month, then the premium charged to the employer will be approximately 71 percent of the month's premium:
22 effective days / 31 days in the month = ~71 percent premium charged to employer.

LBG (Employers with 51+ lives)
Groups with 51 or more employees have two available billing options. Your Account Manager will discuss with you the best option for your specific group. Below is a brief overview of the two options available:

Option 1 *(Proration Method 1):*
This billing option allows a member's coverage to begin on the first day of the month following the designated waiting period that is determined by your company and agreed to by Health Net. The premium is charged for the full monthly premium.

All terminations of coverage will be effective the last day of the month of the coverage month, premium is charged for the full monthly premium.

Option 2 *(Proration Method 5):*
If a member is added during the 1st through the 15th of the coverage month, premium is charged for the full monthly premium. If a member is added during the 16th through the last day of the coverage month, there is no premium charged for the coverage month.

If a member is terminated during the period that includes the 1st through the 15th of the coverage month, there is no premium charged for the coverage month. If a member is terminated during the 16th through the last day of the coverage month, premium is charged for the full monthly premium.

Health Net Invoice

Health Net will send the invoice by the 20th of the month prior to the coverage month. This invoice will list the active subscribers in effect on the company's plan(s).This information will be based on the Health Net enrollment forms and change and cancellation forms received from the company by the 10th of the month during which the invoice is generated (i.e., the month prior to the coverage month). Notification of enrollments, changes or cancellations should not be marked directly on the invoice.

Health Net requires that the employer pay the dollar amount noted on the invoice under the heading "Pay This Amount." Any adjustments to credit or debit the company's account will be reflected on the next invoice.

When Payment Is Due

Payment of an invoice is due to Health Net by the first day of every month for coverage that month; for example, Health Net will send the April invoice by March 20. The company should then remit payment by April 1. There are two advantages for employers to pay as early as possible: 1) to increase the accuracy of the following month's invoice and 2) to avoid any interruption of health care coverage to their employees.

Employers should call the Account Services Unit at 1-800-384-1878 *(groups 2-50 lives)* or 1-800-321-5469 *(groups 51+ lives)* with any billing problems and questions which may arise.

MANUAL BILLING AND PAYMENT PROCESS

Manual Payment Process

- Premiums are payable monthly. Include the remittance advice and payment only.
  - Health applications must always have premium payment submitted concurrently. A minimum of one month's premium must be submitted with the application.
  - Applications submitted without premium will be returned to the broker (except for existing policyholders adding to an in-force policy).
- Indicate the group number and invoice number on the check
  - Make sure payment is submitted on or before the due date. Health Net of the Northeast, Inc. will not accept post-dated checks.
  - Checks must be made payable to Health Net of the Northeast, Inc.
  - Health Net may terminate coverage for any group that does not remit full payment by the end of the grace period on which payment is due. If payment is not received after the grace period is over, Health Net will terminate the group at the end of the month.
- Health Net will not pay claims incurred after the termination date.
- Health Net will not reinstate groups that have been terminated due to a negligent payment history.

Employers need to include their group plan number on all correspondence that is sent to our office. This provides prompt identification and processing.

Send payment to Health Net as follows:

BILLING AND PAYMENT	
Direct Addresses	**Overnight Addresses**
Bank of America **Health Net of Connecticut, Inc.** P.O. Box 30626 Hartford CT 06150-0626	**Bank of America** **Health Net of Connecticut, Inc.** Lock Box # 30626 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108
Bank of America **Health Net of New York, Inc.** P.O. Box 19017 Hartford, CT 06150-9017 *(For NY Charter plans)* **Bank of America** **Health Net Insurance of New York, Inc.** P.O. Box 31965 Hartford CT 06150-1965 *(For NY Outlook POS, NY Outlook EPO and NY Outlook HSA plans)*	**Bank of America** **Health Net of New York, Inc.** Lock Box #19017 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108 *(For NY Charter plans)* **Bank of America** **Health Net Insurance of New York, Inc.** Lock Box #31965 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108 *(For NY Outlook POS, NY Outlook EPO and NY Outlook HSA plans)*
Bank of America **Health Net of New Jersey, Inc.** P.O. Box 30599 Hartford, CT 06150-0599	**Bank of America** **Health Net of New Jersey, Inc.** Lock Box #30599 99 Founders Plaza, 3rd Floor Mailroom East Hartford, CT 06108

ELECTRONIC BILLING AND PAYMENT PROCESS

Online Billing and Enrollment

Billing and Enrollment can be conducted online at **www.healthnet.com**. Eligible employers are able to:

- View and pay bills online
- Research up to two years of billing and payment history
- Enroll, terminate and modify employee and dependent enrollment
- Communicate with billing and enrollment specialists through a secure online message center

Access to all these tools are managed by the respective employer group's client administrator, ensuring security and administrative ease in the management of delegated users.

