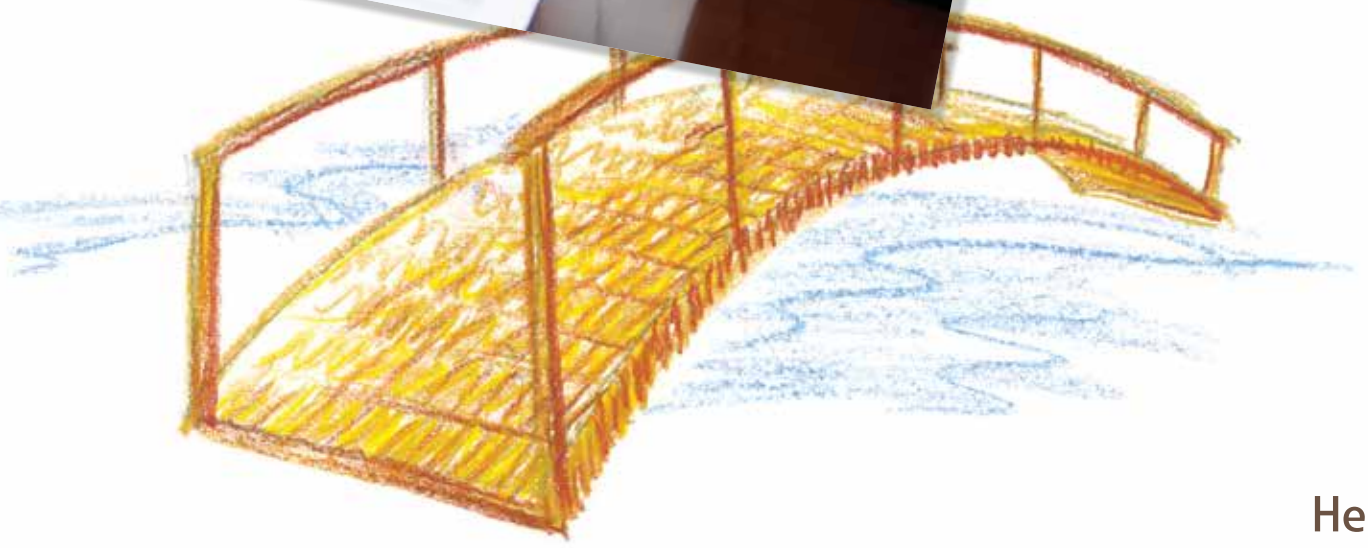
Renewal Guide

Small Group 2.0 brings you perfect-fit coverage and price

Effective October 1, 2017

Mark Rivera,
Health Net
We give you multiple ways to reach us – phone, online and via mobile app.



Health Net®

Simplified. Sustainable.

Small Business-Focused.

That's what we promised when we introduced Small Group 2.0 last year. And that's what we're delivering again for 2017.

You'll have more ways to find your perfect-fit coverage and price sweet spot.

We're expanding our product line with two additional Bronze plans. All plans come complete with pediatric dental and the Health Net extras that help your employees be their healthiest.

Health Net Small Group 2.0 is the place to be for 2017. Let's get your renewal started!

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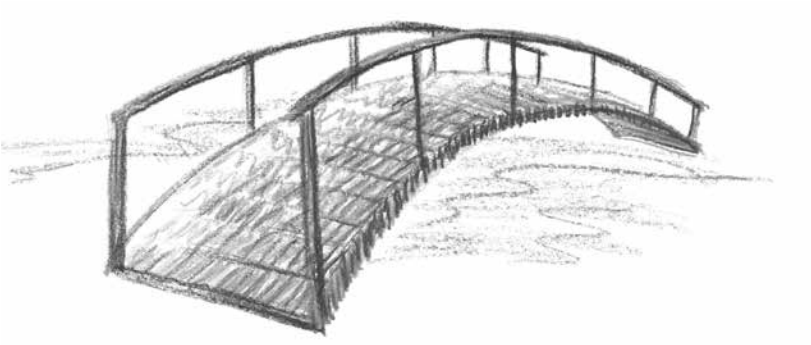

Small Group 2.0 *for 2017*

Simplified, sustainable, small business-focused

Account management

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Portfolio Highlights

Keeping businesses like yours healthy and growing is the reason we created Small Group 2.0. For 2017, we've further fine-tuned the portfolio to bring you simplified sustainability.

PPO plans

Flexible to fit your business is what our PPO designs are all about. We offer plans in all metal tiers and with a wide range of deductible options.

- New for 2017 are two Bronze plans to give you a lower price-point option.
- Pediatric dental and vision are included with all plans.

