*Health Net of California, Inc. and*
*Health Net Life Insurance Company (Health Net)*

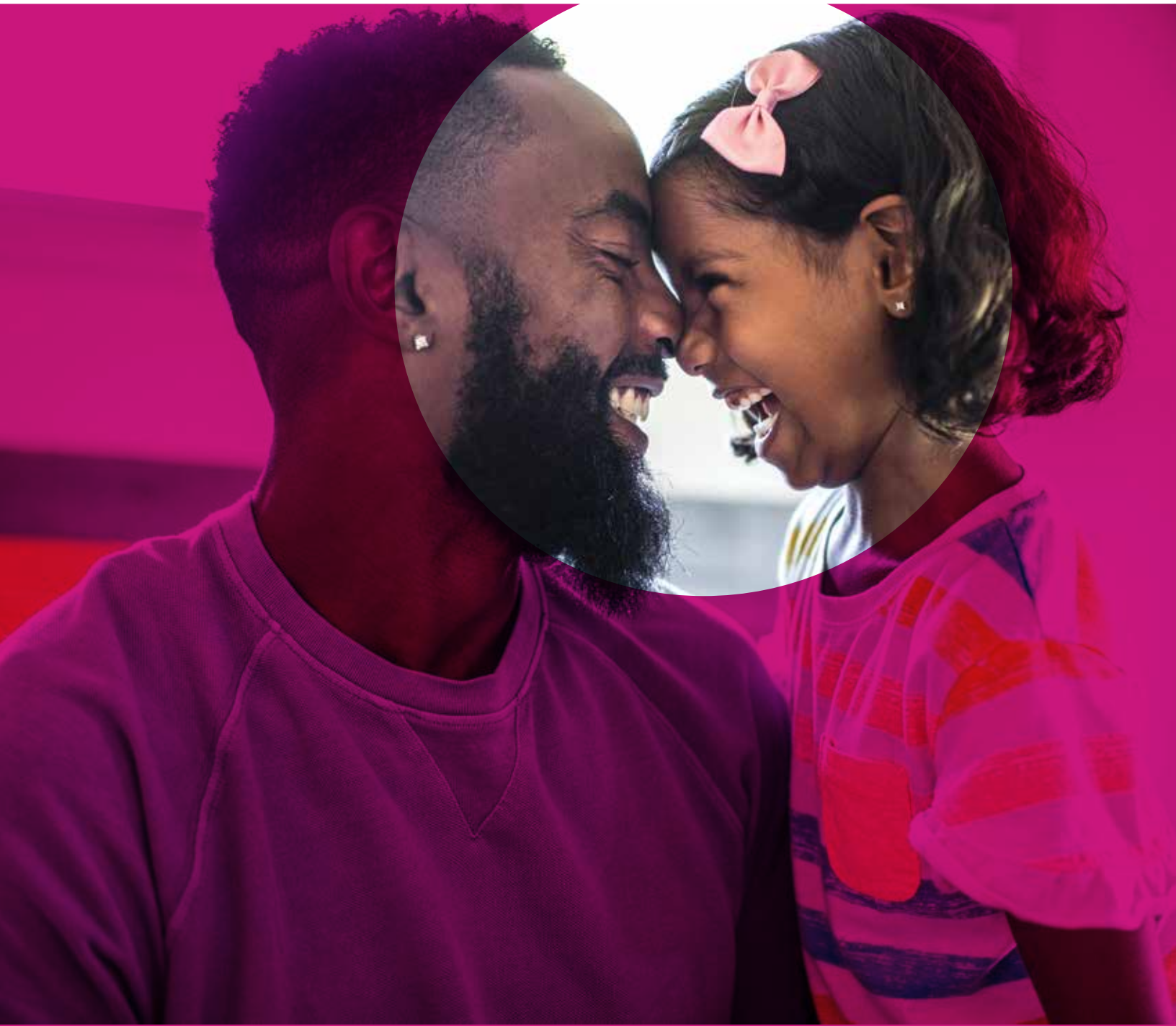
# Welcome to Health Net!

## Large Group

HealthNet.com

***At Health Net, delivering affordable health care is our top priority!***
*With a focus on the unique needs of your business, we are constantly examining the industry to provide forward-thinking solutions employers and employees want and need.*

*Health Net makes it easy for employers to offer low-cost, quality plan choices that give employees peace of mind – helping them to live well and work well.*



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# Administrative

# Customer Service

*At Health Net, customer service is at the heart of everything we do. Health Net employs a team approach to implementing new business and servicing accounts.*

In addition to your dedicated Health Net account manager, we employ a team of professionals to handle the needs of your account.

## www.healthnet.com

### *Account Services Unit*

Phone: 800-547-2967
Fax: 866-848-6715
Email: HN_account_services@healthnet.com

### *Membership/Accounting & Eligibility*

Phone: 800-909-6362, option 3
Fax: 818 676-7411

### *Health Net Billing (Payments)*

Health Net, LLC.
File #52617
Los Angeles, CA 90074-2617
Phone: 800-909-6362, option 2
Fax: 818 676-7411

### *Provider Services*

800-641-7761

### *Health Net Website Tech Support*

Member & Group
(lock outs, password resets, etc.)
Phone: 866-458-1047

### *Health Net Life Department*

Phone: 800-865-6288
Fax: 855-560-2831
HNlife_team@healthnet.com

### *Medicare/Sr. Plus Member Services*

800-431-9007

### *Customer Contact Center*

800-522-0088
Para los que hablan español:
800-331-1777

### *CVS Caremark Customer Service*

800-841-5550
(TTY: 866-236-1069)

### *Health Net Dental Member Services*

866-249-2382
(English and Spanish)

### *Health Net Vision Member Services*

866-392-6058
(English and Spanish)

### *COBRA Direct Pay (DP)*

PO Box 894702
Los Angeles, CA 90189
Phone: 800-977-2207
Fax: 916 935-4420

### *MHN Behavioral Health Services*

Contact Health Net's Customer Contact Center at 800-646-5610 for your behavioral health questions.

### *Health Net Individual & Family Plans*

Need help shopping for a plan?
877-878-7983

### *Already a Health Net member?*

Purchased your plan directly from Health Net: 800-839-2172

Purchased your plan through Covered California: 888-926-4988

### *Mailing enrollment transactions*

Health Net provides Enrollment and Change and Cancellation forms. If you must use a different envelope, you should send it to:

Health Net, LLC.
PO Box 9103
Van Nuys, CA 91409-9103

To access the Employee Enrollment and Change form or any other forms, please register online by going to **www.healthnet.com** > *Employers* > *Register*.

### *Account Services Unit (ASU) for employers*

**An additional resource available to you –** 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 with one-call resolution for the day-to-day administrative issues (e.g., claims questions, benefits questions, verifying eligibility, etc.) that may arise.

### *Contact the Account Services Unit for the following:*

- responses to general inquiries on member benefits and claims
- plan administration
- plan information and materials
- information about policies and procedures

### *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 ensure prompt, accurate and friendly service. A higher level of quality service is achieved through:

- A "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.
- www.healthnet.com. Members can check eligibility/plan information; check copayment information; order ID cards; order an *Evidence of Coverage* (EOC); request materials; change primary care physician name and address; and check claims status.

- Tele-interpreters to assist non-English-speaking members so they can speak to a representative in their own language.
- Formal member appeal process to provide quick solutions.
- Outbound calls for issue resolution follow-through.

# Ensure Your Employees Understand Their Health Care Coverage

**SUMMARY OF BENEFITS AND COVERAGE (SBC) TO ELIGIBLE AND COVERED PERSONS**

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

## Affordable Care Act (ACA) 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)[1] 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.

## 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).

### *Paper SBC*

- **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.

### *Electronic SBC*

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 on page 5 for an e-card or postcard in connection with a website posting of the SBC.

## 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 seven 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 seven 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 seven business days after Health Net receives their request.

### 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.**

[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. § 2520.104b-1(c).

[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.

# Summary of Benefits and Coverage (SBC)

## FIND PLAN INFORMATION FAST

*Choosing a health coverage option is an important choice. The SBCs clearly outline coverage options and can help you make an informed decision.*

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

The example below shows details of an SBC.

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services
**Coverage Period: 01/01/2020-12/31/2020**
**Health Net Life Ins. Co.: PPO Centene Premier**
**Coverage for:** Employee + Family | **Plan Type:** PPO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call the number on your Health Net ID card or 1-800-223-7691 or visit us at www.healthnet.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or www.healthnet.com or you can call 1-800-223-7691 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For preferred providers: $300 member/$600 family. For out-of-network providers: $900 member/$1,800 family per calendar year. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, primary care visits, specialist visits, prescription drugs, emergency room care, urgent care, outpatient mental health/substance abuse office visits, prenatal/postnatal visits, and outpatient rehabilitation services (physical, speech & occupational) are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical limit: For preferred providers: $2,000 member / $6,000 family. For out-of-network providers: $4,000 member / $10,000 family per calendar year. Separate pharmacy limit: $2,000 member / $4,000 family per calendar year. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of **preferred providers**, see www.healthnet.com/providersearch or call 1-800-223-7691. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

# New Members Don't Start Over

**PRIOR-CARRIER DEDUCTIBLE CREDIT ON PPO**

*New PPO members who paid any amount toward their prior medical plan's deductible can get a credit toward their new Health Net PPO deductible.*

## Here's how it works

- **New Health Net PPO policy must replace a PPO plan with their prior carrier.**
- **Employee or dependent has satisfied all or part of the calendar year deductible required under the prior carrier's policy.**
- **Credit will be applied to the covered individual's calendar year deductible on the current Health Net policy.**
- **Proof of deductible satisfaction under the prior carrier policy will be required upon submission of the initial claim for benefits to be payable under the current policy.**

## New group enrollment

All new group cases must include the Explanation of Benefits (EOB) information with the application at the initial time of enrollment or upon submitting the initial claim.

## New employee or dependent enrollment

Submit the new insured's EOB information to the Account Services Unit via the methods below (please be sure to include SSN):

Email: hn_account_services@healthnet.com

Fax: 866-848-6715

# Group Information from Membership Accounting

| Plan | Group number | Plan | Group number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| Our probationary period for new hires is: | | Our group's Open Enrollment is: | |
| | | | |

## When can you add an employee?

- **New hire** – New hires must meet the probationary period you have set for your group. Example: Probationary period is 1st of the month following date of hire *(e.g., full-time employees hired 1/15 would have an effective date of 2/1)*.
- **Open Enrollment** – Once a year at renewal, you can enroll employees and dependents who had previously declined coverage.
- **Loss of coverage** – Remember to include a copy of the Prior Coverage Certificate with the enrollment form when submitting an application due to loss of coverage.

## When can you add a dependent?

Dependents may be added at Open Enrollment or when there is a qualifying event.

## What is a qualifying event?

- Open Enrollment (OE)
- Benefits Reduction
- Loss of Coverage
- Contributions Increase
- Family Status Change (marriage, domestic partnership, birth, legal guardianship or adoption)
- Address change to an out of coverage area
- Out or In Area Job Transfers
- Court Order dependent

All applications for adding new dependents due to a qualifying event must be signed by the subscriber and received by Health Net within 60 days of that event.

## Most common reasons an application is delayed

- Missing date of hire
- Missing date of birth
- Missing signature
- Employee signed both acceptance and declination sections

## Cancellations

Cancellation requests for employees and/or dependents must be received within 30 days of effective date *(e.g., for an employer to cancel an employee effective 4/1, the request must be received by Health Net no later than 4/30)*.

### Notice of Changes to Coverage Terms

Commercial Large Business Group plan contracts will contain updates as shown in the "Notice of Changes to Coverage Terms" document. For details on the benefit or coverage modifications, log in to **www.healthnet.com/noc**. For more information, please contact Health Net Account Management.

**Contact us with billing or eligibility questions**

**Email:**
**HNCalifornia.Enrollment@healthnet.com**

**Phone: 800-909-6362, option 3**

**Fax: 800-977-8990**

# Tools and Resources

# Registering as a Client Administrator

For a brief tour of the Health Net Employer Portal, click on the *Take a Tour* link. It won't take long – we promise.

## Phase One (Steps to follow to request the Access Key)

1. Go to **www.healthnet.com/employer.**
2. Select *Register for Access*.


3. You can choose 1 of 2 methods to sign up:

- **Enter the Group ID number.** (**Note:** 6 characters with numbers and letters can be found on your invoice. If you have multiple Group ID numbers, use the Group ID number designated with the letter A at the end.)

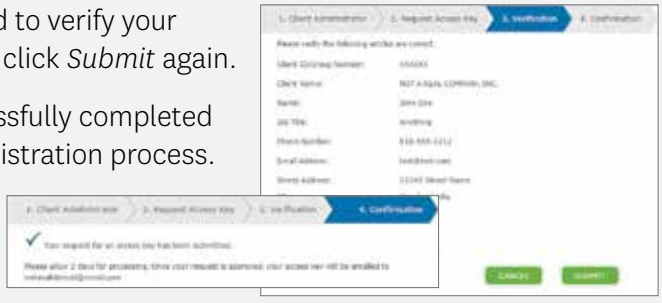
  *Or*

- **Enter the Group Policyholder ID number.** (**Note:** The Policyholder ID number must be 9 digits. Extra zero(s) must be added in front of the Policyholder number to equal 9 total digits.)

4. Select *No, please email me an Access Key*.
5. Click *Submit*.
6. Fill out all required information as indicated by the asterisks and highlighted areas.
7. Click *Submit*.

8. You will be asked to verify your information and click *Submit* again.

You have now successfully completed Phase One of the registration process.



**Please allow two business days for processing.** Once your request is approved, your **16-digit Access Key will be emailed** to the email address provided in your request.

## Phase Two (Steps to follow once the Access Key has been received)

1. Follow steps 1 through 3 from Phase One.
2. Select *Yes, I have an Access Key*, and input the Access Key provided in your email.
3. Then click *Submit* twice.
4. Follow the prompts to create a user account (create a user name and password, and select a Sign-in Seal).
5. You will be asked to verify your information and click *Submit* again.
6. Click *Continue to Manage User Accounts* in order to navigate to the Employer Portal.

**You will now have full access to Health Net's Employer Portal!**

**Questions?** Contact the Account Services Unit at **800-547-2967, option 0.**

# Online Tools and Features

## What employers can do online

### *Manage Accounts & Reports*

- Update online account information
- Add new user[1]
- View and edit users[1]
- Generate enrollment reports
- Allow broker access[1]

### *Member and Employee Support*

- View benefits and eligibility
- View Group Service Agreement
- Decision Power®
- Member discounts
- Preventive care guidelines
- Pharmacy information and drug lists
- Find a pharmacy
- Teen health

### *Manage Enrollment*

- Online enrollment tools and manual
- Employer Guide
- Health Savings Account (HSA)
- Download and print forms

### *Online Billing*

- View my bill
- Pay my bill
- Discontinue paper bill option (See Manage Accounts)

### *Wellness*

- Monthly interactive live health webinars (ask your account manager for details and registration)

### *Health Net News*

- View newsletters

### *Doctor and Hospital Information*

- ProviderSearch
- Supplemental plan provider searches (behavioral health, dental, vision, and alternative care) and other search tools
- Compare hospitals
- Compare medical groups

[1]Available to administrator users only.