Electronic Funds Transfer (EFT) Process

Electronic Funds Transfer (EFT) is the process by which Health Net automatically debits the customer's account on the 5th day of the month, or next business day following the 5th day (if the 5th is a non-banking day, weekend or holiday). The customer is required to submit a signed "Request for EFT" form, along with a voided check of the account to be debited for the premiums. The amount debited against the customer's account is the current month's premium only. It **does not** include any retroactive premiums or manual adjusted premiums applied to an invoice. If there are any retroactive premiums or manual adjusted premiums charged, then the customer must remit a separate payment by check, customer initiated EFT, or any other method of payment separate and apart from the EFT process.

NOTIFYING HEALTH NET OF ENROLLMENT CHANGES

How to Notify Health Net

For prompt, accurate processing of all enrollment transactions, employers need to complete the Health Net Enrollment Form and/or Change and Cancellation Form. On the form, they need to include the company group number and plan code ("Master Package" on form), and send it to Health Net. Copies of these forms can be obtained through your Health Net representative or by logging in to **www.healthnet.com.**

Employer should **NOT** mark any changes directly on their invoice. The forms serve as enrollment/disenrollment notification; the invoices do not. When completing the Health Net enrollment form, employers need to include the name and access code of the primary care physician(s) being selected and coordination of benefits and dependent information, if applicable.

When Forms are Due to Health Net

All Health Net Enrollment Forms and Change and Cancellation Forms must be submitted to the plan by the 10th of the month prior to the effective date of the enrollment and within 31 days of the qualifying event. Meeting this deadline will allow Health Net to reflect these changes and all appropriate premium adjustments on the invoice for the month in which the enrollment, change and/or cancellation is effective.

Late Reports of Enrollments, Changes or Cancellations

All enrollment transactions not reported to Health Net by the 10th of the month will automatically be reflected on the company's Health Net invoice for the following month. The amount due will be adjusted accordingly to conform to the Health Net retroactivity policy.

Retroactivity Policy

Health Net's retroactivity policy allows a one-month retroactive adjustment (credit or debit) for all enrollment transactions. Since a COBRA situation may require more flexibility regarding the reinstatement of members, special provisions will be allowed for COBRA members upon prior approval from Health Net.

Mailing Enrollment Transactions

Health Net provides preaddressed envelopes for submitting Enrollment and Change and Cancellation Forms. If an employer must use a different envelope, they should send it to the address printed on the group invoice. To obtain additional invoices, they can call the Account Services Unit at the number located in the *How To Reach Us* section of the manual.

COBRA Groups

All COBRA groups administered by a Third Party Administrator will be set up with a separate group number.

SECTION SIXTEEN

CLAIMS

16

CLAIMS

The following section will help you understand the process that members should follow when submitting and filing claims.

Claim submission

Although members usually do not have to complete claim forms when obtaining care from an in-network provider, there may be certain situations when they may be required to complete claim forms to receive reimbursement, such as in the following situations:

- When obtaining services from a non-participating laboratory.
- When obtaining care from an out-of-network provider and they have out-of-network coverage.
- When Health Net is the secondary insurance carrier.

Members should submit claim forms and claim resubmission forms to the addresses located in the *How To Reach Us* section of the manual.

Claim filing deadlines

- Commercial Members and participating providers must submit an in-network claim to Health Net within 120 days of the claim's date of service.
- Commercial Members and non-participating providers must submit an out-of-network claim to Health Net within 12 months of the claim's date of service.

Claims that provide all necessary information are processed within 30 business days. Necessary information includes all of the following:

- Patient name and Health Net Member ID#
- Health Net Provider ID#
- Provider information, including Federal Tax ID Number (FTIN)
- Date of service
- Place of service
- Diagnosis code
- Procedure code
- Individual charge for each service
- Provider signature

Explanation of Benefits (EOB)

Health Net will send a member an EOB once it processes a claim for a service provided to the member. This form explains the action taken by Health Net on that claim. Depending on the claim, the EOB may include the amount paid by Health Net, the patient's responsibility, allowed charges, and, if applicable, the reason Health Net denied coverage and its corresponding explanation. The EOB will explain the members' rights to question our decision. Go to the end of this section to see a sample of the Health Net EOB.