The health providers in our networks can change at any time. This can mean that members may have to change doctors to ensure benefit coverage.

Prescription drug coverage

All Health Net medical plans include prescription drug coverage for generic, brand and non-preferred drugs, as well as specialty pharmacy drugs. Member pharmacy expenses accumulate to the out-of-pocket maximum.

Health Net uses a prescription drug formulary, called the Essential Rx Drug List (EDL), for therapeutic drugs, so our members receive quality at reasonable costs. The EDL is updated quarterly.

In-network prescription drug coverage is provided through the Caremark network. See the benefit grids for specifics on each plan design.

Deductible updates by metal tier

- Platinum (LX) plans – Deductible waived on all routine lab, X-ray and imaging services.
- Gold (DX) plans – Deductible waived for routine lab and X-ray services.
- Silver, Bronze (ES) plans – Deductible applies to all routine lab, X-ray and imaging services.

Enhanced Choice

Health Net invites your clients to select a plan from our Enhanced Choice portfolio.

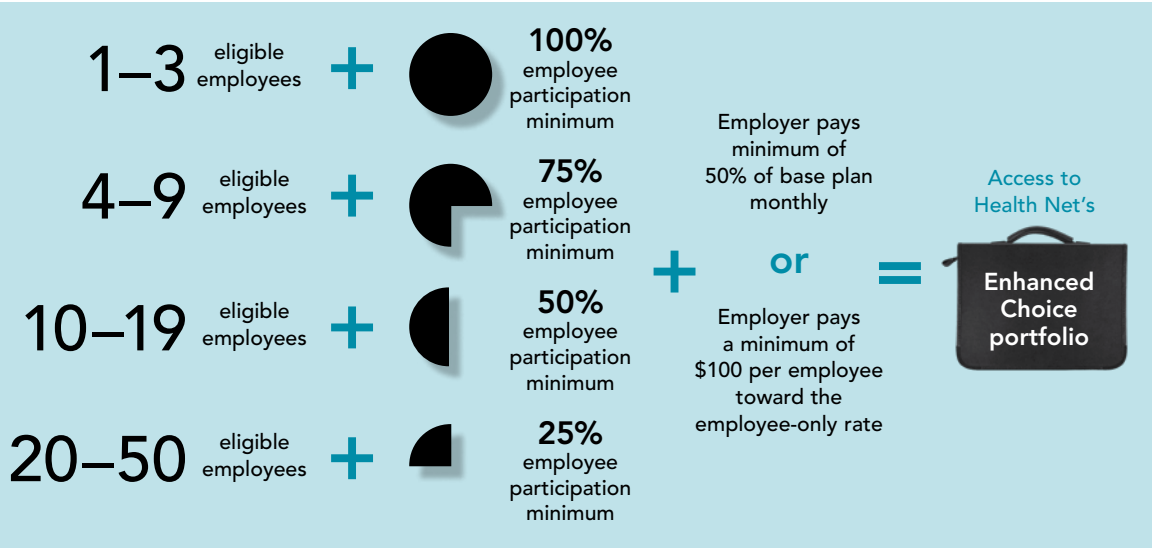
Step 1

Set an employer contribution rate.

Step 2

Choose a medical plan to offer.

Participation guidelines



Key Changes *At-a-*Glance

January 2017 changes and additions

	Plan
PPO – two new plans	• **New!** Bronze W75-5000-5-7150 • **New!** Bronze HD 6550-0-6550
Not available for 2017	• PPO Platinum W15-100-2-1300LX • PPO Gold W25-750-2-5000V
Alternative care network change	First Choice is the statewide alternative care provider. *(Optum network is no longer participating.)*

Benefit changes across plans	*2016*	*2017*
Specialty pharmacy	20% to max of $200	50%, except for HD plan

Plan-specific benefit changes	*2016*	*2017*
PPO	**Plan name: W25-1500-2-4000V**	**Plan name: W25-2000-2-5000DX**
Deductible	$1,500 / $3,000	$2,000 / $4,000
Out-of-pocket maximum	$4,000 / $8,000	$5,000 / $10,000
Lab/X-ray – deductible waived	No	Yes
Pharmacy copayments	$5 / $15 / $30	$15 / $30 / $50
Specialty pharmacy	20% to max of $200	50%

PPO	**Plan name: W30-3500-3-6350ES**	**Plan name: W30-3500-3-7150ES**
Out-of-pocket maximum	$6,350 / $12,700	$7,150 / $14,300
Specialty pharmacy	20% to max of $200	50%

Underwriting

Guidelines Summary

Group eligibility

- 1–50 employees with over 50% of the total group located in Washington, subject to out-of-area requirements below.
- Self-employed individuals and/or sole proprietors, who are submitting as a group of 1, must derive at least 75% of their income from a trade or business. Groups involved in the agricultural trade or business must derive 51% of their income from a trade or business. **Note:** An IRS form 1040, schedule C or F, from the previous calendar year, is required.
- Out-of-area requirements
  - A maximum of 49% of the group's eligible population may be out of Washington's service area.
  - A maximum of 49% of the group's enrolled population may be out of Washington's service area.
  - Those eligible employees who are out of the Washington service area but are in the out-of-state PPO service area may be written on a PPO plan.