## What members can do online

### *My Coverage*

- View and edit account profile
- Access coverage information
- Access *Evidence of Coverage* (EOC) or *Certificate of Insurance* (COI), and *Summary of Benefits and Coverage* (SBC)
- Print Schedule of Benefits and plan overview
- View Prior Authorization List
- Get answers to medical and pharmacy FAQs
- Transition of care information
- Request a patient's cost estimates
- Understand out-of-network benefits
- Request a second opinion

### *My Prescriptions*

- Check drug coverage and medication costs
- Find a pharmacy near me
- Research drug interactions and side effects
- Order prescriptions by mail
- View and download drug lists
- View pharmacy copays
- View benefits summary
- Understand pharmacy benefits
- View pharmacy FAQs
- Manage prescriptions, view history and order medication card
- Print prescription report

### *My Claims*

- File a medical or pharmacy claim
- Look up claim history
- Research a denied claim
- View Explanation of Benefits (EOBs)
- Download and print claim forms

### *ID cards/My Account*

- Print a temporary ID card
- Order ID card
- Change address
- Download/View ID card from Health Net Mobile App
- Change my primary care physician (PCP)

### *ProviderSearch*

- Find and compare physicians
- Search for behavioral health, dental, vision, and alternative care options Search for national PPOs, medical groups, hospitals, CA physician groups and hospital links

### *Wellness Center*

- View My Health Guide
- Complete a RealAge Test (health assessment)
- Populate my Personal Health Profile
- Quit tobacco
- Get tips on a healthy pregnancy
- Access the Nurse Advice Line (24/7 online or by phone)
- Print prevention reminders and care alerts
- Enroll in a health promotion program
- Participate in interactive health conversations
- Attend online health webinars
- Use progress trackers
- Make a healthy recipe
- Healthy family eating strategies
- Research a condition
- Preventive guidelines
- Antibiotic awareness
- Treatment cost advice
- Find and compare medical groups
- Compare hospitals
- Access member discounts
- Learn about advance directives
- Symptom checker

# Click and Go Administration

*Do more and save time with Health Net online. Protected by advanced security, our website is designed to provide you with quick access to information, tools and transactions.*

**Choose the Right Plan** *(pre-log on only)* features our flexible product portfolio, which makes it easy for you to select the right plan at the right price.

**ProviderSearch** is the fast way to locate participating providers and facilities. Search by criteria, such as type of plan, provider, specialty, physician gender, and radius within a specified ZIP code. Information is also available for ancillary services (chiropractic, acupuncture, dental, vision, and behavioral health providers).

**Manage Accounts** makes it easy to change your account information (password, password hint or email address). If you are the primary or secondary administrator to the account, you can add users, view users, or edit user access and information.

**Manage Enrollment** allows you to manage your employee's enrollment selections, add new employees and their dependents, cancel employee or dependent coverage, or change an employee or dependent's information.

**Pay My Bill** is the place to view your interactive bill (with online reconciliation) or pay your bills. You also have the ability to discontinue a paper bill option (See Manage Accounts).

**Health Net News** connects you to Health Net's current and past newsletters.

**Member and Employee Support** gives you important online tools so that you can find information you or your employees need to know quickly and easily.

Here you'll also find member tools like Decision Power® – the Health Net exclusive program that helps reduce high-cost service over-utilization and supports workplace productivity by connecting employees with the information, resources and support that fit their health and their life. You can find highlights of Decision Power on page 45.

# Enrollment Procedures

*In this section, you will find information about:*

- Your annual open enrollment.
- How to enroll new and rehired employees.
- How to enroll existing and acquired dependents.
- Selecting a participating physician group (PPG) for HMO, Elect Open Access,℠ Point of Service (POS), and Elect plans.
- The Health Net ID card.

## About the forms mentioned in this section

To enroll with Health Net, complete the enrollment/change form that corresponds to your eligibility guidelines found in your Group Service Agreement.

## Mental Health Parity and Addiction Equity Act (MHPAEA)

All ACA-compliant benefit plan contracts issued, amended or renewed include benefits in accordance with California state regulations and the Mental Health Parity and Addiction Act of 2008.

## Probationary period

Probationary periods are the length of time that employees must wait before they are eligible to enroll with Health Net. They are determined by each employer group subject to regulatory limits, and agreed to by Health Net.

### *Example 1:*

Date of Hire: 1/30
with a 30-day probationary period: 3/1

### *Example 2:*

Date of hire: 3/15
with a 30-day probationary period: 4/14

The effective date of coverage is typically the first of the month following the completion of the probationary period, if applicable.

Probationary periods are applied to:

- New full-time employees.
- Employees whose status changes from ineligible to eligible.
- Former employees rehired after 30 days from the last day worked.

### *Example:*

Hired: 1/15
Probationary period: First of the month (FOM) following one month.

Coverage effective: 3/1

## Rehires

If a terminated employee is rehired within 30 days, she or he and dependent(s) will be reinstated without a coverage lapse (i.e., a period where there is no coverage).

### *Example:*

Terminated: 8/25
Coverage ends: 9/01
Rehired: 9/18
Coverage reinstated: 9/01

Since the period between termination and rehire is less than 30 days, continuous coverage is provided.

If more than 30 days have elapsed between the termination and rehire date, but under 6 months effective date would be first of the following month. If rehire date is more than 6 months from the termination date, the employee must again fulfill your group's probationary period as if they were a new hire.

### *Example:*

Terminated: 8/25
Coverage ends: 9/01
Rehired: 10/09
Probationary period:
First of the month following one month[1]
Coverage reinstated: 12/01

[1]Varies by employer group.

## An important reminder

Please send completed enrollment/change forms of new enrollments throughout the month as they occur. We must receive signed notification within 30 days of eligibility, or your employees must wait until the next open enrollment. Prompt submission of membership changes will allow Health Net to better serve your account in the following ways.

- The effective dates of coverage for your employees and their dependents will be recorded sooner, resulting in the member receiving the ID card sooner.
- Eligibility will be visible to providers sooner.
- There will be fewer billing adjustments.

To ensure that your employees receive their Health Net ID cards as close as possible to the effective date of coverage, forms must be submitted no later than 10 business days before the effective date of the enrollment. Enrollment forms may be submitted as early as two months prior to the effective date of coverage; however, enrollment forms must be signed and received no later than 30 days after the effective date of enrollment or the open enrollment period (whichever applies).

## Annual open enrollment

### *Requirements*

- Employers must conduct an annual open enrollment for Health Net.
- The employer determines the date for open enrollment.
- The open enrollment period must last at least ten (10) days.
- The open enrollment coincides with the employer's renewal date and occurs during the same month each year.
- The employer must provide copies of SBCs to eligible employees and their families as specified in the Summary of Benefits and the Ensure Your Employees Understand Their Health Care section.

### *What is accomplished during the open enrollment period?*

- Eligible employees and their dependents may join Health Net for the first time.
- Transfer from one health carrier offered by the employer to Health Net.
- Members may add eligible dependents.
- Transfer from one plan or type of plan to another if you offer more than one plan.
- You may add or change plans or product lines, if eligible.

### *What if an employee will not be at work during the open enrollment because of vacation or leave of absence?*

We suggest that you present the open enrollment opportunity to that individual before he or she departs. If this is not possible, we suggest mailing the information regarding open enrollment to the individual.

### *What if an employee has not met the probationary period? May he or she enroll during open enrollment?*

No, the probationary period is not waived because the annual open enrollment occurred. All employees must meet the probationary period as specified in your Application for Group Service Agreement.

### *When would rates change for members?*

For the purpose of rating, the member's age is determined at the time a policy is issued or renewed.

### *How does Health Net help during open enrollment?*

Health Net account managers are available to assist you during open enrollment. They can provide services ranging from supplying enrollment kits, SBCs and forms to conducting question-and-answer sessions for employer groups during open enrollment meetings. Please contact your account manager in advance to arrange the best program for your company.

## Selecting a physician group and primary care physician

### *(for HMO, and the HMO level of benefits for POS and Elect Open Access)*

As part of the enrollment process for HMO and POS, the subscriber and each enrolled dependent should choose a Health Net participating physician group (PPG) and a primary care physician (PCP) from the ProviderSearch tool at www.healthnet.com. The area established by Health Net within which the subscriber may select a PPG to assure reasonable access to care (within a 30-mile radius from the residence or work address)[2] is known as Health Net's enrollment area.
For up-to-date provider availability and listings, members can access the ProviderSearch tool at www.healthnet.com or call the Customer Contact Center for assistance in selecting a PPG or PCP.

Health Net PPGs are multispecialty medical groups with all physicians located at a single site. Other PPGs and medical groups are structured as independent practice associations (IPAs) that, while doctors are located in their own offices at various locations, in every other way function as a PPG. IPAs have a central administrative office.

Each member must select his or her own PPG and PCP. Family members covered under the subscriber may select a different PPG, but they do have to enroll in the same health plan.

If members do not select a PPG and/or PCP, Health Net will assign them one. Notification will be mailed to the member reflecting the assignment, including instructions on changing the PPG or PCP, if desired.

All newborn infants are assigned to the mother's PPG for the first 30 days after birth. If the mother is not a currently enrolled dependent, the newborn is assigned to the father's PPG.

After that, infants may be transferred to a newly requested physician if enrolled within 30 days.

If a new member chooses a PCP who is currently his or her primary care provider, please indicate "Prior Patient" on the New Enrollment form.

### *How does a member transfer from one PPG to another?*

Transferring from one PPG to another is allowed monthly "at will."

A member can change their PCP once a month. The member must request the change either online or by calling the Customer Contact Center. The effective date of the PCP change will be the first of the month following the request as long as the change is completed in the system by the last day of the month. **Note:** If the last day of the month is a Saturday or Sunday, the PCP change will not take effect until a month later.

Members should check the ProviderSearch tool for information about contracted health care providers who are members of the network. Also, members should refer to the *Evidence of Coverage* for information about benefits.

If you have any questions concerning PPG transfers, or would like to request a list of PPGs or a map of our service area, please contact the Health Net Customer Contact Center, your account manager or visit our website at **www.healthnet.com**.

[2]Generally 30 miles, but greater in some rural areas.

## Selecting a participating or preferred provider

### *(for PPO and the PPO level of benefits for POS and Elect Open Access)*

Employees and their dependents do not have to select a participating or preferred provider at the time of enrollment. However, benefits may be more cost-effective for the member if they choose a network-preferred provider at the time they receive health care.

Members should check ProviderSearch for information about contracted health care providers who are members of the network. Also, members should refer to the *Certificate of Insurance* (COI) for information about benefits.

## Health and Safety Code Section 1373.3

To comply with Health and Safety Code Section 1373.3, Health Net allows members to select a provider near their home or work address.

Health Net requires the actual physical work address to accompany requests to enroll members into near-work providers. The physical work address for members must be within 30 miles of the provider.

## Enrolling new employees

### *When does a new employee become eligible for Health Net membership?*

New employees are eligible to become Health Net members if they are full-time permanent employees working 30 hours per week or more and have satisfied the probationary period for your group. If you offer coverage to all part-time (20 hours a week or more) employees, permanent part-time employees may also become Health Net members. If you have any questions concerning eligibility requirements, please contact Health Net's Membership Accounting & Eligibility.

### *How are eligible new employees enrolled?*

To enroll eligible new employees, you must submit a New Enrollment/ Change form.

All new employees who wish to enroll must complete, sign and date their own New Enrollment/ Change form and must receive a copy of their SBC. Missing or incomplete information will cause a delay in enrollment. The new employee should retain a copy of the enrollment form for their records. This should be presented to the health care provider as proof of coverage.[3]

If a new member is receiving care from the PPG, the PPG will require that the member present their ID card before care is received. They may contact the Customer Contact Center (CCC) to request a verification of eligibility form, log in to the www.healthnet.com website to print out a temporary ID card or direct the provider to contact Provider Services for benefit clarification.

Health Net does not require that payment be submitted when you enroll newly eligible members. Payment is due when you receive your statement.

## Qualifying events

### *When can an eligible employee enroll outside of the employer's open enrollment period?*

An employee may enroll with Health Net or add dependents outside of the open enrollment period due to a change in or loss of benefits or contribution levels in current coverage from another group-sponsored plan. The individual must request enrollment within 60 days of the change. You must submit a New Enrollment Change form, a letter to Health Net explaining the change in benefits or contribution level, including the effective date of that change and proof of prior coverage.

### *Examples of qualifying events include, but are not limited to:*

- The subscriber of the other plan has ceased being covered except for either failure to pay the premium contribution, a "for cause" termination, such as fraud or misrepresentation of an important fact, or voluntary termination.
- The other group-sponsored plan is terminated and not replaced with other group coverage.
- The employee loses coverage as a dependent under the spouse's plan due to divorce or legal separation.
- If an employee is enrolled as a dependent in another group-sponsored health plan, and the subscriber of that plan chooses a different plan.

[3]In addition to the temporary ID card, the PPG may require that a new member complete an Eligibility Certification form if his or her name does not appear on the current Eligibility Report.

- If an employee gains new dependents due to birth, adoption or marriage, the employee may enroll himself or herself, and the new dependent. For a new spouse, the effective date of coverage will be the first of the month following the date Health Net receives the application. For a newborn, coverage will commence at the date of birth. For adoption, the effective date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care.

You must submit a letter to Health Net explaining the change in benefits or contribution level, including the effective date of that change. Proof of prior coverage must also be submitted with this letter.

## Enrolling rehired employees

### *Who qualifies as a rehired employee?*

Former employees who have been rehired.

### *Do probationary periods affect the rehire's effective date of coverage?*

If rehired within 30 days, the probationary period is waived. If rehired after 30 days but under 6 months, effective date would be first of the following month.

If rehired after 6 months, probationary period must be met.

### *How are rehired employees enrolled?*

Submit a completed New Enrollment/Change form for each rehire you wish to enroll. The Rehire/Re-enroll option should be indicated.

If the rehire is not a former Health Net member, please follow the instructions found in the Enrolling New Employees section.

If the employee is rehired after 30 days of the last day previously worked, the employee does not qualify as a rehire and is not eligible to enroll in Health Net until he or she completes the probationary period according to the Enrolling New Employees section in this manual.

## Enrolling formerly ineligible employees

### *What effect will probationary periods have on a formerly ineligible employee's effective date of coverage?*

If an existing employee was previously ineligible for Health Net coverage, the probationary period ordinarily imposed on newly hired employees must be met. The probationary period begins on the date the employee begins employment as an eligible employee.

### *How are formerly ineligible employees enrolled?*

Please follow the instructions found in the Enrolling New Employees section.