If you have any questions regarding a particular claim submission, please contact the Account Services Unit or your Health Net representative. Members can check claims online at **www.healthnet.com** or by calling Health Net's Customer Contact Center at 1-800-441-5741.

Health Net®
www.Healthnet.com

HEALTH NET OF CONNECTICUT, INC.
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944 (1)

Patient Information

Subscriber: RONALD A SMITH (2)
Patient: RONALD A SMITH

Provider Information

Sonora Quest Laboratory (3)
1234 Any Street
City ST 06000-000

RONALD A SMITH (4)
123 DRIVE LANE
CITY ST 06000-000

(5) **PLAN: CT COM**

(6) Process Date:	09/30/2005
(7) Client Number:	Z03334
(8) Health Net ID:	HN999999999
(9) Provider ID:	1Z7107
(10) Benefit Year:	01/01/2006-12/31/2006

Patient's Responsibility

(11) Deductible:	0.00
(12) Coinsurance:	0.00
(13) Copay Amount:	0.00
(14) Not Covered:	0.00
(15) Provider May Bill You:	0.00

Questions?

(16) Please contact us at www. healthnet.com or at One Far Mill Crossing P.O. BOX 904 Shelton, CT 06484 or call us at (800) 441-5741.

EXPLANATION OF BENEFITS

THIS IS NOT A BILL – RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

	Charges/ Allowed Charges	Discounts/ Not Covered	Deductibles/ Others Ins.	Copay/ Coinsurance	Plan Pays/ Member Pays
Date(s) of Service: 12/01/2005 (17)			**Claim#** 2005091602975525 (18)		
Service: CARE IN DOCTOR'S OFF (19)			**Reasons: OF** (20)		
	67.09 (22)	60.44 (24)	0.00 (11)	0.00 (13)	6.65 (26)
	6.65 (23)	0.00 (14)	0.00 (25)	0.00 (12)	0.00 (15)
Date of Service: 01/10/20006			**Claim#** 200601910297562		
Service: CARE IN DOCTOR'S OFF			**Reasons: OF**		
	60.00	40.00	0.00	0.00	6.65
	6.00	0.00	0.00	0.00	0.00
Claim Total (27)	127.09	100.44	0.00	0.00	13.30
	12.65	0.00	0.00	0.00	0.00
Total: (28)	127.09	100.44	0.00	0.00	13.30
	12.65	0.00	0.00	0.00	0.00

Payment: (29) 0.00 Interest: 0.00 Date:

Notes OF (21) PROVIDER MAY BILL YOU THIS COINSURANCE PERCENTAGE OR COPAY DOLLAR AMOUNT PER YOUR PLAN.

(30)

Benefit Year	Member Deductible	Family Deductible	Member Coinsurance
2006	0.00	0.00	0.00
2007	0.00	0.00	0.00
(31) **Health Net paid Year-to-date**		0.00	

If you are covered by more than one carrier for medical benefits, file all claims with each carrier and provide each with information regarding all of the coverage you have.

If you suspect fraud or abuse please contact the Fraud Hotline at 1 (800) 747-0877.

THIS DETAIL EXPLANATION WILL CLARIFY YOUR PAYMENT RESPONSIBILITIES OR REIMBURSEMENT. PLEASE SEE LAST PAGE FOR IMPORTANT ADDITIONAL INFORMATION AND TELEPHONE NUMBERS.