Participation/Contribution

- The subscriber group must employ at least one eligible employee and must be a Washington small employer as defined by Washington and/or federal regulations.
- All enrolled employees must have a bona fide partnership, independent contractor, or employer-employee relationship with the subscriber group.
- For groups of 1–3 eligible employees, 100% participation is required.
- For groups of 4–9 eligible employees, 75% participation is required.
- For groups of 10–19 eligible employees, 50% participation is required.
- For groups of 20+ eligible employees, 25% participation is required.
- Employees waiving coverage due to group coverage through another employer (i.e., spousal coverage), Medicare, Medicaid CHAMPUS, Indian Health Services, or the Washington Health Plan will not be counted against minimum participation.
- A minimum group contribution of 50% or $100 of the employee premium is required.

Employee eligibility

- The employer group determines the number of hours an employee must work in order to be considered eligible. The employer may determine the hours worked for eligibility between 20 and 40 hours per week.
- Probationary period for new hires can be first of the month following date of hire, one month, 30 days, or 60 days. **Note:** All coverage must begin the first of the month following the date the probationary period is met.

Note: A Form 5208 A/B and ownership documentation must accompany a request for a first of the month following date of hire probationary period.

- Retirees are not eligible.
- Workers' compensation must cover all employees except owners and those exempt by the definition of the Washington WCD.

Benefit offering – single plan offering only

- Groups of 1–50 employees may elect one medical plan only.

Dental

- Dental enrollment can differ from medical enrollment, but the eligible subscriber must enroll in all products taken by any family member.
- Minimum employer contribution must be 50 percent of employee-only dental coverage.
- A minimum of 2 employees must enroll.

Renewal group paperwork requirements for groups

- Washington Census Form
- Washington Enrollment & Eligibility Inquiry Form

Rate information

- 12-month rate guarantee for renewing businesses.
- Rating is based on the employer's principal business address in Washington for all employees, whether residing in Washington or out of state.
- Age-banded rates only.

Medicare secondary payer data collection

Please see the Taxpayer Identification and Worldwide Employee Count Verification Form to record any changes to your TIN and to update your worldwide employee counts.

This request is the result of a new federal reporting requirement for health plans to provide CMS (Centers for Medicare & Medicaid Services) with certain information that will enable CMS to more effectively pay for the health insurance benefits of Medicare beneficiaries who also have coverage under group health plan arrangements. We appreciate your assistance and timely response to our data request so that we may comply with this mandate.

Understanding Rates

At Health Net, our goal is to minimize rate adjustments, so you can continue to provide health care benefits to your employees.

Rates take into account many variables, such as new technologies and rising health care costs. Changes related to the Affordable Care Act (ACA) for ACA-compliant health plans also impact rates.

Rate variables for ACA-compliant plans

- Age – limited to a 1:3 ratio. Example: The rate for a 64-year-old can't be more than three times (300%) the rate for a 21-year-old.
- Each family member is rated individually based on his/her age. For the purpose of rating, the member's age is determined at the time a policy is issued or renewed.
- Only the first three children under age 21 are charged.
- Rating is based on the employer's physical address in Washington for all employees, whether residing in Washington or out of state.
- Regional rating areas are now grouped together for rating based upon the regions chosen by the state of Washington.
- Health status has been removed as a rating factor.
- Your premium is priced as part of one Health Net rating pool.
- Your pricing is adjusted to reflect the average risk in the state of Washington.

Rate increases and potential offsets

We give a 12-month rate guarantee for new and renewing businesses.

After that, rate increases are typically necessary for us to continue providing quality care. We realize that higher health expenditures have an impact on small businesses, especially in today's challenging economy.

You may be able to offset a renewal rate increase or even save over current rates by switching to a different plan or plans. For example, a plan with a deductible or a higher office visit copayment could lower rates.

In the event additional federal or state legislative guidance or regulatory requirements emerge that result in a modification of the estimated impact of the benefit mandates, taxes or fees, Health Net reserves the right to further adjust our premium schedule.