## Enrolling dependents

### *What is the definition of a dependent?*

Health Net defines eligible dependents as members of the employee's family[4] who meet the eligibility requirements for coverage listed below and who are included on the New Enrollment/Change form completed and signed by the subscriber.

- The subscriber's lawful spouse.
- A child of the subscriber or spouse, or both. The child may be a natural child, adopted child, legal dependent or stepchild. The child of a domestic partner who meets the above requirements is also an eligible dependent, provided domestic partner eligibility is applicable to your group and is required for all Health Net of California, Inc. and Health Net Life Insurance Company plans.
- A covered dependent is defined as a child of the subscriber and/or spouse up to 26 years old. The child of a domestic partner who meets the above requirements is also an eligible dependent provided domestic partner eligibility is applicable to your group and is required for all Health Net of California, Inc. and Health Net Life Insurance Company plans.
- A child who is mentally or physically handicapped and is incapable of self-sustaining employment. The child must have been continuously covered as a dependent of the subscriber or spouse under a previous group health plan at the time the child reached the age limit.

**Important:** We have highlighted some of the most common qualifications; however, your group's requirements may be significantly different. Please check your Application for Group Service Agreement/Group Policy for details.

Newborns of the subscriber or spouse are covered automatically

[4]For the purposes of enrolling in Health Net, a family is defined as the employee and his or her spouse and children, including legally adopted children or children for whom the employee or spouse is legal guardian. Health Net is required by California law to treat domestic partners in the same manner as spouses.

for the first 30 days from birth or, in the case of a newly adopted child, from the date that the birth parent or appropriate legal authority grants the subscriber or his or her spouse, in writing, the right to control the child's health care.

Only newborns or adopted children who are eligible for enrollment under the Health Net plan, and who are enrolled within 60 days of the date of birth or, from the date the right to control health care is acquired, will continue to be covered after the initial 30-day automatic coverage period. The subscriber must enroll the child through the employer by completing and submitting a New Enrollment/ Change form to receive coverage beyond the initial 30-day coverage period. The assigned effective date is the first of the month following the qualifying event.

### *How are dependents enrolled?*

To enroll eligible dependents, the employee/subscriber must submit a fully completed New Enrollment/ Change form. The Add Dependent option must be checked, all the dependents the subscriber wishes to add must be indicated on the form, and it must be signed and dated by the subscriber.

Remember that, except in the case of a loss or change in other coverage or family status (marriage, birth or adoption), existing dependents may only be enrolled at initial enrollment or subsequent open enrollment periods.

## Enrolling newly acquired dependents

### *What is the definition of a newly acquired dependent?*

A newly acquired dependent is a spouse or child who joins the family as an eligible dependent (through marriage, birth or adoption) after the date the subscriber's coverage becomes effective. **Note:** When a subscriber's covered dependent child gives birth to a child, the newborn grandchild of the subscriber is not eligible for coverage. (See the section Enrolling Dependents for additional information.)

### *When may newly acquired dependents be enrolled in a Health Net plan?*

- Newly acquired dependents may enroll in Health Net up to 60 days from the date of birth, or the date that the legal right to control health care is granted for adoption, the date of the court order granting guardianship, the date of marriage, or of domestic partnership.
- If a newly acquired dependent is not enrolled within 60 days from the date of acquisition, the newly acquired dependent is not eligible for enrollment until the next open enrollment period.

### *When does coverage become effective for a newly acquired dependent?*

**Spouses:** A new spouse must be enrolled within 60 days of marriage. Coverage will begin on the first of the month following the date the application is received.

**Newborns:** Newborns of the subscriber or spouse are covered from the moment of birth. However, that coverage is automatically provided for only the first 30 days following birth. In order for coverage to continue, the child must be enrolled before the 60th day of life.

For HMO and POS plans, the child will be enrolled under the mother's PPG if the mother is an enrolled Health Net member. The child will be enrolled with the subscriber's PPG if the mother is not an enrolled Health Net member. The dependent child can then be enrolled with another PPG after the first day of the following month.

**Adoptees:** A dependent child who is being adopted will be covered automatically for the first 30 days following the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care. After 60 days, the newly adopted child who is eligible to be enrolled (i.e., adoptee of the subscriber or spouse) must be enrolled by the subscriber as a family member to continue coverage without a lapse. The subscriber must enroll the adopted child through the employer within 60 days following the date the legal right to control health care is acquired. Copies of the signed consent form will be required.

**Wards or subjects to guardianship:** A dependent who is within the age limit and who is a legally acquired dependent (ward) of the subscriber or covered spouse must be enrolled within 60 days of the commencement date of legal

guardianship. Coverage will begin as of the first of the calendar month following Health Net's receipt of the enrollment request. Proof that the subscriber or covered spouse is a court-appointed legal guardian will be required.

### *How are billing charges affected by adding newly acquired dependents?*

There will be additional billing charges for the newly acquired dependent if his or her enrollment causes the subscriber's contract to become a two-party (employee + spouse [no child(ren)] or employee + child(ren) [no spouse]) or family (employee + spouse + child[ren]) contract type. The billing charges will start on the dependent's effective date. If enrollment is completed within 60 days of this date, the effective date will be the first of the month following the month in which the dependent was acquired. Some groups may not be impacted by adding dependents and should contact their account manager to verify.

### *How are newly acquired eligible dependents enrolled?*

To enroll newly acquired eligible dependents, you must submit a completed, signed and dated New Enrollment/Change form for each employee who wishes to enroll newly acquired dependents.

**Important:** Newborns and adopted children will be covered for the first 30 days, but enrollment of acquired dependents is never automatic. Completion/Submission of a New Enrollment/Change form is required.

Health Net will require that enrollment requests for children who have been placed in the subscriber's or spouse's custody for adoption be accompanied by a copy of the signed consent form.

Enrollment requests for children who have become wards must be accompanied by a copy of the court order establishing the guardianship.

## Health Net ID card

Soon after enrollment, members will receive their Health Net ID card. This card should be carried by the member at all times to be used when obtaining medical or hospital care and when purchasing covered prescription drugs.

For HMO, Elect and POS plans, it includes the name, address and telephone number of the member's PPG. In addition, the card has printed instructions that remind the member that all medical and hospital services must be rendered or authorized by the selected PPG in order to be covered by Health Net. Elect Open Access, POS and PPO ID cards also have a list of the services that require certification.

ID cards will be issued under the following conditions:

- Enrollment in Health Net
- Change of PPG or PCP (HMO and POS plans only)
- Change in medical plans
- Transfer to COBRA coverage
- Member name change
- As requested by the member

As dependents are added to an existing subscriber's contract or as replacement cards are ordered, a card will be issued for that member only.


The ID card will identify the individual as a Health Net member.

**If an employee knows that he or she has a dependent child outside the Health Net HMO service area,** the employee must still choose a Health Net primary care physician for that child.

**For members with HMO plans,** Health Net will cover an out-of-area dependent for the cost of emergency and urgent care, minus any applicable copayment. Health Net will not pay for routine care such as Pap tests, physical exams or elective surgery when a dependent is away from the service area. A Health Net network physician may render these services once the dependent returns to the Health Net service area.

**If your employees and their dependents are enrolled in one of the Health Net POS plans,** out-of-area dependents always have the option of using the out-of-network portion of their plan to access care. A detailed description is provided in the ***Certificate of Insurance*** or ***Evidence of Coverage***.

# Out-of-Area Dependents

*All individuals (i.e., your employees and their eligible dependents) enrolling in a Health Net HMO, Elect Open Access, Point-of-Service (POS), or Elect plan must choose a primary care physician in order to be covered.*

## Routine care/ follow-up care

If a dependent requires routine or follow-up care while out-of-area:

- **HMO member:** Claims will be denied unless Health Net has given prior authorization.
- **POS member:** Claims will be paid at the in-network level if provided in-state by a Health Net California PPO or out-of-state by a Health Net national network (First Health) provider. Claims will be paid at the out-of-network benefit level for other providers. Members should obtain prior authorization from Health Net for those services requiring authorization as identified in the member's plan documents.
- **PPO member:** Claims will be paid at the in-network level if provided in-state by Health Net's California PPO network or out-of-state by a Health Net national network (First Health) provider. Claims will be paid at the out-of-network benefit level for other providers. Members should obtain prior authorization from Health Net for those services requiring authorization as identified in the member's plan documents.

The normal guidelines/criteria still apply for services that require prior authorization.

## Out-of-area emergency care

If an out-of-area dependent has a medical emergency, as defined in the plan documents, he or she should seek care at a local emergency room. The hospital or a family member need only notify Health Net if the dependent is admitted to the hospital so that Health Net may follow the course of his or her treatment. Under a POS plan, care following an emergency requires prior authorization in order to be covered as an in-network service. If a POS member obtains follow-up care without prior authorization, the services are paid as out-of-network.

HMO members require prior authorization from their medical group for out-of-area services following the emergency.

## Out-of-area urgent care

When an out-of-area dependent needs to see a doctor urgently but the situation is not an emergency, he or she should first contact his or her primary care physician or Health Net treating physician for advice. A detailed description is provided in the *Certificate of Insurance* or *Evidence of Coverage*.

In considering coverage for urgent care outside the service area, Health Net will review the situation to confirm that the signs and symptoms at the time of treatment required urgent care.

## Bills from nonparticipating providers

### *Submitting bills to Health Net*

To be reimbursed for medical bills from nonparticipating physicians or providers, members must send the bills to Health Net.

Members must be sure to include the following information:

- A completed Health Net Medical Claim form. Members may obtain copies from the Health Net Customer Contact Center or online at www.healthnet.com.
- The itemized bill with the date(s) of service, diagnosis and complete treatment information.
- Health Net ID number and two-digit suffix listed on the ID card of the member who received services.
- A brief explanation of why services were needed and could not be obtained from a Health Net plan physician or provider.
- An *Explanation of Benefits* (EOB) from the primary insurance carrier if the member has other health coverage that is primary.
- A statement of payment if the member has paid the provider.

### *For emergency care*

After receiving all of the information listed above, if services were rendered due to an emergency, Health Net may send a questionnaire.

### *Payment of claims*

When Health Net approves a non-plan claim, payment is generally made directly to the provider. However, if the information Health Net receives indicates that the provider was already paid, the plan will reimburse the member directly with proof of payment.

**Note:**

- Proof of payment on a doctor's prescription form is **not** acceptable.
- Invoices are **not** acceptable forms of proof of payment.

## Coverage upon reaching maximum age

### *When coverage ends*

A dependent child covered under the extended age limit will terminate according to criteria agreed upon in advance by your company and Health Net.

### *Notification requirements*

It is your employee's responsibility to notify Health Net and your company's benefits office of changes in dependent eligibility status. Health Net will remind your employee about dependent eligibility status 90 days prior to the time that, according to our records, a child will reach the maximum age for dependent coverage.

### *Other coverage options*

When the dependent child is ineligible for coverage, see the Continuation of Coverage section for information on plan options.

# Online Enrollment and Billing

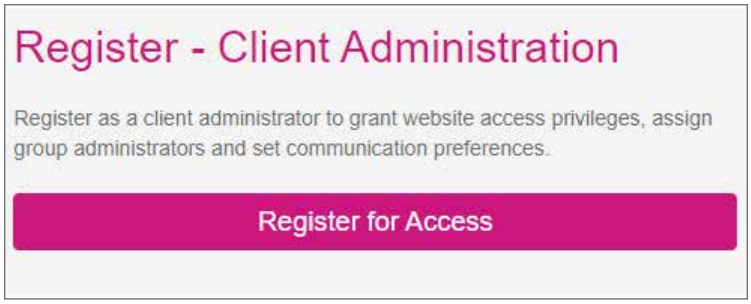
**ADMINISTRATION WITH THE CLICK OF A BUTTON**

*Online enrollment and billing makes it quick and easy to manage enrollments and changes, pay your bills, and run reports at* ***www.healthnet.com*** *– all with a single sign-on.*

## Enrollment management

At **www.healthnet.com**, you have the tools to:

- Enroll employees and dependents
- Cancel or reinstate coverage
- Update enrolled employee and dependent information, including, but not limited to:
  - name
  - marital status
  - contact information




You can also perform detailed searches by a variety of criteria, including, but not limited to:

- SSN
- Name
- Enrollment status

Canceling coverage is just as convenient, and built-in safeguards protect your employees against accidental cancellation. You can also transition employees to COBRA in a matter of minutes. To cancel coverage, you follow the same search procedure as mentioned above.

The reinstatement feature saves you time by retaining all of the insured's information so you don't have to repeat data entry when reinstating coverage.

**Note:** Date of hire and provider information are not retained for canceled members.

**With online enrollment and billing, you can:**

- **Enroll employees and dependents.**
- **Cancel and reinstate coverage.**
- **Pay bills online and schedule payments.**
- **Manage multiple payment options.**
- **Run billing and enrollment reports.**
- **Make plan changes for Open Enrollment.**

## Billing

View and pay your bills online, anytime.

### *It's all in the details*

Your online bill allows you to easily sift through all the details, such as:

- See employees' and dependents' enrollment status for a useful view of account activity.
- Make adjustments to your employee roster.
- Update your payment amount due (subject to verification).
- Disable/enable paper billing.

### *Hassle-free payments*

Paying your bills at www.healthnet.com is easy. You can schedule one-time payments or set up recurring payments with any combination of accounts and amounts. It's quick and secure, and you're done in minutes.

You even have the ability to nickname your account and then simply select your payment method in the future. And you can go in and update your account whenever you want.

Plus, check on transaction status, get bill notices via email and stop receiving paper bills by mail.

**Please note, groups that enroll through Covered California™ for Small Business (CCSB):**

- **Will not have the "Pay My Bill" tab available. Bills must be paid through the Exchange.**
- **Will only have viewing privilege on the "Manage Enrollment" tab. Any changes must be submitted through the Exchange.**

## Reporting

Reports. We all have to do them, but www.healthnet.com makes it quicker and easier. You'll get results in 24 hours or less for up to two years of account activity.

Select from standard reports or customize them for your needs. Request one-time reports or set up recurring reports for ongoing executive meetings. You have the ability to choose from a variety of reports (including Active Member Roster and Canceled Member Roster), and establish subsections within those report groups. If you like, we'll even send you a notification when your report is ready. Simply select this option when generating your report (enter your email address in the space provided and check that box).

Your reports are kept at www.healthnet.com for up to 30 days, or you can download or print them for easy reference.

## Managing your account

You're in the driver's seat when it comes to setting up and managing access to www.healthnet.com. We give you control over who accesses billing and enrollment information in your company.

Here's a quick overview of the different account types available to our employers at www.healthnet.com.

### *Group administrator*

One primary client administrator is chosen by the employer at initial enrollment. Primary client administrators will receive an email that includes a registration "key" and instructions for registering at www.healthnet.com. Primary client administrators may choose a secondary client administrator as well as create delegate user accounts.

### *Secondary client administrator*

The secondary client administrator may have access to the same functions and features as the primary client administrator. The primary client administrator may choose to limit this access. Some examples of a secondary client administrator are accounting, human resources, corporate, etc.