CALL-OUT NUMBERS	FIELD NAME AND DESCRIPTION
1	Health Net of (location) address.
2	Name(s) of the policy subscriber/patient.
3	Provider name and address.
4	Name and address of Patient or Subscriber (if patient is under age 18).
5	Type of contract the member holds (POS, PPO etc.)
6	Process Date – Date the claim was extracted for payment.
7	Client Number assigned by Health Net that identifies a specific member group.
8	Health Net member identification number (ID) that appears on the membership card.
9	Provider ID number assigned by Health Net that identifies attending provider.
10	Benefit Year – Current benefit year that the member is enrolled in.
11	Deductible - The amount on this service that was applied to the member's yearly deductible.
12	Coinsurance - Percentage of allowed charges that the member is responsible for according to the Evidence of Coverage or similar document. Your plan deductible (if any), and amounts in excess of Health Net's Maximum Allowable Amount (as defined in your plan), are always your responsibility.
13	Copay Amount - The dollar amount that the member is responsible for according to the Evidence of Coverage or similar document.
14	Not Covered – Any portion of the charges that the member is responsible for paying, including but not limited to: services not covered under the Evidence of Coverage or similar document, the difference between total charges and the allowed charges, or the penalty for failing to obtain prior authorization on required services per the Evidence of Coverage or similar document.
15	Provider May Bill You – The amount the member is responsible for paying to the physician/provider.
16	Questions - Member inquiry information.
17	Date of Service - The date the service was rendered by the physician/provider or the date of admission for inpatient hospital stays.
18	Claim # - The number the health plan assigned to the claim.
19	Service - The category of care received.
20	Reasons - The remark code and its corresponding explanation (which can be found at the bottom of the statement) further explains payment or denial of the service. Refer to item number 21.
21	Notes - The remark code and its corresponding explanation further explains payment or denial of the service.
22	Charges - The full amount billed by the physician/provider.
23	Allowed Charges - Total charges minus any not covered or discounted amount equals the allowed charges.
24	A discounted amount off total charges that the health plan has negotiated with the physician/provider; the member is not responsible for this amount.

25	Other Insurance - The amount paid by another insurance carrier. The amount is subtracted from the allowed charges and may reduce the member's responsibility.
26	Plan Pays - The amount remaining after adjustment, including other insurance, deductible, coinsurance and copayment amounts have been subtracted from the allowed charges.
27	Claim Total - Total amount of charges billed by the physician/provider for a specific claim.
28	Total amount of all claim numbers on the Explanation of Benefits (EOB).
29	Payment to member. If dollars are populated in this field it will match the check received by the member. If the dollar amount is zero, payment was made to the provider, or no benefit was payable.
30	Year-to-date totals for member and family deductibles, and member coinsurance.
31	Lifetime Paid - The amount paid by Health Net, Inc. on the member's behalf during the current calendar year.

SECTION SEVENTEEN

LEGAL INFORMATION/MISCELLANEOUS ITEMS

17

LEGAL INFORMATION AND OTHER MISCELLANEOUS ITEMS

The following will provide you with additional legal information and miscellaneous items that will help you in managing your Health Net business.

Applicant / Client Responsibility

Health Net requires all applicants age 18 and older to personally read, complete and assume accountability for the "Conditions of Enrollment" by signing and dating the application. All applications must be completed and signed in **blue or black** ink by the applicant and the applicant's spouse. The applicant or payor is held accountable for the accuracy of all health information including omitted alcohol/drug use. All plan change requests must be completed by the applicant/insured member.

Retroactive Action (Rescissions)

Health Net may initiate a retroactive action ("rescission") at any time due to false or omitted health history information on the application. Claims submitted are audited to ensure that pre-existing conditions not listed on the application were not diagnosed, evaluated, or treated during specified periods prior to enrollment. If a pre-existing condition that should have been disclosed is discovered, the contract may be retroactively canceled and premiums may be refunded, less any claims paid.

Broker commission is adversely affected by any retroactive cancellations. Any commissions paid on a policy which is rescinded in whole or in part will be charged back accordingly and collected from the broker.

Rate Guarantee

Rates can be adjusted with 30-day notice to member. [Note: New Jersey requires 60-day notice.]

Effective Dates

Health Net offers the 1st and 15th of the month effective dates. Insurance brokers have no authority to bind coverage or assign effective dates. Effective dates for applications will not be backdated.

Discrimination

Health Net strives to provide coverage to all applicants who either meet Health Net's underwriting guidelines or qualify for HIPAA guaranteed coverage. Health Net does not discriminate among applicants by race, religion, gender, color, national origin, or other conditions or criteria that are unrelated to the applicant's health status.

OTHER MISCELLANEOUS ITEMS

QUALITY ASSURANCE (HEDIS)

The quality of care provided to our members is also evidenced in routinely high scores received on the Health Plan Employer Data Information Set (HEDIS). The report is defined by The National Committee for Quality Assurance (NCQA) and produced annually by health plans. Health Net has developed treatment protocols and guidelines for preventive services such as physical exams and immunizations as well as disease and procedure specific guidelines for treating heart attacks, and using and monitoring drugs.