Notice of the Exchange

All employers subject to the Fair Labor Standards Act (FLSA), Section 18, must provide written notice about the Health Insurance Exchange – Small Business Health Options Program (SHOP) – to each new employee at the time of hire.

- The written notification must include information about the Exchange and whether or not the employer's lowest cost health plan meets minimum value and affordability standards as defined under the Affordable Care Act (ACA).

Learn more about the various ACA provisions with our Roadmap to Reform. Go to www.healthnet.com/employer/reformguide.

- A plan meets minimum value if it covers at least 60% of allowable costs and is considered affordable if the employee's share of the premium for the lowest cost plan available to the employee is not more than 9.5% of the employee's W-2 wages.

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

Small business tax credits

The ACA offers a tax credit to qualifying small businesses. To be eligible for the tax credit, small employers must enroll through the Small Business Health Options Program, or SHOP, and must pay at least 50% of the health insurance premium, employ 25 full-time equivalent employees or less, and have an average annual full-time equivalent wage that is $50,000 or less. The maximum available credit applies to firms with 10 or fewer full-time equivalent employees and average a full-time equivalent wage that is $25,000 or less. A sliding scale reduces the credit as average full-time equivalent compensation and the number of full-time equivalent employees increases. The maximum proportion is currently 50%. Finally, small employers must file the IRS Form 8941 to receive the tax credit. Form 8941 and more information about the tax credit can be found on the IRS website at http://www.irs.gov/pub/irs-pdf/i8941.pdf.

Employer mandate

While the ACA does not specifically mandate that all employer groups with 50 or more full-time employees offer medical coverage, employers may be subject to potential tax penalties if they do not offer affordable coverage to employees and at least one employee receives a premium tax credit or cost-sharing subsidy for an Exchange plan.

Under the Affordable Care Act (ACA) employer mandate, employer groups with 100 or more full-time or full-time equivalent employees (FTEs) may be subject to a tax penalty if they do not offer affordable medical coverage to their employees in 2016. Employer groups with 50 to 99 full-time or full-time equivalent employees must report to the IRS on their workers and coverage for 2016 but are not subject to any employer shared responsibility penalty until 2017.

Note: To be subject to the mandate, an employer group must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed an average of at least 30 hours per week.

Probationary periods

Federal law requires that a group health plan and a health insurance issuer offering group health insurance coverage shall not apply any probationary period that exceeds 90 days.

The probationary period is the period of time set by an employer before coverage becomes effective for a new employee enrolling into the group's health benefit coverage.

The following probationary periods are available:

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

We cannot allow split probationary periods.

Please give us a call if you have questions about how these issues may impact your health plan. We recommend that, before making any new health care coverage decisions, you consult with your legal counsel and tax advisors to determine the best approach for your company in light of health care reform.

Summary of Benefits and Coverage document requirements[1]

As required by the ACA, health plans and employer groups must provide the *Summary of Benefits and Coverage (SBC)* to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA Continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net. To search for an SBC, go to www.healthnet.com/sbc and follow the instructions as indicated.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in paper or electronic form (i.e., email or Internet posting).

- If you provide a paper copy, the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on *four double-sided pages*.
- If you mail a paper copy, you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.
- For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.[2]
- If you email the SBC, you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- If you post the SBC on the Internet, you must advise your employees by email or paper that the SBC is available on the Internet, and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request. You may use the Model Language in the box below for an e-card or postcard in connection with a website posting of an SBC:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a *Summary of Benefits and Coverage* (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: https://www.healthnet.com/portal/shopping/sbc.action or at <[group's website.com]>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.

[2]Such requirements can be found at 29 C.F.R. § 2520.140b-1(b).

Timing of SBC distribution

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC *by the first day the employee is eligible to enroll in the plan.*
- **Special enrollees.** For special enrollees,[3] you must provide the SBCs *within 90 days following enrollment.*
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed.*

If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year.* If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than 7 business days after issuance of the new policy or the receipt of written confirmation of intent to renew your group health plan.*

At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than 7 business days following your receipt of the request.

Notice of SBC modification

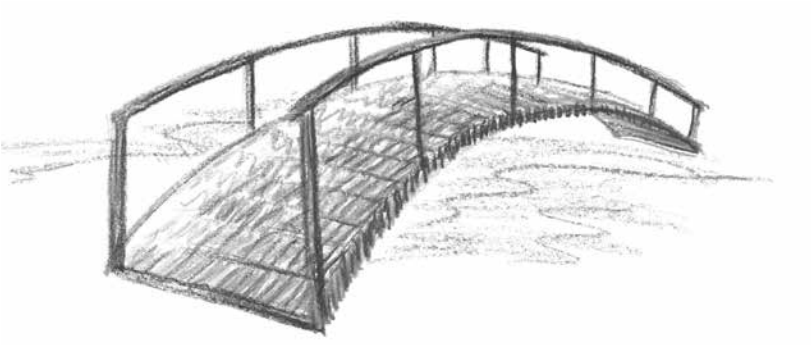
Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees *no later than 60 days prior to the date on which change(s) become effective.* You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary of bolded terms used in the SBC by visiting www.cciio.cms.gov, or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within 7 business days after Health Net receives their request.

