Health Net®

Large Business Application

for Group Service Agreement/Group Policy

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

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are neither obligations of, nor guaranteed by, the Health Net Entities.

Application is hereby made for a Group Service Agreement/Group Policy provided by the Health Net Entities, the DBP Entities and/or the Fidelity Entities, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring coverage hereunder. The following information regarding employee data is being submitted to allow the Health Net Entities, the DBP Entities and/or the Fidelity Entities to determine the eligibility of employees seeking enrollment.

Welcome to Health Net

Simple steps for completing the form:

1. Carefully review and select the plan option(s) that are best for your business.
2. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

Health Net Medical: 1-800-522-0088 (*English*)
1-877-891-9050 (*Cantonese*)
1-877-339-8596 (*Korean*)
1-877-891-9053 (*Mandarin*)
1-800-331-1777 (*Spanish*)
1-877-891-9051 (*Tagalog*)
1-877-339-8621 (*Vietnamese*)

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

For administrative use only:	
Existing Business/Group	**New Business/Group**
PO Box 9103	Please send all completed
Van Nuys, CA 91409-9103	paperwork to your designated
www.healthnet.com	account executive or broker.

1. Employer group information

Corporate name or (DBA):	SIC:	Names of: ☐ Affiliates ☐ Subsidiaries to be included

Location address:	City:	State:	ZIP:
Billing address (if different than location):	City:	State:	ZIP:

Tax ID number (TIN):	Total number of employees worldwide:

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

2. Eligibility information

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

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

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

Eligible dependents

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

Domestic partners

All new group plans effective after January 2, 2005, must provide domestic partner coverage equivalent to the spouse coverage offered.

Standard ☐ All members – Same sex or opposite sex partners qualify for coverage.

Extended ☐ All members qualify – Same sex or opposite sex at any age can be enrolled.

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

3. Effective date information

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

4. Employer mandate *(Determination of full-time employee status and eligibility)*

If you are subject to Employer Shared Responsibility, please indicate the measurement method used for determining full-time status for each of your group's eligible classes.

Measurement effective date:

Describe your group's eligible classes (for example, hourly employees)	**Measurement method (check only one method for each employee class)**
Eligible class:	☐ Monthly ☐ Look-back (Length of measurement period, _____months)
Eligible class:	☐ Monthly ☐ Look-back (Length of measurement period, _____months)
Eligible class:	☐ Monthly ☐ Look-back (Length of measurement period, _____months)
Eligible class:	☐ Monthly ☐ Look-back (Length of measurement period, _____months)

If your group's total number of employees who are offered coverage changes by more than 10% as a result of the change in the measurement method, Health Net may request census information on the new eligible employees and dependents, and rates may be subject to change.

5. Current carrier *(List current carrier if any.)*

Is your company currently active with other health insurance? ☐ Yes ☐ No

If so, will you be canceling your other health insurance if approved with Health Net? ☐ Yes ☐ No

Current health insurance carrier: _____

Will Health Net be the only carrier? ☐ Yes ☐ No

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

Workers' compensation carrier: _____

Number of enrollees not covered by workers' compensation: _____

(Employers required to have workers' compensation must have a policy in effect to be eligible with Health Net.)

6. Employer's probationary period

1. Will there be eligibility conditions that will apply prior to the probationary period (e.g., being in an eligible job classification, achieving job-related licensure requirements, or satisfying a "reasonable and bona fide employment-based orientation period")?
   ☐ Yes ☐ No
2. Employer's probationary period for new hires/rehires – First of the month following:
   ☐ Date of hire ☐ 1 mo. ☐ 30 days ☐ 60 days*
3. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No
4. Number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30

*Health Net will adjust the effective date for new enrollees if needed to ensure that the waiting period does not exceed 90 days.