### *Delegate user*

Access to the application functionality and notification preferences is based on what was granted by the group administrators. A third party administrator is an example of a delegate user.

# Billing Procedures

*The following section explains the billing and payment method we utilize and includes information on our online billing services.*

## Billing and payments

### *Billing method: members added or terminated within a specific month*

This allows a member's coverage to begin on the first day of the month following the designated probationary 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 coverage month; the full monthly premium is charged.

### *Health Net invoice*

Health Net will send your invoice between the 4th and 28th of the month prior to the coverage month (this date is customizable). This invoice will list the active subscribers in effect on your plan(s). This information will be based on the Health Net enrollment forms and change and cancellation forms received from you and processed by Health Net before the bill run date for the month during which the invoice is generated (i.e., the month prior to the coverage month).

Health Net requests that you pay the dollar amount noted on the invoice under the heading "Please Pay This Amount." If there are any questions or concerns about paying this amount, please call the Membership Accounting & Eligibility Department and speak to your assigned accounting representative. Any adjustments to credit or debit your 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 between March 4 and March 28. Your group should then remit payment by April 1. There are two advantages for you 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 your employees.

## Manual billing and payment process

### *Manual payment process*

Premiums are payable monthly. Just include the invoice and payment. If adjusting from Health Net's billed amount, please indicate what charge line is being adjusted on the front page of the invoice premiums. Please also include all names, bill periods and dollar amounts for any premium adjustments that are made from Health Net's original billed amount. If there are any questions about this process, please call the Membership Accounting & Eligibility Department and speak to your assigned accounting representative for assistance in determining the appropriate information to include.

- Indicate the group number on the check.
- Make sure payment is submitted on or before the due date. Health Net will not accept postdated checks.
- Checks must be made payable to Health Net of California, Inc. or Health Net Life Insurance Company.
- 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.

**Employer groups should call the Membership Accounting & Eligibility Department with any billing problems and questions which may arise.**

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

**Health Net's Billing and Enrollment contact information can be found in the Customer Service section of this employer welcome guide.**

## 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 prior 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 is managed by your respective 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 debits the customer's account electronically, upon their request. After the customer calculates the amount of payment to be submitted on the Health Net Billing and Enrollment website for the invoice being reviewed, your pre-registered account is debited.

For more information about how to register and/or use the online Billing and Enrollment website, please contact your enrollment or accounting representative, and they can connect you with Health Net's online billing services team.

## Notifying Health Net of enrollment changes

### *How to notify Health Net*

For prompt, accurate processing of all enrollment transactions, you need to complete the Health Net Enrollment Form and/or Change and Cancellation Form. On the form, you need to include the appropriate group number that corresponds to the product (HMO, PPO, etc.) and population (active, COBRA, retiree, etc.) the subscriber has chosen, 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.

The forms serve as enrollment/disenrollment notification. When completing the Health Net enrollment form, please include the name and access code of the primary care physician(s) being selected and coordination of benefits and dependent information, if applicable. Cancellations can also be reported on the Health Net invoice using the Membership Changes section of the invoice. Please see the Billing Statement section for additional information.

### *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 60 days for new adds; however, other changes (cancellations, for example) must be within 30 days. 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 eligibility transactions not reported to Health Net in enough time to be processed prior to the bill run date for your account 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.

### *Mailing enrollment transactions*

Health Net provides Enrollment and Change and Cancellation forms. If you must use a different envelope, you should send it to:

Health Net, Inc.
PO Box 9103
Van Nuys, CA 91409-9103

To obtain additional forms, please call the Account Services Unit at the number located in the Customer Service section of the manual.

### *COBRA groups*

All COBRA groups administered by a third-party administrator will be set up with a separate group number.

# Billing Statement

## A SIMPLE GUIDE FOR READING AND UNDERSTANDING YOUR BILL

**Online billing and eligibility**

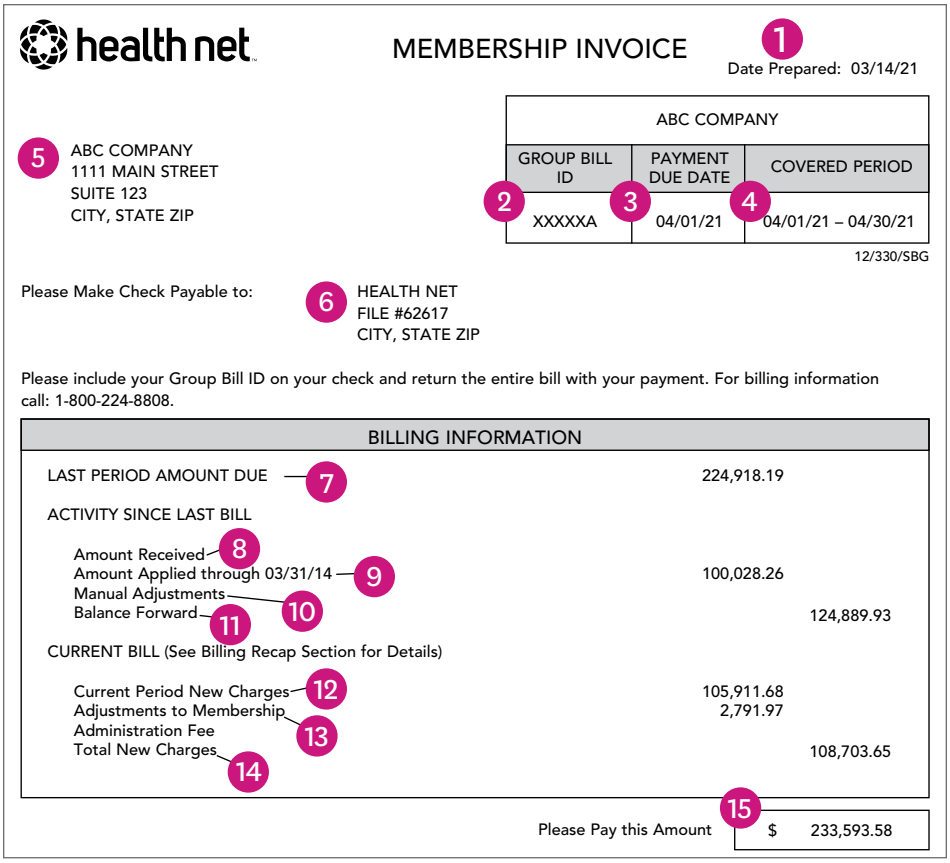
You can now receive your bills and process your employee eligibility online! Simply register for Health Net Online Billing and Enrollment at **www.healthnet.com**.

Health Net is pleased to offer these special features on your billing statements:

- **Simple format** – Bold headlines and amounts that make it easier for you to locate critical information on the bill.
- **Consolidated billing** – Multiple group numbers and their associated charges will be combined on one bill, resulting in less time and effort preparing your premium payment.
- **Duplex printing** – Detailed charges are printed on the front and back of your statement, resulting in a smaller, more environmentally friendly bill.
- **Bill customization** – Our system provides flexibility that allows you to customize portions of the billing statement to better meet your needs. Please contact your accounting representative to discuss customization options.
- **Global Health Net messages** – Messages can be communicated to you on the bill statement, eliminating the need for separate correspondence.

## Questions about your statement?

Please contact your broker or Health Net account manager.

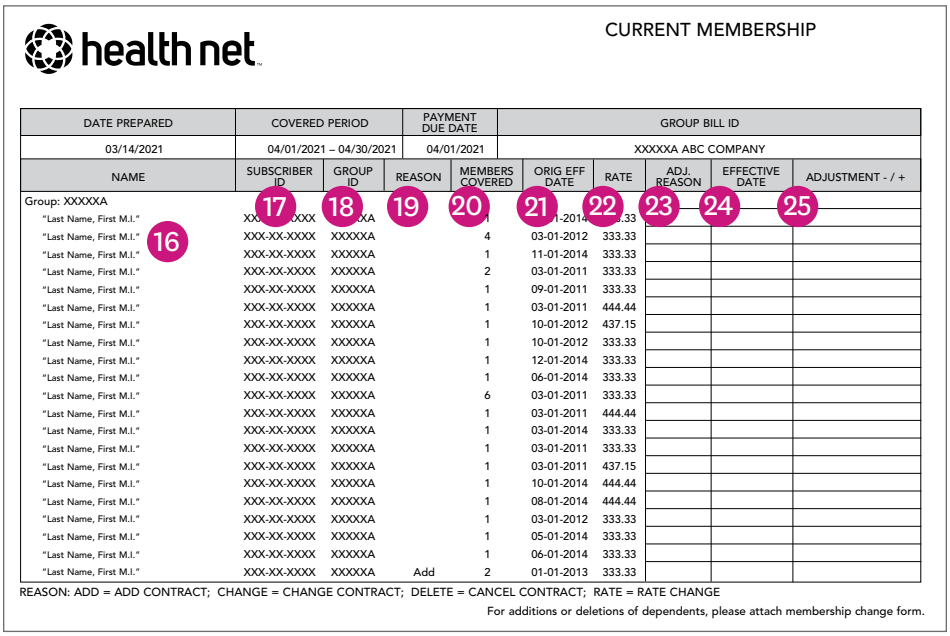



## Billing statement

1. **Date prepared** – Date the bill was generated by the billing system. Any information received after this date will not be reflected on the current bill.
2. **Group bill ID** – Identifies an organization for which services are provided and billed.
3. **Payment due date** – Date when the charges for a bill are due.
4. **Covered period** – Start and end of the current billing period in which services are provided.
5. **Mailing address** – For your organization.
6. **Make check payable to** – Health Net address to which the checks should be sent.
7. **Last period amount due** – Includes any charges that were billed previously for which payments have not yet been received. If your payment was received after the date this bill was prepared (see item 1), it will not be reflected in this amount.
8. **Amount received** – Total payments received since the last bill generated. Payments displayed here must be applied to the balances on your account before reducing the last period amount due.
9. **Amount applied** – Total amount of checks received and applied to premiums since the last bill generated.
10. **Manual adjustments** – Non-system-generated accounting adjustments.
11. **Balance forward** – Result of last period amount due, minus amount applied, plus manual adjustments.
12. **Current period new charges** – Current premium for all employees who are provided coverage through Health Net.
13. **Adjustments to membership** – Contract-level adjustments that apply to prior periods (e.g., add a member, cancel a member) or a change in contract, such as adding a spouse.
14. **Total new charges** – Sum of current new charges.
15. **Please pay this amount** – Sum of the balance forward and total new charges.

## Current Membership

This section lists contract-level charges for the current billing period and provides spaces to indicate adjustments to current members. Please use this sheet to indicate any changes you have to existing members. If additional space is needed, please feel free to use the Membership Changes section of the bill.



health net

CURRENT MEMBERSHIP

| DATE PREPARED | COVERED PERIOD | PAYMENT DUE DATE | GROUP BILL ID |
|---|---|---|---|
| 03/14/2021 | 04/01/2021 – 04/30/2021 | 04/01/2021 | XXXXXA ABC COMPANY |

| NAME | SUBSCRIBER ID | GROUP ID | REASON | MEMBERS COVERED | ORIG EFF DATE | RATE | ADJ. REASON | EFFECTIVE DATE | ADJUSTMENT - / + |
|---|---|---|---|---|---|---|---|---|---|
| Group: XXXXXA | | | | | | | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 4 | 03-01-2012 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 11-01-2014 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 2 | 03-01-2011 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 09-01-2011 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 03-01-2011 | 444.44 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 10-01-2012 | 437.15 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 10-01-2012 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 12-01-2014 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 06-01-2014 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 6 | 03-01-2011 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 03-01-2011 | 444.44 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 03-01-2014 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 03-01-2011 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 03-01-2011 | 437.15 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 10-01-2014 | 444.44 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 08-01-2014 | 444.44 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 03-01-2012 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 05-01-2014 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | | 1 | 06-01-2014 | 333.33 | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Add | 2 | 01-01-2013 | 333.33 | | | |

REASON: ADD = ADD CONTRACT; CHANGE = CHANGE CONTRACT; DELETE = CANCEL CONTRACT; RATE = RATE CHANGE

For additions or deletions of dependents, please attach membership change form.

16. **Name** – Subscriber/Employee name.
17. **Subscriber ID** – Subscriber's Social Security number or identification number.
18. **Group ID** – Identifies a group of employees in your organization for which specific product services are provided.
19. **Reason** – Type of change applied to a specific subscriber.
20. **Members covered** – Number of individuals covered in the contract. If there is a change in this number, this column will show the old and new value, e.g., 1>2. In this example, the contract reflects an add to the contract from 1 to 2.
21. **Orig. eff. date** – The original effective date is the date on which the subscriber's contract became effective under the particular group ID.
22. **Rate** – Premium amount charged for the subscriber.
23. **Adj. reason** – In this column, please indicate changes in contract (e.g., cancel a member) that will require a financial adjustment. When a contract-level change is made, please fill out and attach a membership change form.
24. **Effective date** – In this column, please indicate the date you would like the change to be effective. Please refer to your Service Agreement for the specific policy.
25. **Adjustment -/+** – In this column, please indicate the financial adjustment for contract-level changes based on current rates.

## Adjustments to Membership

This page provides an itemization of changes made to previous bill periods retroactively based on information received since the previous bill date.

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ADJUSTMENTS
TO MEMBERSHIP

| DATE PREPARED | COVERED PERIOD | | PAYMENT DUE DATE | GROUP BILL TO | | | |
|---|---|---|---|---|---|---|---|
| 03/14/2021 | 04/01/2021 – 04/30/2021 | | 04/01/2021 | XXXXXA ABC COMPANY | | | |
| NAME | SUBSCRIBER ID | GROUP ID | REASON | MEMBERS COVERED | EFFECTIVE DATE | AMOUNT ADJUSTED | TOTALS |
| Group: XXXXXA | | | | | | | |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Change | 2 > 1 | 11/01/12 | 222.22- | |
| | | | | 1 > 2 | 11/01/12 | 222.22 | |
| | | | | 2 > 1 | 12/01/12 | 222.22- | |
| | | | | 1 > 2 | 12/01/12 | 222.22 | |
| | | | | 2 > 1 | 01/01/14 | 222.22- | |
| | | | | 1 > 2 | 01/01/14 | 222.22 | |
| | | | | | | | 0.00 |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Add | 1 | 11/01/12 | 222.22 | |
| | | | | | 12/01/12 | 222.22 | |
| | | | | | 01/01/14 | 222.22 | |
| | | | | | | | 666.66 |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Add | 1 | 01/01/14 | 222.22 | |
| | | | | | | | 222.22 |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Add | 1 | 12/01/12 | 222.22 | |
| | | | | | 01/01/14 | 222.22 | |
| | | | | | | | 444.44 |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Add | 1 | 12/01/12 | 222.22 | |
| | | | | | 01/01/14 | 222.22 | |
| | | | | | | | 444.44 |
| "Last Name, First M.I." | XXX-XX-XXXX | XXXXXA | Add | 1 | 12/01/12 | 222.22 | |
| | | | | | 01/01/14 | 222.22 | |
| | | | | | | | 444.44 |

REASON: ADD = ADD CONTRACT; CHANGE = CHANGE CONTRACT; DELETE= CANCEL CONTRACT; RATE = RATE CHANGE
The effective date of retroactive adjustments for additions or terminations will be in accordance with rules established by Health Net. In no event will the effective date be more than 90 days prior to the date of Health Net's receipt of the written request. Retroactive adjustments for Small Business Groups (AB-1672 business) are contractually limited to a maximum of 30 days.