Effective July 5, 2006, The National Committee for Quality Assurance (NCQA) awarded an accreditation status of "Excellent" for service and clinical quality to all three of Health Net of the Northeast's commercial lines of HMO and POS plans. Health Net was also awarded "Quality Plus Distinction" in Member Connections for effectively engaging members in their care, especially via the Web. The "Excellent" status, according to NCQA, is reserved for only those plans that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement and deliver excellent clinical care.

Health Insurance Portability and Accountability Act (HIPAA)

Health Net is pleased to acknowledge that we are HIPAA compliant with the Privacy provision, Transactions and Code Sets provision, and the security requirements of HIPAA. We have developed policies and procedures to ensure that our members' information is protected and safeguarded according to the law. A Notice of Privacy Policy (NOPP) is sent to members annually outlining their individual rights.

Health Net's Confidentiality Policy

For the Customer Contact Center to release confidential medical information regarding a Member's claims, Health Net requires that the Member complete and sign the Member Authorization Form. The completed Authorization Form provides Health Net with a signed, written release from the Member (or from a legal guardian/power of attorney, with appropriate documentation) authorizing us to release the confidential information to the benefits administrator or broker. The following explains what information regarding a Member's claim can and cannot be released to a broker without the Member's signed, written authorization:

An Authorization Form is required for:

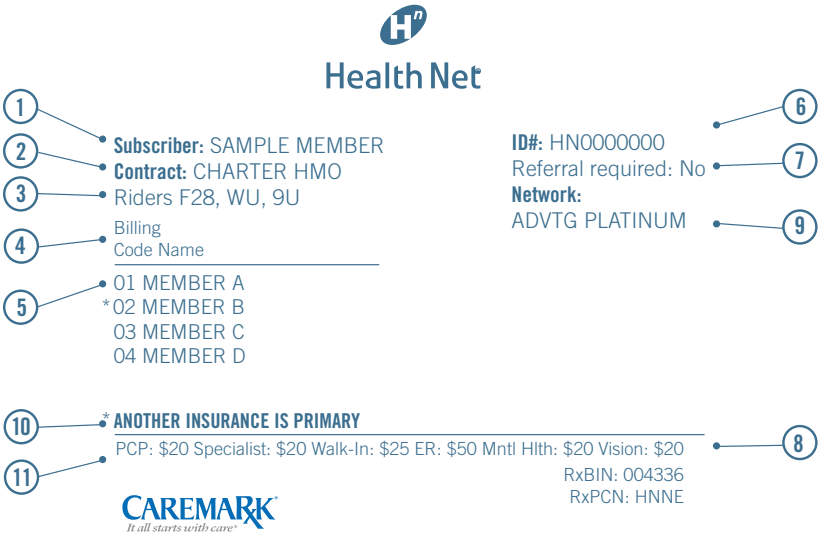
- Diagnosis codes
- Provider names
- CPT codes
- Explanation of Benefits
- Social Security Number
- Member authorizations on file
- Inquiries regarding which Members of a group utilized the plan during a retroactive group disenrollment

An Authorization Form is NOT required for:

- Health Net Member ID number
- Claims payment date
- Check number
- Claim status (paid, denied, currently in process)
- Amount paid on the claim
- Amount on a particular claim that was applied to copayment, deductible, coinsurance
- Denial code if it does not indicate diagnosis
- Member's effective date of coverage or termination with Health Net
- Name, date of birth, date of hire

Sample Health Net Identification (ID) Card

Below is an example of a Health Net ID card. Actual Member cards may vary slightly.



1. **Subscriber:** This is the name of the person who is the policy holder.
2. **Contract:** This is the name of member's Health Net contract and indicates the set of benefits for which they are eligible.
3. **Riders:** The codes refer to any additional coverage provided by the members plan.
4. **Billing Code:** This identifies the specific Health Net member.
5. **Name:** Identifies the subscriber and eligible members.
6. **ID #:** This number, along with the two-digit billing code, is used to identify an eligible member.
7. **Referral Required:** No: Plan does not require a referral from primary care physician (PCP) to see a participating specialist.
8. **Copayment:** The dollar amount indicates the copayment that will be required at the time of service from a participating physician and provider.
9. **Network:** The Network is a group of providers who have agreed to provide covered services (as defined in your plan) to Health Net members. The Network varies by product.
10. **Footnote:** An asterisk preceding a member's first name indicates that another health plan is the primary insurer for that individual.
11. **Caremark:** If you have prescription coverage with Health Net, this vendor is responsible for paying prescription claims.

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NE61876 (11/09)