If you have any questions, please contact your Health Net account manager.

[3]Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6.



Plans At-a-Glance

Health Net®

Washington *Small Group Portfolio*[1]

2017

Plan name	*Member(s) responsibility*											
	Metal level	Deductible[2] (single / family)	Out-of-pocket maximum[2] (single / family)	Office visit (PCP / Spec.)	Coinsurance	Deductible waived		Inpatient hospital	Outpatient surgery (ASC / Hospital)	Emergency room (copay waived if admitted)	Urgent care	Pharmacy[3]
						Lab and X-ray	CT/MRI/ PET/SPEC					
PPO												
W15-250-2-1500LX	Platinum	$250 / $500	$1,500 / $3,000	$15	20% / 40%	20% / Yes	20% / Yes	20%	15% / 20%	$250 + 20%	$50	$10 / $20 / $40 / 50%
W20-500-2-2000LX	Platinum	$500 / $1,000	$2,000 / $4,000	$20	20% / 40%	20% / Yes	20% / Yes	20%	15% / 20%	$250 + 20%	$50	$10 / $20 / $40 / 50%
W30-1000-2-5000DX	Gold	$1,000 / $2,000	$5,000 / $10,000	$30	20% / 40%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20%	$50	$15 / $30 / $50 / 50%
W25-2000-2-5000DX	Gold	$2,000 / $4,000	$5,000 / $10,000	$25	20% / 40%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20%	$50	$15 / $30 / $50 / 50%
W30-3500-3-7150ES	Silver	$3,500 / $7,000	$7,150 / $14,300	$30	30% / 50%	30% / No	30% / No	30%	25% / 30%	$250 + 20%	$50	$15 / $30 / $50 / 50%
W75-5000-5-7150ES	Bronze	$5,000 / $10,000	$7,150 / $14,300	$75 after ded.	50% / 50%	50% / No	50% / No	50%	45% / 50%	50%	$50 after ded.	$10 / 30% / 50% / 50% coinsurance after $500 ded.
HD6550-0-6550	Bronze	$6,550 / $13,100	$6,550 / $13,100	0% after ded.	0% after ded.	0% after ded. / No	0% after ded. / No	0% after ded.	0% after ded.	0% after ded.	0% after ded.	0% after ded.

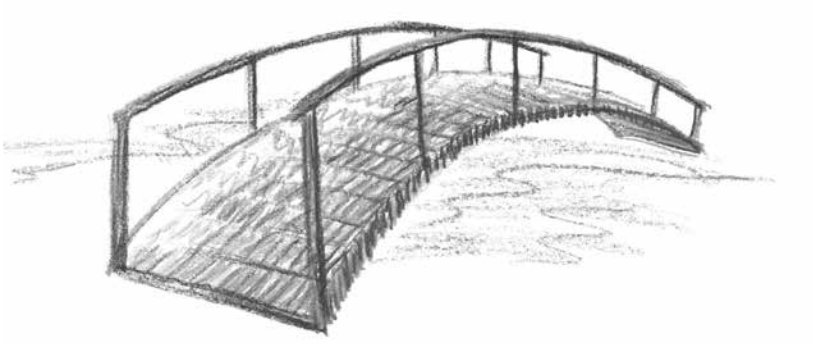
Plan name	*Member(s) responsibility*						
	Alternative care core						
PPO	Office visit (15 visits maximum each; naturopaths unlimited)						
	Chiropractic care (In-network / Out-of-network)	Acupuncture care (In-network / Out-of-network)	Naturopathic care (In-network / Out-of-network)	Massage therapy (In-network / Out-of-network)			
W15-250-2-1500LX	$15 / 40%	$15 / 40%	$15 / 40%	$15 / 40%			
W20-500-2-2000LX	$20 / 40%	$20 / 40%	$20 / 40%	$20 / 40%			
W30-1000-2-5000DX	$30 / 40%	$30 / 40%	$30 / 40%	$30 / 40%			
W25-2000-2-5000DX	$25 / 40%	$25 / 40%	$25 / 40%	$25 / 40%			
W30-3500-3-7150ES	$30 / 50%	$30 / 50%	$30 / 50%	$30 / 50%			
W75-5000-5-7150ES	$75 after ded. / 50%	$75 after ded. / 50%	$75 after ded. / 50%	$75 after ded. / 50%			
HD6550-0-6550	0% after ded.	0% after ded.	0% after ded.	0% after ded.			
Adult dental	**Deductible (single / family)**	**Maximum calendar year**	**Coinsurance (Preventive/basic/major/ortho)**	**Cleanings**	**Exams**	**X-rays**	
Plus WD50-185-1500	$50 / $150	$1,500	0% / 20% / 50% / Not covered	0%	0%	0%	

[1]All medical plans include pediatric vision and pediatric dental coverage.