## Membership Changes

This page provides a blank worksheet for you to inform Health Net of any additions you wish to make to your membership (e.g., add a subscriber). It provides space for the subscriber's name, subscriber ID, group ID, effective date, adjustment, and total adjustments. Also, please include enrollment forms for all new additions to membership. These changes must be faxed to the Billing and Enrollment team. Only faxes are accepted at this time.

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MEMBERSHIP CHANGES

| DATE PREPARED | COVERED PERIOD | PAYMENT DUE DATE | GROUP BILL ID |
|---|---|---|---|
| 03/14/2021 | 04/01/2021 – 04/30/2021 | 04/01/2021 | XXXXXA ABC COMPANY |

| NAME | SUBSCRIBER ID | GROUP ID | EFFECTIVE DATE | REASON CODE | ADJUSTMENT |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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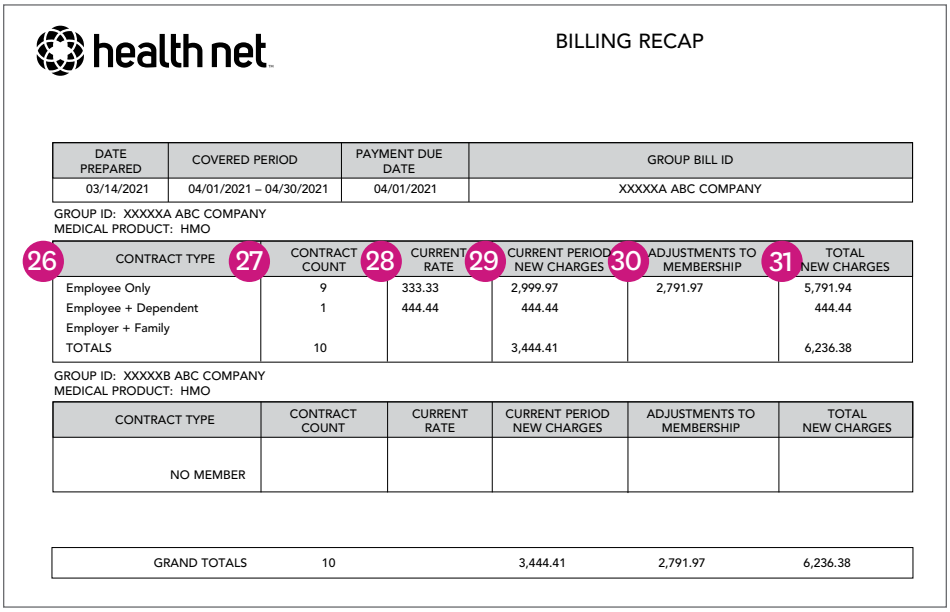
| | | | | | |
| | | | | | |
| | | | | TOTAL ADJUSTMENTS | $ |

REASON: ADD = ADD CONTRACT; CHANGE = CHANGE CONTRACT; DELETE = CANCEL CONTRACT; RATE = RATE CHANGE
For additions or deletions of dependents, please attach membership change forms.

## Billing Recap

This section provides a breakdown of current and retroactive charges by contract type within a product group.



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BILLING RECAP

| DATE PREPARED | COVERED PERIOD | PAYMENT DUE DATE | GROUP BILL ID |
|---|---|---|---|
| 03/14/2021 | 04/01/2021 – 04/30/2021 | 04/01/2021 | XXXXXA ABC COMPANY |

GROUP ID: XXXXXA ABC COMPANY
MEDICAL PRODUCT: HMO

| 26 CONTRACT TYPE | 27 CONTRACT COUNT | 28 CURRENT RATE | 29 CURRENT PERIOD NEW CHARGES | 30 ADJUSTMENTS TO MEMBERSHIP | 31 TOTAL NEW CHARGES |
|---|---|---|---|---|---|
| Employee Only | 9 | 333.33 | 2,999.97 | 2,791.97 | 5,791.94 |
| Employee + Dependent | 1 | 444.44 | 444.44 | | 444.44 |
| Employer + Family | | | | | |
| TOTALS | 10 | | 3,444.41 | | 6,236.38 |

GROUP ID: XXXXXB ABC COMPANY
MEDICAL PRODUCT: HMO

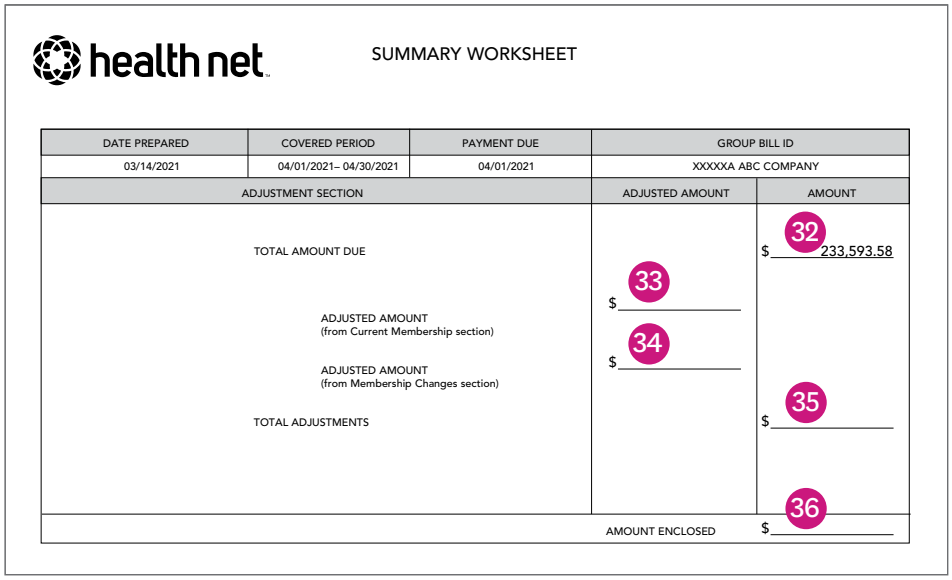
| CONTRACT TYPE | CONTRACT COUNT | CURRENT RATE | CURRENT PERIOD NEW CHARGES | ADJUSTMENTS TO MEMBERSHIP | TOTAL NEW CHARGES |
|---|---|---|---|---|---|
| NO MEMBER | | | | | |

| GRAND TOTALS | 10 | 3,444.41 | 2,791.97 | 6,236.38 |
|---|---|---|---|---|

26. **Contract type** – Describes who is covered by the subscriber for a product group.
27. **Contract count** – Total number of subscribers (employees) per contract type.
28. **Current rate** – Rate charged for the contract type. For Large Business Groups, may also reflect age or region rating.
29. **Current period new charges** – Contract count times current rate.
30. **Adjustments to membership** – Sum of all retroactive charges for each contract type.
31. **Total new charges** – New charges plus adjustments to membership.

## Summary Worksheet

This section provides you with spaces to recalculate the total amount due based on the adjustments you have indicated. This is optional and is provided for your convenience.



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SUMMARY WORKSHEET

| DATE PREPARED | COVERED PERIOD | PAYMENT DUE | GROUP BILL ID |
|---|---|---|---|
| 03/14/2021 | 04/01/2021– 04/30/2021 | 04/01/2021 | XXXXXA ABC COMPANY |

| ADJUSTMENT SECTION | ADJUSTED AMOUNT | AMOUNT |
|---|---|---|
| TOTAL AMOUNT DUE | | 32 $ 233,593.58 |
| ADJUSTED AMOUNT (from Current Membership section) | 33 $ | |
| ADJUSTED AMOUNT (from Membership Changes section) | 34 $ | |
| TOTAL ADJUSTMENTS | | 35 $ |
| AMOUNT ENCLOSED | | 36 $ |

32. **Total amount due** – Amount due to Health Net prior to any adjustments.
33. **Adjusted amount** – Total amount of adjustments calculated from changes to current members (see Current Membership section).
34. **Adjusted amount** – Total amount of adjustments calculated from additions to membership (see Membership Changes section).
35. **Total adjustments** – Sum of adjustments to current members and additions to membership.
36. **Amount enclosed** – Total amount submitted by group to Health Net.

# Claims Information

*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 nonparticipating 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 on their Health Net ID card.

## Claim filing deadlines

- Members must submit a claim to Health Net within 365 days of the claim's date of service.
- Participating providers must submit claims per their contract which in most cases will be less than 365 days from the date of service. AB 1455 advises participating providers have 120 days for initial claim submissions.

Claims that provide all necessary information are processed within 30–45 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 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 member's rights to appeal our decision. Members may contact the Customer Contact Center if help is needed to understand their EOB.

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

# Coordination of Benefits (COB)

*The following is a summary of information, benefits and services which are fully described in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI), which is subject to change.*

The information provided in this section explains how Health Net uses that information to make sure members receive the maximum amount of allowable coverage.

It is possible for employees to be enrolled in Health Net as well as another group health plan that offers some of the same benefits. In such instances, Health Net will coordinate benefits with the other carrier to provide members with the maximum amount of allowable coverage, while avoiding duplicate payment for the same benefits. This coordination is meant to protect both you as the employer and Health Net members from higher premiums that could otherwise result from such duplicate payment.

Health Net collects information about other coverages through information provided on the Health Net enrollment application and questionnaires mailed directly to members.

## Determining who pays first

### *Employees, spouses and dependents (in most instances)*

The plan that covers the member as a subscriber or through the member's place of work is the "Primary Plan," the plan that pays first. The plan that covers the member as a spouse or dependent is the "Secondary Plan," the plan that pays second.

### *Active employees with retiree coverage*

A plan that covers a person as an active employee is primary over a plan that covers that person as a retiree.

### *Dependents covered under both parents' plans*

The parent whose birthday occurs first in the year has the primary plan; the other parent's plan is the secondary plan for the children's claims. The actual year of birth does not matter, only the month and day. This is known as the "birthday rule" and it applies to children of unwed, as well as married, parents.

In rare instances where the other plan follows the gender rule rather than the birthday rule, the gender rules apply.

### *When parents are divorced or separated*

If the divorce decree or separation agreement specifies that one parent has responsibility for the children's medical expenses, that parent's plan pays first if it has been informed of the decree or agreement. If the children are covered as dependents under the other parent's health plan, that plan pays second.

In the absence of an agreement or decree that specifies which parent has responsibility for the children's medical expenses, or if the decree or agreement has not been made known to the appropriate plan, the plan of the parent with physical custody pays first, the plan of that parent's spouse (the step-parent) pays second, and the plan of the natural parent without physical custody pays third.

### *None of the above*

If the above rules do not establish which plan should pay first, the plan that has covered the member for the longer period of time is primary.

## Billing when Health Net is primary

### *Accessing care from a Health Net participating provider*

If a member receives services from a network provider and pays a copayment, he or she may ask the physician/provider for a "bill" to submit to the secondary carrier. By filing a claim with the other insurance company, the member may be able to be reimbursed for the copayment or at least obtain credit toward that plan's deductible.

### *Accessing care from a non-Health Net participating provider*

Members who access out-of-network services in accordance with their plan design must submit a claim form to Health Net. Health Net will render payment in accordance with the member's plan design. The member may then submit the balance of the claim to the secondary carrier for consideration.

Members who do not have out-of-network benefits as part of their plan design are not eligible for benefits from Health Net when they receive services from a nonparticipating provider, unless Health Net has, as an exception, approved those services in advance, or the services were for urgent or emergent situations. However, members may be eligible for benefits from their other carrier and should therefore submit claims to that carrier.

## Billing when Health Net is secondary

### *Accessing care from any provider (Health Net participating or nonparticipating)*

Members should present their Health Net ID card at the physician/provider's office. If the member has primary coverage through another carrier, it is his or her responsibility to inform the provider of which carrier should be billed first.

### *When a provider requires payment at the time services are rendered*

When Health Net is secondary, physicians/providers are advised that they should not request payment from members at the time services are rendered, except for copayments. If members do pay more than a copayment at the time services are rendered, they may be reimbursed by Health Net after the physician has been paid. There is an 18-month deadline for submitting claims involving coordination of benefits.

### *Billing the primary carrier*

Members should request a copy of the bill and submit a claim to their primary carrier. If appropriate, members should indicate on the claim form that payment be mailed directly to the physician/provider. Usually, benefits can be assigned to the physician/provider via the member's signature in a specific spot on the claim form.

## Explanation of Benefits

The primary carrier will then send the member an Explanation of Benefits (EOB) form, which tells how much of the bill, if any, the carrier paid. A sample of a Health Net EOB form can be found at the end of the Claims Information section.

## Billing Health Net

The physician/provider should submit a photocopy of the primary carrier's EOB form and a corresponding claim form to Health Net. These items must come to Health Net in one package. To ensure this happens, members should:

1. Send a photocopy of the EOB form from the primary carrier, along with their Health Net ID number, to the physician/provider who rendered the services.
2. If appropriate, send the physician/provider the full amount of any checks received for their services from the primary carrier, along with a photocopy of the EOB form.
3. Instruct the physician/provider to forward the photocopy of the EOB form and the corresponding claim to Health Net.

When Health Net receives this information, the plan will pay on the balance of the claim, up to the Health Net-contracted amount. If the primary carrier already paid the contracted amount, Health Net will not make any further payments, and the provider may not "balance bill" the member.

If the primary carrier applies all or part of its payment toward that plan's deductible, Health Net will pay on the balance of covered services, up to the plan's allowed amount. Any balance due cannot be charged to the member.

If the service involves a copayment, the member's liability for the copayment will be determined by the coordination of benefits process.

## When Health Net is primary

Health Net will pay benefits in accordance with the member's EOC. This decision affects all dependents as long as the dependent does not carry his or her own automobile insurance that states the primary carrier as anything other than Health Net.

- Claims from $0 to $5,000 – No-fault will pay 80 percent; Health Net will pay 20 percent.
- Claims over $5,000 – No-fault will pay 100 percent after member pays the deductible.

## When Health Net is secondary

When Health Net is secondary, the plan will pay the lesser amount of the allowable expense left after the primary insurance has paid the equivalent value of services if Health Net was primary.

## Coordination with non-insurance carriers: workers' compensation

All claims related to a work-related injury or illness should be submitted to your company's workers' compensation carrier for consideration, not to Health Net. If the workers' compensation carrier contests that the claim is work-related, Health Net will provide benefits upon receipt of the denial and will pursue the matter with the workers' compensation carrier.