7. Employer contribution *(Note: Employer contribution for health is a minimum of 50% or $175[1], and for Life is 50%.)*

Employee Medical: _____% or $_____ Employee Dental: _____% Employee Vision: _____% Employee Life: _____%

Dependent Medical: _____% or $_____ Dependent Dental: _____% Dependent Vision: _____%

Note: Dental and Vision can be either voluntary or employer-paid. If employer-paid, you must complete the employer contribution. If you select Dental and/or Vision with no contribution, indicate "0."

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

Groups taking multiple plans, select your package:

☐ Enhanced Choice ☐ ExcelCare Choice ☐ SmartCare Choice

Groups with a single plan, select your network:

☐ Full network (HMO and EOA) ☐ ExcelCare Network[2] (HMO and EOA)

SmartCare HMO[3]

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

Other plan options

HMO Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50	**HMO Value** ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50	**HMO Advantage** ☐ 25 ☐ 35 ☐ 45
HMO Standard Dual Network[4] ☐ 20 ☐ 30	**HMO Value Dual Network[4]** ☐ 30 ☐ 40	
EOA Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50	**EOA Value** ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50	**EOA Advantage** ☐ 25 ☐ 35 ☐ 45
PPO Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45	**PPO Value** ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45	**PPO Advantage** ☐ 45
HSA[5] Value PPO ☐ 4500 Integrated ☐ Yes ☐ No		**POS** ☐ 10 ☐ 20

HRA PPO

☐ 3000 ☐ 5000 Integrated ☐ Yes ☐ No

If "Yes," select one option: ☐ Plan A: HRA pays first ☐ Plan B: Member pays first ☐ Plan C: HRA with debit card

Salud con Health Net

☐ HMO y Más 15[6] ☐ HMO y Más 25[6] ☐ HMO y Más 35[6] ☐ Salud Mexico[7]

☐ **Other:** _____

Ancillary options

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

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

9. Life and AD&D benefit selection *(If Health Net Life is selected, all full-time employees are eligible.)*

☐ **Option A** – $15,000 flat amount for all employees.

☐ **Option B** – $25,000 flat amount for all employees.

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

Life Insurance

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

_____

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

_____

10. Health questionnaire (For new groups only.)

All employer groups must answer "Yes" or "No" to the following questions. If "Yes" is selected for any of the questions, please provide additional information in the space provided below. If necessary, additional sheet(s) may be attached. The employer should not disclose anything in this application that is prohibited from disclosure under state or federal law.

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

1. To your knowledge, has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or AIDS-related complex (ARC) by a medical professional? ☐ Yes ☐ No
2. To your knowledge, are there any current pregnancies or hospitalizations for any employee, dependent of an employee, or person to be covered? ☐ Yes ☐ No
3. To your knowledge, is there any employee, dependent of an employee, or person to be covered who has received more than $5,000 of medical care in the past two (2) years? ☐ Yes ☐ No
4. To your knowledge, has any employee, dependent of an employee, or person to be covered had treatment for or been diagnosed with any diseases or defects of the following: autoimmune system, blood, heart, intestines, kidney, liver, lungs, or stomach, in the past two (2) years? ☐ Yes ☐ No
5. To your knowledge, has any employee, dependent of an employee, or person to be covered had treatment for or been diagnosed with any of the following conditions: lupus, cancer, chest pain, heart attack, hepatitis, respiratory disorders, central nervous system disorders, hemophilia or other disorders of the blood, mental health conditions, or substance use disorders, in the past two (2) years? ☐ Yes ☐ No

This health information is collected and reviewed for rating purposes only. This health information will not be used as a basis for approving or declining the employer's application for coverage or the enrollment of any individual to be covered under the group policy. This health information will not be used to impose any pre-existing condition benefit or eligibility exclusion or limitation, or to impose any premium rate or contribution level on an individual to be covered under the group policy. Such uses of health information, other than for group rating purposes, are prohibited by state and federal law.

_____

_____

_____

11. Off-cycle dental/vision plan addition renewal cycle

Your renewal date for your dental and/or vision plan addition will be coordinated with your Medical Plan renewal date.