[2]The annual out-of-pocket maximum includes the annual deductible, copayments and coinsurance. After the out-of-pocket maximum is reached in a calendar year, we will pay the covered services during the rest of that calendar year at 100% of our contract rates for participating provider services and at 100% of the maximum allowable amount (MAA) for out-of-network (OON) services. Members are still responsible for OON-billed charges that exceed MAA.

[3]Prescription drug tiers are Tier 1: Generic; Tier 2: Brand Preferred; Tier 3: Non-Preferred; SP: Specialty. Deductible waived unless otherwise noted.

This brochure is intended to be used for marketing purposes only and presents general information. Please refer to the Benefit Schedule and Agreement for details, limitations, exclusions, and other terms and conditions of coverage.



Ancillary Programs

One-stop shopping for dental, vision and alternative care

Designing a well-rounded benefits package is easy with Health Net. Complementing our collection of medical plans are the essentials that help your employees be their healthiest and most productive, which is good for business!

Pediatric Dental

(Available to children up to age 19)

Necessary dental care for children up to age 19 is covered. This plan covers limited pediatric dental services as described below. You can see any licensed dentist and receive benefits for covered services and supplies.

However, if you do see an in-network provider, charges for covered services will be limited to Health Net's contracted amount with the provider.

Dental summary of benefits		
Benefit Annual deductible	$100 deductible applies to all services	
Annual calendar year benefit maximum	None	
	Coinsurance	
	In-network	**Out-of-network**[1]
Preventive Routine exams	0%	0%
Bitewings X-rays	0%	0%
Prophylaxis (cleaning)	0%	0%
Fluoride	0%	0%
Sealants	0%	0%
Space maintainers	0%	0%
Basic Restorative	50%	50%
Endodontics	50%	50%
Periodontics	50%	50%
Oral surgery	50%	50%
Major Crowns	50%	50%
Denture and bridgework	50%	50%
Orthodontics Medically necessary orthodontics	50%	50%

[1]Out-of-network allowance: **When you use a nonparticipating provider, your plan benefits are based on the maximum allowable amount (MAA).** There is usually a difference between the amount your provider actually charges for a service and how much of that billed charge we allow as the MAA. Your plan pays a percentage of the MAA rather than a percentage of the billed charge. If your provider charges more than the MAA, you are responsible for the difference between the billed charge and the MAA.

Pediatric Vision

(Available to children up to age 19)

This plan covers medically necessary vision services and supplies for children up to age 19 as described below. To receive maximum benefits, you must use participating providers.

Covered services	*You are responsible for*
Routine eye exam limit: 1 per calendar year	$0 copay
Comprehensive eye exam, including dilation if professionally indicated and with refraction limit: 1 per calendar year	$0 copay
Lenses limit: 1 pair per calendar year, including: – Single vision, bifocal, trifocal, lenticular – Glass or plastic	$0 copay
Provider-selected frames limit: 1 per calendar year	$0 copay
Optional lenses and treatments including: • UV treatment • Tint (fashion, gradient and glass-grey) • Standard plastic scratch coating • Standard polycarbonate • Photocromatic / Transitions plastic • Standard anti-reflective coating • Polarized • Standard progressive lenses • Hi-index lenses • Blended segment lenses • Intermediate vision lenses • Select or ultra progressive lenses	$0 copay
Provider-selected contact lenses; 1-year supply is covered every calendar year (in lieu of eyeglass lenses): • Disposables • Conventional • Medically necessary Contact lens allowance: Allowances are one-time-use benefits; no remaining balance.	$0 copay

Optional Adult Dental

(Available to members ages 19 and up)

Health Net dental underwriting guidelines

Eligibility rules must be the same for medical and dental. Minimum employer contribution must be 50 percent of employee-only dental coverage.

The subscriber must participate in both medical and dental; however, the subscriber can choose which dependents will participate in dental. The subscriber must be enrolled in both. A minimum of 2 employees must enroll. A minimum of 10 employees must enroll in any plan with orthodontia.