## Coordination with non-insurance carriers: accidents/other party liability

Upon notification that a member has been injured, Health Net sends a questionnaire to the member. The questionnaire asks for complete details of how, when and where the accident occurred and if the member has hired an attorney. The COB Department researches all aspects of the situation. Health Net then provides benefits according to the coverage provided. If the member is successful in his or her lawsuit, Health Net may be reimbursed a portion of the amount it paid toward the claim(s).

A Health Net participating physician/provider cannot recover any money from a third-party settlement for charges related to medical services provided to Health Net members. However, physicians/providers are not prohibited from billing the member's attorney for copies of medical records, preparation of medical-legal reports, and providing expert medical testimony. Participating physicians/providers cannot require a Health Net member to:

- Sign an agreement that indicates the physician/provider does not have to look to Health Net for payment of medical services; or
- Sign an agreement that requires payment of any of the member's settlement amounts by the attorney, or by the member, to the physician/provider for medical services.

# Member Appeal and Grievance Process

*The following is a summary of information, benefits and services which are fully described in the member's Evidence of Coverage (EOC)/Certificate of Insurance (COI).*

Health Net has implemented a medical necessity appeal process and an administrative grievance process for use when a member does not agree with a decision that we have made. Requests may be submitted by phone, fax, mail, or online.

## Medical necessity appeal process

If a member disagrees with a Health Net decision that a health care service is not medically necessary and appropriate, the member (or someone he or she designates with specific written consent of the member) may initiate an appeal process. Upon receipt of the request for appeal, the issue will be investigated and reviewed by Health Net clinical staff. Under certain circumstances, the member may request an expedited appeal. Health Net's written final adverse determination will advise the complainant of their state's external review process. Members may also file an appeal or grievance through our website at www.healthnet.com.

## Non-medical necessity grievance

If a member disagrees with a Health Net decision that is not based on medical necessity, the member (or someone he or she designates with specific written consent of the member) may use the Health Net grievance process to resolve the issue. The member may initiate a grievance via phone by calling the Customer Contact Center. To submit a grievance in writing, please mail to:

Health Net Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410

The grievance determination letter will advise the member of available options should the member disagree with the outcome of the grievance. Prior to filing a grievance, the member always has the option of contacting the Customer Contact Center for assistance in resolving his or her issue. Please note that at any time a member may file a complaint with the appropriate state regulator.

If the member prefers to submit a grievance via fax or by mail, the Customer Contact Center representative will provide the fax number.

# Continuity of Care and Case Management Programs

*This section is included to help you understand the Health Net Continuity of Care Program. Continuity of care (COC) is when a new member is allowed to continue seeing a nonparticipating provider at an in-network level of benefits.*

Please note that in addition to having a qualifying medical condition, a member or his or her authorized representative must submit a Continuity of Care Assistance Request Form within time frames and conditions outlined in their ***Evidence of Coverage*** (EOC)/ ***Certificate of Insurance*** (COI).

Health Net covers health care services provided under continuity 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 continuity of care provisions.

To be eligible for COC services, members must be receiving care for one of the six medical conditions listed in Health and Safety Code Section 1373.96 (AB1286), which are as follows:

- **Acute condition** – sudden onset of symptom due to illness/injury.
- **Serious chronic condition** – disease/illness/disorder continues without cure and/ or requires ongoing treatment; continue until safe to transfer care, up to 12 months.
- **Pregnancy** – three trimesters through postpartum.
- **Terminal illness** – incurable/ irreversible, high probability of causing death.
- **Care of newborn child** – birth through 36 months, with care not to exceed 12 months.
- **Scheduled surgery** – must be plan-authorized and scheduled within 180 days from the provider contract termination date or Health Net effective date of coverage.

Current Health Net members and new enrollees are eligible for COC services in any of the following instances:

- The employer has a new member join Health Net from another health plan or insurer.
- A specific benefit plan change resulting in a different provider network.
- A participating physician group (PPG) change due to PPG closure or involuntary transfer of the member to another PPG.
- A primary care physician (PCP) change when the PCP changes affiliation with a PPG or the Health Net contract terminated.
- Continuity of care with a noncontracted mental health provider for a new member when they change to Health Net.

Initiating a request for the COC services process is quite simple:

- The member (or employer) advises Health Net of any continuity of care needs within 60 days of the effective date of the member's Health Net coverage or within 30 days of the provider contract termination.
- A Health Net Continuity Assistance Request Form is submitted. The member will be asked to select a PPG and PCP for any services not directly related to the condition for which continuity of care services are approved.

## Care management programs

### *Integrated Care Mangement*

Health Net uses an Integrated Care Management (ICM) model. ICM is a holistic, transparent approach with greater focus on patient empowerment and coordinating all aspects – medical, physical, and social – of the member's care. We integrate behavioral and physical health services through a primary case manager to improve outcomes for complex patients. In addition to a primary case manager, high-risk members have an Interdisciplinary Care Team consisting of the member's family/ caregiver, additional case managers as needed, primary care physician, behavioral health specialist if needed, pharmacist, social worker, and medical director. Case managers continually screen to identify behavioral health issues, including substance/opioid abuse, depression, anxiety, and stress. This team works together to support the provider's treatment plan and to ensure seamless and coordinated care for the member. Our ICM model improves health outcomes and appropriate utilization, as well as reduces costs for complex patients.

The integrated care management program targets members at risk or who are experiencing a significant medical and/or behavioral 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.

Members with high-risk chronic conditions receive support through personalized interventions and contemporary behavior change methodologies to better manage conditions through education, empowerment and support. Programs include Heart Failure, Chronic Obstructive Pulmonary disease, Coronary Artery Disease, Diabetes, and Asthma.

### *Care Coordination*

Members receive care at the provider group level. Our delegated provider groups play a crucial role in assisting members in accessing appropriate services to help achieve the goals of treatment and care and support positive health outcomes.

### *Transition Care Management (TCM) Program*

Provides a comprehensive, integrated transition process that supports Health Net's high-risk members during movement between levels of care. The program strives to create a smooth transition from one setting to another and to reduce rehospitalization risks and other potentially adverse events. Care transition interventions are focused on coaching the member and the member's support system during the inpatient stay and post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

### *Palliative*

Care Connections is a service provided by Health Net, at no cost to the member, medical group or doctor. A team of physicians, nurses, social workers, and coordinators provide an extra layer of support to your members with severe progressive disease and in need of symptom control, advance care planning or psycho-social support.

# Continuation of Coverage

**COVERAGE OPTIONS FOLLOWING TERMINATION, INCLUDING CONTINUATION OF COVERAGE**

*In this section, you will find information about:*

- Federal COBRA
- Leave of absence
- Extension of benefits (due to total disability)
- Cal-COBRA
- Individual & Family Plans

**Note:** The Section 125 rule only applies if deductions for the employee's health insurance are taken out on a pre-tax basis. Even then, employees may not make changes at will except for cancelling coverage. They must still wait until open enrollment unless they experience a qualified family status change as defined by Health Insurance Portability and Accountability Act (HIPAA).

### *Can former Health Net members continue coverage following termination?*

Most former Health Net group members are able to continue to be covered under one of the continuation options outlined in this chapter.

### *Who is not eligible to continue coverage under Health Net plans?*

Continuing coverage is not available to members who have had group coverage terminated by Health Net for any of the following reasons:

- The member knowingly omitted or misrepresented a material fact on the Member Enrollment and Change form.
- The member utilized fraud or deception in the use of Health Net or the PPG services or facilities, or knowingly permitted such fraud or deception by another.
- The member moved out of the Health Net service area.

### *Coverage options following termination*

**Federal COBRA Continuation Coverage:** Federal law says that many employers who had 20 or more employees on at least 50% of its working days during the preceding calendar year must offer continuation coverage. This law is known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

### *IRS Section 125*

Under the IRS Section 125 rules, individuals may not change their enrollment or benefits elections in mid-year. The only time an individual may make a mid-year election change on a pre-tax basis is upon a change in family status if the plan allows mid-year election changes due to changes in family status.

Under IRS regulations, changes in family status include:

- Marriage, divorce, legal separation, or annulment of the employee.
- Death of the employee's spouse or dependent.
- Birth or adoption of the employee's child or placement for adoption.
- Commencement or termination of employment of the employee's spouse.
- A switch from part-time to full-time status, or vice versa, by the employee or the employee's spouse or other qualified dependent.
- An unpaid leave of absence taken by the employee or employee's spouse.
- A significant change in the health coverage of the employee or spouse attributable to the spouse's employment.Changes in work schedule for employee or any qualified dependent, including strike or lockout or return from an unpaid leave of absence.
- A change in the place of residence or worksite of the employee, spouse or dependent.

The temporary regulations also add the following three new events upon which a change in election can occur under an accident and health plan or group term life insurance component of a flex plan:

- If a change in status occurs that results in entitlement to COBRA continuation coverage by the employee, spouse or dependent, the employee may increase his or her flex plan election amount to pay for the COBRA coverage on a pre-tax basis.

- If the employee, spouse or dependent becomes entitled to Medicare or Medicaid (other than pediatric vaccines), the employee may elect to cancel the coverage of the employee, spouse or dependent.
- If the plan receives a qualified medical child support order (QMED) pertaining to an employee's dependent, the employee may elect to add the child to the plan (if the QMED requires coverage) or drop the child from the plan (if the QMED requires the ex-spouse to provide coverage).

Section 125 dictates that members may not necessarily be allowed to cancel their membership at any time. The determination of when they can and can't cancel is the responsibility of the employer group.

**Cal-COBRA continuation coverage:** For employers with fewer than 20 employees on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage.

**Cal-COBRA extension for former federal COBRA beneficiaries:** For employers who must provide federal COBRA Continuation Coverage for a period of less than 36 months, Health Net is required by California law to offer a Cal-COBRA extension for a maximum combined period of 36 months.

### *Health Net Individual & Family Plans*

Health Net is now an option for enrolling over-age dependents and employees leaving your company wishing to explore options other than COBRA or Cal-COBRA coverage.

Should employees wish to apply for coverage under our Individual & Family Plans for any reason, they may contact an agent or broker, or call the **Health Net Individual & Family Plans number. This can be located in the Customer Service section of this manual.** Individuals who purchase an IFP plan forfeit their rights to COBRA and Cal-COBRA continuation rights. Application for an individual policy may also be made at our website at www.healthnet.com.

# Benefits and Services

# Understanding Your Health Net Pharmacy Benefits

*Health Net makes it easy for you to access and understand your pharmacy benefit coverage and cost-saving options. Our plan benefits cover the majority of prescription medications approved by the U.S. Food and Drug Administration (FDA). We strive to support you and your doctor by offering a wide variety of affordable medications. And we offer the tools to help you make informed decisions to save money and to get the most out of your pharmacy benefit. Not all plans are the same, however. Be sure to refer to your coverage documents for details about your specific plan.*[1]

**!**

**Certain plans will cover most female prescription contraceptives and other prevention medications at $0 cost-share.**[1]

[1]The *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legal binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

## Tiered Benefit Plans

Health Net has easy-to-use pharmacy benefits that offer the convenience you want with the value you're looking for. Our two tier, three tier and four tier plans provide both generic and brand-name prescription drug coverage. Keep in mind that coverage on some products may not follow the generic and brand tier system. To stay current on specific tier information, please refer to your plan documents[1] and Health Net's drug list for coverage and cost-share information and any limits or restrictions.

A few plans may have a Specialty tier, which is also covered under your pharmacy benefit. Most Specialty tier drugs require prior authorization – the process of getting approval from Health Net for certain drugs before they are covered. These drugs are usually provided by a Specialty pharmacy contracted by Health Net. Please consult your plan documents[1] to see whether your pharmacy benefit includes the Specialty tier. You can also reference the Specialty tier drug list at **www.healthnet.com** for coverage details.

### *Two tier benefit*

| Prescription is for: | You pay: |
|---|---|
| **Generic drugs** on the drug list | In most cases, the **lower copayment (Tier 1)** |
| **Brand-name drugs** on the drug list | In most cases, the **higher copayment (Tier 2)** |

### *Three tier benefit*

| Prescription is for: | You pay: |
|---|---|
| **Generic drugs** on the drug list **(preferred generics)** | In most cases, the **lowest copayment (Tier I)** |
| **Brand-name drugs** on the drug list **(preferred brands)** | In most cases, the **higher copayment (Tier 2)** |
| **Brand or generic drugs** not on the drug list **(non-preferred drugs)** | In most cases, the **highest copayment (Tier 3)** |

### *Three tier with specialty benefit*

| Prescription is for: | You pay: |
|---|---|
| **Most generic drugs and low-cost preferred brands** | In most cases, the **lowest copayment (Tier I)** |
| **Non-preferred generics and preferred brand-name drugs on the drug list** | In most cases, the **higher copayment (Tier 2)** |
| **Non-preferred brands** | In most cases, the **higher copayment (Tier 3)** |
| **Specialty drugs** | In most cases, the **highest copayment (Tier 4)** |

**Note:** Pharmacy cost-shares apply toward the annual out-of-pocket maximum (OOPM) on your plan. Please consult your plan documents for specific details regarding annual cost-sharing limits.

Get more done online!

Register from the home page at **www.healthnet.com.**

[1]The *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legal binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

# Maintenance Choice® Program

**FLEXIBILITY AND COST SAVINGS ALL IN ONE**

*As a Health Net member, you can save time, hassle and costs by using the Maintenance Choice program. Note: Not all plans offer Maintenance Choice; please check your plan documents to see which programs are available to you.*

## Two options – one choice for convenience!

The Maintenance Choice program gives you two options for filling and refilling your three-month[2] maintenance prescriptions:

### 1 At a CVS Pharmacy®

***Advantages of a CVS Pharmacy retail location:***

- Pick up your medications directly from the pharmacy at a time that is convenient for you.
- Same-day prescription availability.
- Talk face to face with a pharmacist.

### 2 Through the CVS Caremark® Mail Service Pharmacy[1]

***Advantages of the CVS Caremark Mail Service Pharmacy:***

- Convenient home delivery.
- Receive your medications in confidential, tamper-resistant and (when necessary) temperature-controlled packaging.
- *Have questions?* Talk to a pharmacist by phone.

**With both options,** you receive up to a three-month[2] supply of your maintenance medications, usually at a lower cost than if you filled three 30-day prescriptions at a retail pharmacy.

[1]For either option, you may be responsible for a copayment. Please review the prescription details of your health plan for copayment information.

[2]Actual quantity may vary depending on your plan.

## What is a maintenance medication?

A maintenance medication is a prescription drug taken continuously to manage chronic or long-term conditions, such as high blood pressure, asthma, diabetes, or high cholesterol, and when dosage adjustments are either no longer required or made infrequently.

Non-maintenance medications include:

- Antibiotics that treat infections.
- Drugs used for pain and/or acute medical conditions.
- Drugs not taken chronically on an ongoing basis.
- Drugs that have a specified course of therapy.
- Drugs for which the physician must occasionally adjust the dose for a patient.