12. Mailing methods

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

13. Underwriting criteria

General conditions

The issuance of coverage and a Group Service Agreement/Group Policy is subject to underwriting review and approval by the Health Net Entities, the DBP Entities and/or the Fidelity Entities and receipt of the first month's premium. The initial quoted rates are subject to the Health Net Entities, the DBP Entities and/or the Fidelity Entities' review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by the Health Net Entities, the DBP Entities and/or the Fidelity Entities as appropriate within specified time requirements.

The following standard minimum participation and contribution requirements apply unless modified in quote or renewal Underwriting Assumptions.

Minimum Contribution is defined as, the employer contribution toward Health Net's premium must be equal to or greater than 50% or $175 of employee single premium.

Minimum Participation is defined as, where coverage is offered on a contributory basis, health plan enrollment represents the greater of 75% of the eligible active employee population or 38 enrolled active employees; if more than one health plan is offered, Health Net's enrollment represents the greater of 38% of the eligible employee population or 19 enrolled active employees; if coverage is offered on a non-contributory basis, health plan enrollment will be 100% of the eligible employee population.

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

14. Disclaimer/Binding Arbitration Agreement

This is an application only. Coverage and the issuance of a Group Service Agreement/Group Policy is subject to review and approval by the Health Net Entities, the DBP Entities and/or the Fidelity Entities and receipt of the first month's premium. The undersigned hereby acknowledges that the preceding information constitutes true and complete representations to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. Should it be determined at the time of enrollment or during the 24-month period after the Group Service Agreement/Group Policy is issued that there has been an act of fraud or an intentional misrepresentation of material fact with respect to the application, as prohibited by the terms of this Group Service Agreement/Group Policy, the Group Service Agreement/Group Policy may be rescinded or canceled with 30 days advance written notice of such rescission or cancelation. After 24 months following the issuance of a Group Service Agreement/Group Policy, the Health Net Entities, the DBP Entities and/or the Fidelity Entities will not rescind, cancel, or limit any of the provisions of the Group Service Agreement/Group Policy due to any omissions, misrepresentations, or inaccuracies in the application, whether willful or not. Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year. Applicant, in the event this Application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the agreement(s)/ Policy and to forward such amounts in advance of the due date to the Health Net Entities, the DBP Entities, and/or the Fidelity Entities, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group and deletions from the group. Please return this Application to your Health Net and/or Health Net Life account executive or broker as specified.

Applicant, in the event this Application is accepted, agrees to cooperate with Health Net Entities in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information provided by the Health Net Entities, "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder.

The undersigned hereby acknowledges responsibility for obtaining and for sending an electronic or printed copy of the summary of benefits and coverage document ("SBC") to plan participants and beneficiaries. To retrieve your group's SBCs, go to www.healthnet.com/sbc. This "Application for Group Service Agreement/Group Policy" and any attached Addendum, together with the Health Net Entities, the DBP Entities, and/or the Fidelity Entities Plan Contract or Insurance Policy (as referenced herein), and the employee enrollment forms, form the entire agreement between the parties.

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

14. Disclaimer/Binding Arbitration Agreement (continued)

BINDING ARBITRATION AGREEMENT: On behalf of the group applicant, and subject to certain restrictions prohibiting application of mandatory arbitration to members of employer groups subject to ERISA, 29 U.S.C. SECTION 1001, et seq., I understand and agree that any and all disputes or disagreements between the group (or enrolled members) and the Health Net Entities, the DBP Entities, and/or the Fidelity Entities regarding the construction, interpretation, performance, or breach of the Health Net Entities, the DBP Entities, and/or the Fidelity Entities Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities, and/or the Fidelity Entities Plan Contract or Insurance Policy, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities, and/or the Fidelity Entities, are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the DBP Entities, and/or the Fidelity Entities involving claims for medical services malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. In the event that the total amount of damages claimed is $50,000 or less with respect to disputes involving alleged professional liability or medical malpractice, the parties shall, within 30 days of submission of the demand for arbitration, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $50,000. If the parties fail to reach an agreement during this time frame, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter, in accordance with California Code of Civil Procedure 1281.6. A more detailed arbitration provision is included in the Health Net Entities, the DBP Entities, and/or the Fidelity Entities Plan Contract or Insurance Policy.