Adult Dental Plan

- No orthodontia.
- Hold harmless on MAA if network provider used; otherwise, no benefit distinction in- versus out-of-network.
- MAA is 90th percentile of HIAA.

Benefits[1]	*WD50-185-1500*
Annual deductible per person	$50
Annual deductible per family	$150
Annual plan maximum per person	$1,500
Lifetime orthodontic services per person	Not covered
	In-network / Out-of-network
Diagnostic and preventive[1]	100%
Basic services	80%
Major services	50%
Orthodontic services	Not covered

[1]The deductible does not apply to diagnostic and preventive services.

Well Net

When you go with Small Group 2.0, you get Health Net's Well Net. Well Net connects employees with chiropractic, acupuncture, naturopathic, and massage therapy services.

Plan name	*Member(s) responsibility*			
PPO	Alternative care core			
	Office visit (15 visit maximum each; naturopathic care unlimited)			
	Chiropractic care	Acupuncture care	Naturopathic care	Massage therapy
W15-250-2-1500LX	$15 / 40%	$15 / 40%	$15 / 40%	$15 / 40%
W20-500-2-2000LX	$20 / 40%	$20 / 40%	$20 / 40%	$20 / 40%
W30-1000-2-5000DX	$30 / 40%	$30 / 40%	$30 / 40%	$30 / 40%
W25-2000-2-5000DX	$25 / 40%	$25 / 40%	$25 / 40%	$25 / 40%
W30-3500-3-1750ES	$30 / 50%	$30 / 50%	$30 / 50%	$30 / 50%
W75-5000-2-1750ES	$75, after deductible / 50%	$75, after deductible / 50%	$75, after deductible / 50%	$75, after deductible / 50%
HD6550-0-6550	0%, after deductible	0%, after deductible	0%, after deductible	0%, after deductible

Contact Sales at 1-888-802-7001. You can also send a message through our website at www.healthnet.com.

Alternative care

Health Net offers a full range of complementary care options. Members can choose from a broad network of credentialed health care providers who offer alternative health care services. Participating providers are part of the First Choice network.

More Than an ID Card

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

Decision Power®: Health & Wellness

Decision Power is an integrated program created to engage people in their health. With personalized tools and achievable goals, employees can feel confident in their ability to make positive and lasting behavioral changes.

Through Decision Power, we deliver a personalized and accessible approach to wellness. Here are just a few of the ways we help employees achieve improved wellness:

- Get help with a specific health goal.
- Learn about treatment options.
- Try an online Health Promotion program.
- Assess health risks with a Health Risk Questionnaire.
- Track diet, exercise or cholesterol.
- Better manage chronic illness.
- Take advantage of discounts on health products and services.

Focus on early access and prevention

Here at Health Net, we don't wait until people get sick to help out. Our job, always, is to connect your client's employees with the care they need – We want them to use their benefits!

That's why we're starting outreach – phone calls, mailings and more – to encourage our members to get their annual wellness exam. It costs $0 out-of-pocket and is the best way for people to know their health status – and for Health Net to know how best to meet their health needs.

From there, we can connect people to the care and resources to help them be their healthiest. Our resources span the full spectrum of health from timesaving conveniences to in-depth support.

Our outreach efforts elevate the core Decision Power priority: to help reduce high-cost service utilization and support workplace productivity by connecting employees with information, resources and support. Boosting health through prevention and early access to care is another way we're doing just that.

Support online and on the go

Self-service at www.healthnet.com

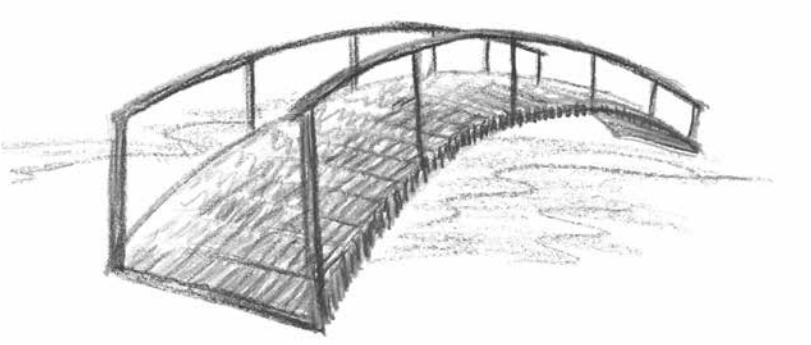
HealthNet.com guides you and your employees to the information you want and need with intuitive navigation and useful links.

It's also the place to find network doctors, hospitals and other services. ProviderSearch at HealthNet.com delivers results by location, specialty or office hours. Bookmark www.healthnet.com for fast and easy access to ProviderSearch, benefit information, wellness programs, ID cards, and more!