## What is the benefit of this program?

Using mail service or obtaining your maintenance medications from a CVS Pharmacy allows you to fill up to a three-month[2] supply, usually at a reduced copayment, ultimately minimizing your out-of-pocket costs. You'll enjoy the ease and convenience of mail service, or pick up your medications at a time that is convenient for you at a CVS Pharmacy.

## Getting started

There are several ways to start your three-month supply of maintenance medications with CVS Caremark:

- Call the CVS Caremark Maintenance Choice program at 888-624-1139 to have your prescriptions filled through the CVS Caremark Mail Service Pharmacy or at a CVS Pharmacy retail location.
- Go to your nearest CVS Pharmacy retail location. The pharmacy will contact your doctor to obtain your three-month prescription.
- Have your doctor send your three-month prescription to the CVS Caremark Mail Service Pharmacy in one of the following ways:
  - **Call** 800-378-5697
  - **Fax** 800-378-0323

For more information about CVS Caremark, call **888-624-1139**. To learn more about your pharmacy benefits, call Health Net's Customer Contact Center at the number listed on your ID card or log in to **www.healthnet.com**.

# Decision Power:® Health & Wellness

**A HELPFUL GUIDE FOR EMPLOYERS**

*When it comes to wellness, everyone brings a different understanding with unique and personal goals.*

**Good for people, good for business.**
Decision Power from Health Net is our long-term investment in the health of your organization. There is active collaboration and decision-making between doctors and patients.

We at Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) created Decision Power as a bridge between knowing how to achieve improved wellness, and getting the support and confidence to take action. Whether focused on staying fit or facing a serious diagnosis, Decision Power can help your employees and their doctors make the right health and treatment decisions.

Here are some of the actions available through Decision Power:

- Get help with a specific health goal.
- Track diet, exercise or cholesterol.
- Try an online health program (RealAge Programs).
- Learn about health risks.
- Access nurse advice 24/7.
- Adapt to living with illness.

## Decision Power wellness solution

The Decision Power online health portal offers members a central hub for their selected wellness programs and activities, featuring a personalized home page with engaging content to increase online participation. Once a member completes the online Health Assessment the home page is updated with personalized recommendations. These may include online health modules – such as RealAge Programs, trackers or health challenges – or enrollment into a health coaching or care management program.

## Online Wellness Resources

Looking for a more flexible way to improve your health and wellness on your own terms? Our content library—a rich array of physical, emotional, social, financial health and clinical materials—consists of numerous articles and videos related to healthy weight, improving your diet, stress management, tobacco cessation and more! Online wellness resources consist of health articles, trackers, health videos, health challenges and more!

## Start Smart for Your Baby®

Start Smart for Your Baby (SSFB) is a program for pregnant people, providing custom support and care for a healthy pregnancy and baby. Members will receive health education materials such as Mother's Guide to Pregnancy and Guide to Life After Delivery, and can request guidance from a care manager throughout their pregnancy. It is already part of your benefits and will not cost you a thing.

## Wellness health coaching

You may improve your health by interacting with a virtual health coach online or by engaging with a live health professional by telephone. Coaching outreach is driven by your specific needs. The program offers flexible communication, including secure email, eLearning modules and telephone. The online features include coaching tools like journaling, goal-setting and exercise/food trackers.

## Care management programs

Decision Power wellness programs integrate with Health Net's care management programs, offering a range of vital case management services for members at risk for chronic health conditions and those already diagnosed, as well as severely ill individuals and premature and fragile newborns. In all cases, members must meet the high-risk criteria or have a chronic condition diagnosis from their doctor.

## Health information that's close at hand

### *Nurse advice line*

Employees get peace of mind, day or night, with 24/7 access to experienced registered nurses via phone for questions about injuries, illnesses, medical conditions, and care. With this vital resource, employees can reduce unnecessary and expensive emergency room visits and better manage their health.

### *Care reminder messages*

You'll get useful reminders about steps you can take to prevent gaps in your care. These include tests to keep you healthy, yearly shots and more! Your doctors may also get these reminders so that they can better observe your health status.

# Healthy Discounts

**GET HEALTHY, STAY HEALTHY AND SAVE MONEY WITH HEALTHY DISCOUNTS!**

## Manage your weight

### WeightWatchers

**WW.com/us/healthnet** **866-896-2655 (TTY: 711)**

**Health Net partnered with WeightWatchers to help you reach your weight loss and wellness goals.**

- The WW program allows you to lose weight while eating the foods you love, and guides you towards eating healthier, moving more, and developing a positive mindset.
- All Health Net Commercial Plan Members get an exclusive discount of 50% off the retail price and can join now for as low as $8.48 per month.
- For more information and to enroll, visit **WW.com/us/healthnet**
- Already a WW member? You can sync your current WW account to get this discount online or by contacting customer service at 866-204-2885.

### Jenny Craig

**www.jennycraig.com/healthnet** **877-Jenny70 (TTY: 711)**

Tell the agent you're a Health Net member to receive special offers.

- Get $200 in Food Savings*

*(continued)*

**Find a Healthy Discounts partner**

Call or go online. Make an appointment and be sure to show your Health Net ID card to receive your discount.

*Food savings redeemed as 8 consecutive weeks of $25 US food credits with full planned menu purchase (avg. $200 US/$200 CAD) each week. Prices subject to change. Active program enrollment and eligibility status required. Valid only for new members. Valid at participating centers. Not valid at jennycraig.com. No cash value. Expires 12/31/2022.

## Fitness club discounts

### Active&Fit Direct

877-771-2746

Sign up at www.healthnet.com (Group members) or www.myhealthnetca.com (Individual & Family Plan members) to access the Active&Fit Direct website, found under the Wellness Center tab. The Active&Fit Direct Program[3] offers discount memberships to more than 11,000 fitness centers. The cost is just $25 a month (plus a one-time $25 signup fee and taxes).

## Chiropractic, acupuncture and more

### ChooseHealthy

877-335-2746

Sign up at www.healthnet.com (Group members) or www.myhealthnetca.com (Individual & Family Plan members) to access the ChooseHealthy website, found under the Wellness Center tab. Receive a 25 percent discount on fees from network acupuncturists, chiropractors and massage therapists.

## Health and wellness products

### ChooseHealthy & ChooseHealthy Store

877-335-2746

Enroll at www.healthnet.com (Group members) or www.myhealthnetca.com (Individual & Family Plan members) to access the ChooseHealthy website, found under the Wellness Center tab. Through the ChooseHealthy store, you can buy health and wellness products at a discount. Health Net members receive free standard shipping on most orders.

## Eye care

### EyeMed Vision Care

www.eyemedvisioncare.com/healthnet 866-559-5252 (TTY: 711)

Receive discounts on eye exams, frames and lenses at more than 20,000 stores, such as Target Optical and LensCrafters.

- 15% off retail price for conventional contact lenses.
- 35% off retail price of any frame offered in store.
- $50 single, $70 bifocal, $105 trifocal plastic lenses.[4]
- 15% discount on retail laser vision correction or 5% off the promotional price.

## Hearing aids and screenings

### Hearing Care Solutions

www.hearingcaresolutions.com 866-344-7756

For more information or to make an appointment, call Monday–Friday, 5 a.m. to 5 p.m. Pacific time or visit the Hearing Care Solutions website.

Health Net members and their families receive free hearing exams and discounts on hearing aids.

All hearing aids include:

- Three-year warranty (includes loss and damage).
- Two-year supply of batteries (up to 128 cells).
- Unlimited follow-up visits for one year.
- 60-day evaluation period.

### NationsHearing

www.NationsHearing.com/healthnet 800-996-0234

Health Net members and their immediate family members (grandparents,parents, spouse, and children) receive:

- Yearly hearing test at no extra cost
- Hearing aids from all major brands
- Set discount prices with hearing aids starting at $681
- Low pricing and a 60-day, 100% money-back guarantee
- Three-year repair warranty
- Three years of batteries included
- One-time replacement plan for lost, stolen or damaged hearing aids
- 12- and 18-month financing options with 0% APR, no money down
- Concierge services

[1]WW discount program is available for members and effective 1/1/2019.

[2]Available in participating areas only. Local Meeting Voucher discounts vary with region.

[3]Members/spouses must be 18 years or older to take part. Fees will vary based on fitness center selection. There is a 2-month commitment required. The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Direct is a trademark of ASH and used with permission herein. Not all services may be available in all areas and the program may be changed (including monthly and enrollment fees and/or the introductory period) or discontinued at any time. The Active&Fit Direct Program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit logo is a trademark of ASH and used with permission herein.

[4]The discount is a vailable only when a complete pair of glasses is purchased. Items purchased separately will be discounted 20% on the retail price.

Healthy Discounts is not intended to take the place of any covered benefits and is offered to the member in addition to, rather than instead of, covered benefits. This information is not intended as a substitute for professional medical care. Please always follow your health care provider's instructions. All programs are subject to change. Health Net Healthy Discounts offers discounts on health products and reduced-fee health services. Healthy Discounts providers are independent businesses. Members purchase services and/or supplies directly from these providers. Questions regarding the Healthy Discounts program should be directed to Health Net's Member Services Department. Questions regarding a Healthy Discounts provider should be directed to that provider.

Price and availability: Discounts for Healthy Discounts products are based on the providers' regular retail prices and usual charges. Providers' prices and charges are subject to change without notice. All discounted products and services are subject to availability. Some restrictions may apply. Liability: Health Net makes no endorsements or warranties on any of the products or services offered through the Healthy Discounts program and assumes no liability for such.

# Health Net's ProviderSearch

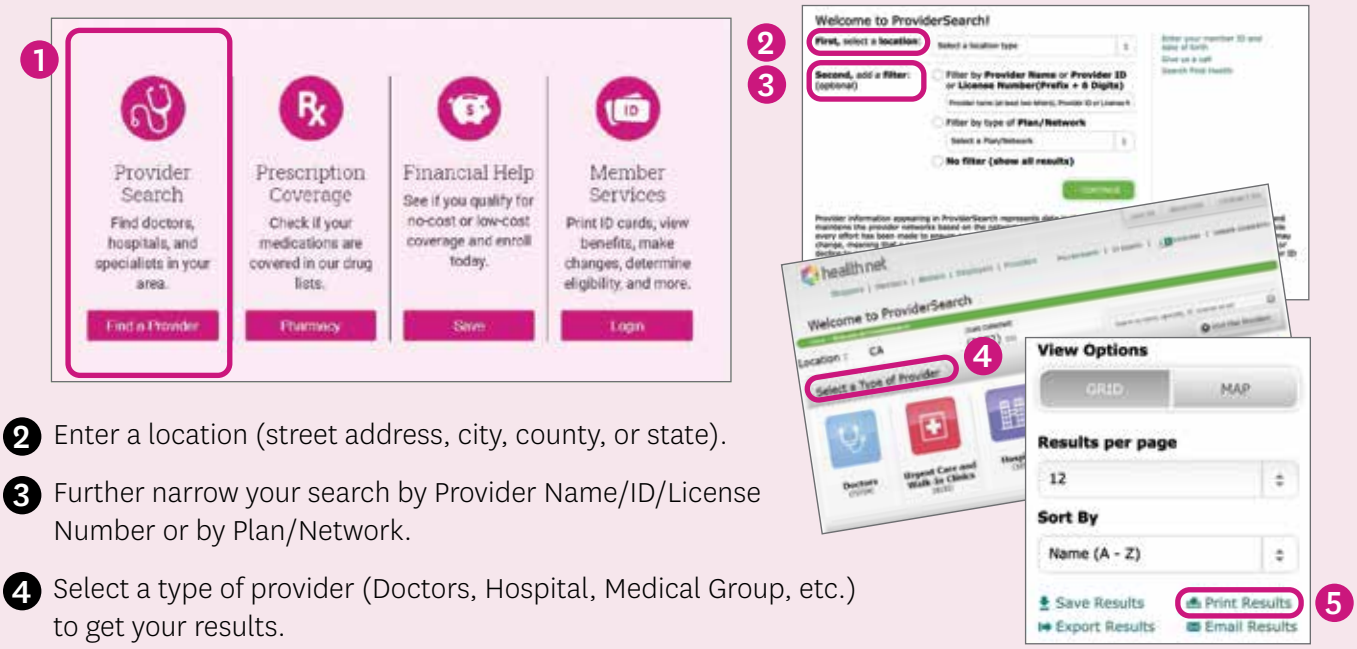
**FIND A PHYSICIAN – FAST!**

*With ProviderSearch, you'll quickly find the most up-to-date listings of qualified in-network doctors, urgent care centers, hospitals, and other types of health care providers near your home or work.*

## Not yet registered online?

You can still use ProviderSearch! Here's how:

1. From our home page (www.healthnet.com), click on *Find a Provider*



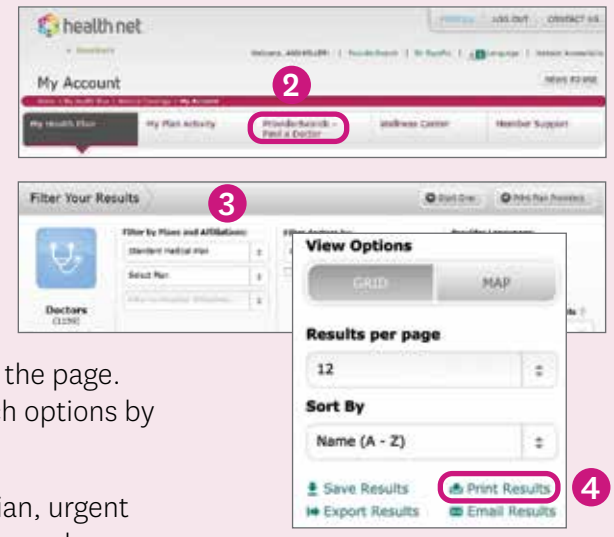

2. Enter a location (street address, city, county, or state).
3. Further narrow your search by Provider Name/ID/License Number or by Plan/Network.
4. Select a type of provider (Doctors, Hospital, Medical Group, etc.) to get your results.
5. Finally, you can click on *Print Results* to print your search results.

For more information, click the Give us a call link in the ProviderSearch box.

*(continued)*

## Already a member?

1. Visit **www.healthnet.com**, and click the *Log In* button.


2. Click on the *Find a Provider* tab located at the top of the page. *ProviderSearch – Find a Doctor* pre-loads your search options by your location.
3. Further narrow your search by provider type (physician, urgent care centers, hospital), plan type, specialties, gender, and languages spoken.
4. Finally, click on *Print Results* to print your search results.

**Questions?**
*Call the number located on your member ID card.*

## Choose a high-performing hospital for a better experience

On the Health Net website, you get access to the Hospital Advisor Tool from WebMD, with details about:

- The types of services offered at each hospital and quality ratings for their care, including information on patient experience.
- Results from the Leapfrog Hospital Survey, a national leader in hospital quality information.
- The Leapfrog Hospital Safety Grade, which gives each hospital a letter grade (A to F) for how safely they care for patients.