Officer of the company signature:	Officer title:	Date:

Applicant's signature above confirms: 1) Applicant's agreement to all the terms and conditions set out in this Application, including the Conditions of Enrollment and Underwriting Assumptions; and 2) the accuracy and completeness of the information that the Applicant has entered in this Application.

15. Broker information

Broker name:	Health Net broker ID #:	Broker lic. #:	Date submitted:
Agency name:	Telephone #:	Fax #:	Email address:
Address:	City:	State:	ZIP:
Broker/Consultant signature:	Date:	Account executive name:	Date:
General agent/ID #: Beere & Purves, Inc.			Date:
General agent verification: Open Enrollment materials provided to the Employer included the applicable *Summary of Benefits and Coverage* (SBC).		General agent representative signature:	

Second broker information

Broker name:	Health Net broker ID #:	Broker lic. #:	Date submitted:
Agency name:	Telephone #:	Fax #:	Email address:
Address:	City:	State:	ZIP:
Broker/Consultant signature:	Date:	Account executive name:	Date:
General agent/ID #:			Date:
General agent verification: Open Enrollment materials provided to the Employer included the applicable SBC.		General agent representative signature:	

16. Agent/broker certification

I, _____ (name of agent/broker),
(NOTE: You must select the appropriate box. You may only select one box.)

☐ did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

OR

☐ assisted the applicant(s) in submitting this application. I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

If I willfully state as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).

Please answer all questions 1 through 3:

1. Who filled out and completed the application form? _____

2. Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3. Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

17. For Health Net use only				
Underwriter signature:	Date:	Approved: ☐ Medical ☐ Dental ☐ Vision Declined: ☐ Medical ☐ Dental ☐ Vision	Billing #:	Effective date:
Representative signature:	Date:	Group # (Health):	Policyholder # (Life):	Medical plan:

Health Net of California, Inc. offers the following products: HMO, Salud, Elect, Elect Open Access, Select, Seniority Plus. Health Net Life Insurance Company offers the following products: EPO, PPO, PPO HSA-Compatible, PPO Integrated HSA, PPO Integrated HRA, Flex Net, Life and AD&D insurance. Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity. Dental Benefit Providers of California, Inc. offers the following product: Dental HMO. Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: Vision PPO.

[1]Multi-plan packages require a minimum of 50% of the lowest cost plan (excluding Salud) or $175 per employee. Single plan option requires a minimum of 50% or $100 per employee.

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

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

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

[5]HSA-compatible.

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

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

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

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

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

FRM001903EL00 (4/15)

51-100 GSA 1/15

Health Net®

Ensure *Your Employees* Understand *Their Health Care*

Summary of Benefits and Coverage to eligible and covered persons

Instructions for reproduction and distribution.

An Affordable Care Act (ACA)[1] *requirement for employers that sponsor group health plans*

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

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

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net.

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

SBC form and manner

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

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

(continued)

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.
[2]Such requirements can be found at 29 C.F.R. § 2520.140b-1(b)

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

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

The SBC is available online at: <[group's website.com]>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

Timing of SBC distribution

For plan years with open enrollment beginning on or after September 23, 2012, you must provide the SBC as follows:

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC *by the first day the employee is eligible to enroll in the plan*.
- **Special enrollees.** For special enrollees[3], you must provide the SBCs *within 90 days following enrollment*.
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed*. If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year*. If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than 7 business days after issuance of new policy or the receipt of written confirmation of intent to renew your group health plan*.

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

Notice of SBC modification

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

Uniform glossary

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

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

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