Health Net Mobile

Keeping track of the details – even critical details like health care information – can be daunting with our on-the-go, jam-packed lives. That's why we created the Health Net Mobile app.

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



Group Administration

Group *Administration*

This quick reference section provides tips for applications, handling group changes and using our convenient online billing and enrollment tools. You'll find all the forms you need in the Forms & Brochures section at www.healthnet.com.

Application tips

Double check that these items are complete to speed processing of your application:

- Group numbers including the suffix (alpha letter).
- Date of hire.
- Date of birth.
- Signatures – Employees must sign both the acceptance and declination sections.
- Signatures – If an employee is accepting some form of coverage but is declining another benefit, then the employee must sign both the acceptance and declination sections.

Group numbers

A group number is created for your organization and will stay the same unless you change or add plans.

Handling group changes

Adding employees or dependents

Groups can add employees at the following times:

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

  Example: The probationary period is the first of the month following date of hire. An employee hired on January 15 would have a March 1 effective date.

  1. Counting from January 15 to January 31 is 16 or 17 days (depending if you use date of hire as day 1 or not), so February 1 thru February 13 is the 30th day.
  2. Coverage effective date would be March 1 (first of the month following date of hire, after 30 days).

- Open Enrollment – During the annual renewal period, groups can enroll employees and dependents that had previously declined coverage.
- Loss of coverage – Application requires a copy of the Prior Coverage Certificate with the enrollment form.

Outside of Open Enrollment, dependents can only be added if there is a qualifying event, which includes, but is not limited to:

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

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

Important!

Recurring bill payment – For group renewals, any plan changes (i.e., new and/or existing plans canceled) will auto delete a recurring payment date.

1) Log in to your employer account at www.healthnet.com.

2) Your recurring payment date must be reestablished. If your bill is already online, you will need to make a one-time manual payment, then reestablish your recurring payment date. A recurring payment will schedule and draft your next bill that cycle. If you elect not to reestablish a recurring payment date, you can simply make an online manual payment or mail a check for your premium. Making payments by the due date keeps your account current and out of risk of termination because of nonpayment.

Billing contacts

Our Membership Accounting is available to answer any billing or eligibility questions. Below are several ways to contact our Membership Accounting Department.

Phone: 1-888-802-7001
Email: HNORMembership@healthnet.com
Fax: 1-855-607-0982

To pay your bill, mail payments to:

Health Net Health Plan of Oregon, Inc.
PO Box 749393
Los Angeles, CA 90074-9393

Please remember to send allocation directions if you have multiple medical plans and are sending one payment. Health Net billing will need to know how to apply specific portions of the total check to the separate group numbers.

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

Canceling employee/dependent coverage

When should Health Net be notified of a cancellation?

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

Why is timely notification important?

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

How does cancellation of the subscriber's coverage affect the coverage of his or her dependents?

When the subscriber's coverage is canceled, all covered dependents also lose eligibility and are canceled automatically.

[1]Permitted days are subject to contract agreement.

How is employee coverage canceled?

The group administrator may process the change through the Online Billing and Enrollment tool at www.healthnet.com. You may also use the following methods:

Email: HNORMembership@healthnet.com

Regular fax: 1-855-607-0982
(Non urgent – Membership has 3 business days to complete.)

Urgent fax: 1-855-346-5774
(Must enter Urgent in the subject line. Will be processed within 24 hours.)

How can a dependent's coverage be canceled if the subscriber continues to be covered?

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

Enrollment and Change Form

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

Online billing and enrollment

Convenience and control 24/7

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

With Online Billing and Enrollment, groups can:

- Edit payment amounts.
- View and print billing statements.
- Make an online payment (checking/savings accounts).
- Set up a one-time payment date for an automatic payment.
- Set up recurring monthly payments.
- Retain up to 24 months of billing and payment history for easy access (active payor parent group only).
- Track and update eligibility.
- View, add and update enrollment information anytime.
- Utilize convenient reporting features.
  - Active member roster
  - Canceled member roster
  - Enrollment requests

All reports are easily downloaded into a PDF or CSV format.

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

Simplified. Sustainable. Small business-focused.
Health Net has you covered.

Questions? We're here with answers.

- Call your Health Net account manager.
- Visit us online at www.healthnet.com.
- See ACA-related information at www.healthnet.com/employer/reformguide.
- Read the latest news about Health Net at www.healthnetpulse.com.

For more information please contact

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway, Ste. 200
Tigard, OR 97223

Small Business Group
Sales and Account Management
1-888-802-7001

Assistance for the hearing and speech impaired
TTY users call 711.

www.healthnet.com

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