# First Health: National PPO Network

***Ready to enroll in Health Net's PPO?*** *When you do, you will have peace of mind knowing that you are covered anytime, anywhere with First Health – Health Net's national PPO network. Keep this important information handy regarding using the First Health network.*

## The First Health network

Health Net has an arrangement with First Health, a national network of doctors and hospitals throughout the U.S. This arrangement allows you as a Health Net PPO member to receive health care services at a contracted rate whether you reside or travel outside of California.

## Find a national provider online

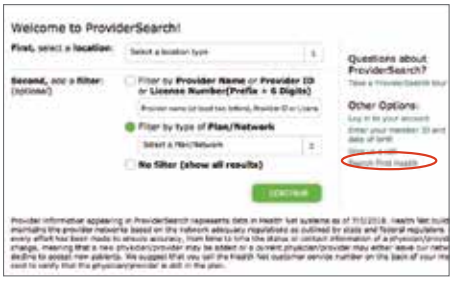
Health Net is here to make finding a provider easy for you. With our ProviderSearch tool, you can find a doctor, hospital, urgent care center, or any provider in our national PPO network quickly.

**Important:** When visiting a provider, be sure to show your Health Net ID card (with the First Health logo) to identify yourself as a First Health member.

## Go to **www.healthnet.com** and follow these simple steps:


1 Click on *ProviderSearch – Find a doctor*.


3 Choose and fill in the requested information, and click *Search now*.




2 Click *Search First Health*.

## Choose a First Health provider

To ensure you get in-network benefits when visiting a provider for regular services[1] **outside** of California, identify yourself as a First Health member, or ask the provider if he or she participates in the First Health network.

If you receive care from a provider not contracted with First Health, you may have to pay higher out-of-pocket costs at the time of service and will then need to submit a claim to receive your reimbursement.

In case of an emergency, go to the nearest emergency or urgent care facility, even if it is not a contracted Health Net provider.

### When should I use First Health?

Knowing when to use Health Net's national PPO provider network is key to ensuring you pay the lowest out-of-pocket costs possible. This chart will help you decide which network to choose when obtaining regular services.[1]

| | |
|---|---|
| ***In-state employees*** | |
| **Within California** | Use the Health Net in-state PPO network (in-network tier) |
| **Outside California** | Use the First Health provider network (in-network tier) |
| **Through an out-of-network provider** | Covered[1] (out-of-network tier) |
| ***Out-of-state employees*** | |
| **Both within and outside of California** | Use the First Health provider network (in-network tier) |
| **Through an out-of-network provider** | Covered[1] (out-of-network tier) |

PPO members who have an emergency or urgent situation should go to the nearest emergency or urgent care facility as soon as possible, even if it is not a Health Net or First Health provider (in-network tier). You or a family member should contact Health Net as soon as possible.

[1]Please refer to your Certificate of Insurance for exclusions and limitations.

# Group Term Life Insurance

## How to apply for group term life insurance

You may apply for Term Life Insurance and Accidental Death & Dismemberment coverage with Health Net Life Insurance Company at the time of your original Application for Group Service Agreement/Group Policy submission to Health Net for medical coverage.

If you wish to add life insurance to your portfolio of coverage after the original effective date of your medical coverage, you will need to complete an Application for Group Service Agreement/Group Policy and forward it to Health Net Account Management. For more details on adding group term life to your policy, please contact Account Management.

As a new account, all of the eligible employees will need to complete the Group Term Life Insurance section of the Enrollment and Change Form. Some contracts require that all employees participate in the life insurance coverage, even if they have declined medical coverage through Health Net. Please see your policy regarding this requirement.

Employees may be added to your plan throughout the year as they become eligible. They may use the same enrollment form as for medical, the Enrollment and Change Form.

If employees wish to make changes to their beneficiary designation throughout the year, they may complete and sign that section of this form and forward it to the Health Net Life Premium Accounting and Eligibility Department at any time.

## Probationary waiting period

As with medical, there is a probationary waiting period before coverage is effective. A probationary waiting period is the length of time that employees must wait before they have coverage. You can find the specific probationary waiting period in your Group Service Agreement and in your Health Net Life Insurance Company Policy.

## Contribution

Basic Life & Accidental Death & Dismemberment must be offered on a non-contributory basis (100% employer contribution to the employee premium). It's expected under this requirement that all eligible employees will enroll in the life coverage. Any variance in contribution must receive Underwriting approval. Supplemental Life, when written in conjunction with Basic Life, may be offered on a contributory bases 0% – employer contribution level. All employees eligible for the Basic Life plan must also be eligible for Supplemental Life coverage.

## Enrollment/Disenrollment

To provide the financial security that your employees desire, Health Net Life Insurance Company needs some basic information. For new employees, you and the employee will need to complete the Enrollment and Change Form. This may be forwarded to Health Net Life Insurance Company as part of the medical coverage application, or it may be sent separately via fax or mail.

**For off-renewal enrollment, please contact your broker or Health Net account manager.**

For disenrollment, you may simply indicate on your monthly bill that an employee has terminated, with the termination date. To assist you with this, there is a Premium Adjustment Report that will aid you as you adjust your monthly invoice.

## Billing procedures

### *Monthly billing*

### *Your group number*

In most cases, your group number for term life insurance coverage is the same as your Health Net policyholder identification number. Every month, your company will receive a Billing Summary for all of your group term life insurance and Accidental Death & Dismemberment coverage.

Billing for group term life insurance products is separate from your medical billing. You will receive a separate invoice with instructions to remit payment to a unique post office box.

Your monthly bill will include:

- Group Term Life Billing Summary.
- Group Term Life Billing.
- Premium Adjustment Report.

The Group Term Life Billing Summary lists the amount due, net any adjustments from prior periods. Please return a copy of this with your remittance.

The Group Term Life Billing is a list of all covered employees and benefit elections they have made. Please review this for accuracy to ensure the billing is correct.

The Premium Adjustment Report is a worksheet to assist you as you adjust your monthly bill. Please include this with your remittance.

### *How payment should be remitted*

Please make your check payable to Health Net Life Insurance Company. In addition, we ask that you write your account number on the face of your check and the current billing period for which you are making payment. Mail your payment to the address listed on your Billing Summary.

Along with your remittance, please include a copy of your Group Term Life Billing Summary, the Premium Adjustment Report, if necessary, and copies of the enrollment forms for all newly eligible employees, or for changes made to coverage or beneficiary designation.

### *When payment should be submitted*

Premium payments are due before the date the coverage is in effect. Payments due on December 1 are due to the PO box before December 1.
We do allow a 31-day grace period, however, before we retroactively cancel an account for late payment.

### *When payments are submitted late*

If we have not received your payment by the due date, we usually contact the broker or you directly to make payment arrangements. If payment is not received within the grace period, your account may be subject to cancellation.

## Claims

Claims for covered benefits under your group term life insurance policy are handled separately from medical claims. In the event of a death, a certified death certificate and claim form will be required at a minimum to establish proof of loss. Other documents may be required, including coroner's reports, police reports, legal affidavits, and/or trustee documentation.

As the employer, you will be required to complete the Policyholder Statement and Named Beneficiary Statement on the claim form. Instructions are included on the form to ensure timely processing of the claim.

# Mental Health and Substance Use Disorder

*The following is a summary of information, benefits and services which are fully described in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI).*

Managed Health Network (MHN),[1] Health Net's behavioral health subsidiary, administers all mental health and substance use disorder benefits (except for Medicare members).

To determine which mental health and substance use disorder benefits are available to your company's employees and to determine in which state your contract is written, please consult your benefit documents or contact your Health Net account manager.

## Basic coverage

### *Mental health*

Mental health care includes evaluative and crisis intervention services for the treatment of emotional disorders and mental illness. MHN covers treatment of both the acute and chronic phases of mental health and substance use disorders. "Acute" is defined as reaching a crisis rapidly, but with potential to get well. Coverage includes evaluation, crisis intervention and treatment.

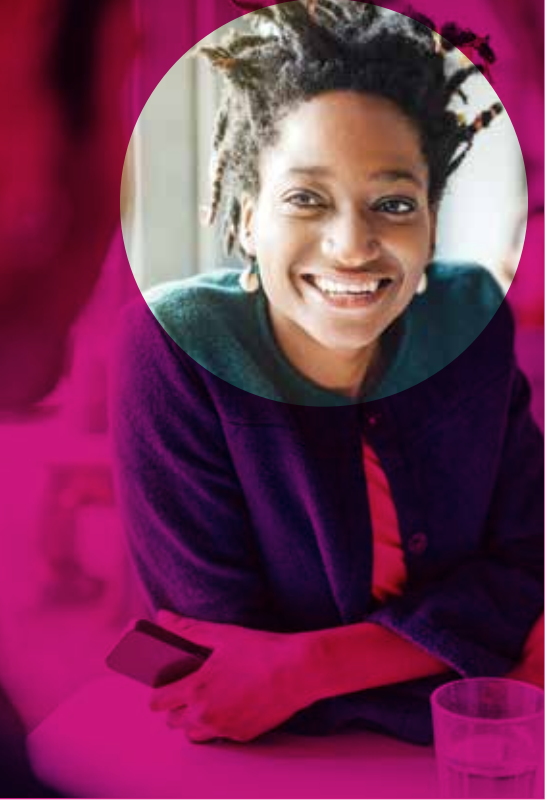
### *Substance use disorder*

Substance use disorder is the misuse or excessive use of alcohol and/or drugs or use of a drug without medical justification. Substance use disorder coverage usually includes detoxification, treatment and aftercare. Treatment can take place in an inpatient or outpatient setting.

### *Detoxification*

Detoxification is a medically safe process to remove or free a user from the intoxicating or addictive substance in the body (e.g., heroin or alcohol). The detoxification process can take from three to seven days depending on the type of substance the detoxification is treating.

Please note: Health Net complies with all applicable Mental Health Parity legislation.



# Dental and Vision

## Dental coverage

*Dental coverage may be purchased in conjunction with a Health Net medical plan or on a standalone basis. Members of groups that have purchased dental coverage will find benefit coverage, terms and conditions in their Evidence of Coverage (EOC) or Certificate of Insurance (COI).*

## Here is a quick summary of the options we offer:

### Dental HMO

**Dental HMO is available to California employees and family members who live or work within the Health Net Dental HMO service area.**

- As part of the enrollment process, each employee enrolling in the dental HMO plan chooses a primary care dentist within 30 miles of where he or she lives or works, and includes that information on the enrollment form.
- Each covered family member may select a different Dental HMO provider.
- If the employee does not select a primary care dentist at the time of enrollment, Health Net will assign a primary care dentist for the employee (and all enrolled family members).
- All dental care must be provided by the member's DHMO provider – exceptions are emergencies and referrals authorized by Dental Benefit Providers of California, Inc. (DBP).

### Dental PPO

**Health Net Dental PPO plans offer members flexibility and the choice of using any licensed dentist.**

- Using a Health Net network dental provider generally saves members out-of-pocket expenses.
- For services obtained out-of-network, members submit claims to:

  Health Net Dental
  Attn.: Claims Unit
  PO Box 30567
  Salt Lake City, UT 84130-0567
- Health Net Dental Member Services is available to answer questions about dental plan coverage, order ID cards, relay the most up-to-date provider information, and more.
- You can also visit us online at www.healthnet.com > *Employers* > *See Large Group Plans* > *Dental plan overview* > *Go to the Health Net Dental Website.*

Health Net Dental HMO and PPO plans are offered and serviced by Dental Benefit Providers of California, Inc. (DBP). Obligations of DBP are not the obligations of or guaranteed by Health Net, LLC. or it affiliates.

## Adult Vision coverage

Adult PPO vision coverage may be purchased in conjunction with a Health Net medical plan or on a standalone basis.

Health Net Vision PPO plans offer employees and family members a choice of any licensed vision provider and access to a large network of independent providers for greater cost savings. The Health Net Vision network includes optical retailers LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JCPenney Optical, giving members:

- **More provider choices.**
- **Added convenience** – vision care in the same place they shop.
- **Flexible appointments** – Health Net's exclusive vision network features evening and weekend appointments to fit every schedule.

Members should refer to their COI for terms and conditions of coverage, including which services are limited or excluded from coverage.

**For services obtained out-of-network, members submit claims to:**

Health Net Vision
Attn.: OON Claims
PO Box 8504
Mason, OH 45040-711

Health Net Vision plans are underwritten by Health Net Life Insurance Company and serviced by Envolve Vision Inc. and EyeMed Vision Care, LLC. Discounts on vision care services and products are made available by EyeMed. EyeMed is not affiliated with Health Net Life Insurance Company. obligations of EyeMed are not the obligations of or guaranteed by Health Net Life Insurance Company.

# Employee Communication Materials

*We believe it is very important to communicate with members about their benefits as well as other helpful information. Read below to learn more about the type of communications your employees can expect to receive from us throughout the year.*

## Enrollment packets

***An employee's guide to enrollment***

Enrollment packets educate prospective members about Health Net and the benefits available to them through your company. This information can be distributed during your company's open enrollment period, during your plan year when a new hire becomes eligible for benefits, or when a current employee becomes eligible for benefits due to a qualifying event.

Enrollment packets typically include the following:

- Enrollment form
- Health plan product and Health Net company overview
- Company-specific benefit summary
- Information on some of our value-added wellness programs

To make arrangements to receive enrollment packets, please call your account manager.

## Member newsletter

***Plan news and programs to keep members healthy***

Our member newsletter is written by experienced staff members and mailed directly to members' homes once a year. It informs members about plan news and provides key information about how to stay healthy and take advantage of all the programs Health Net has to offer.

## Special, targeted mailings

***Wellness and disease management information***

Targeted mailings quickly disseminate important information to a specific population of Health Net members.

Examples of special, targeted mailings in the past include:

- Mammogram reminders to women of targeted age groups.
- Cervical cancer screening reminders to women of targeted age groups.
- Immunization reminders and suggested schedules for children.

# Legal Information/ 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 ages 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. All plan change requests must be completed by the applicant/insured member.

## Effective dates

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

## Quality assurance HEDIS®

The quality of care provided to our members is also evidenced in routinely high scores received on the Healthcare Effectiveness Data and Information Set (HEDIS).

The HEDIS 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.

## 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 Account Services Unit 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. A member's claim cannot be released to a broker without the member's signed, written authorization.

**Health Net does not discriminate among applicants by race, religion, gender, color, national origin, or other conditions or criteria that are related to the applicant's health status.**

# Coverage for Every Stage of Life™

*For 40 years, Health Net has supported individuals and families through various stages of life, and that's what we continue to do.*

Our focus on quality helps ensure the care our members receive is the right care for them. To help in that effort, our dynamic website features simple navigation and easy-to-find information – giving large business groups and their employees a convenience-driven interactive health plan experience. For fast and easy access to the information you need, visit **www.healthnet.com**.

**To access the Employee Enrollment and Change form or any other forms, please register online by going to www.healthnet.com > *Employers* > *Register*.**

Health Net's Nondiscrimination Notice



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