



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

Health Net's Exclusive ID Card Express

EMPLOYER GUIDE

FOR GROUPS OF 101-500



*Coverage for
every stage of life™*



You Have Our Word, Backed by \$7,500!

As a new Health Net employer group, we want to make sure your employees have access to their health care benefits right away. We guarantee we'll mail out their ID cards in ten working days, or we'll pay you \$7,500. No other California health care company offers a promise like that.

The Health Net guarantee

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



WHO IS ELIGIBLE?

- New California groups only;
- With 101 to 500 employees; and
- Choose from Health Net's Enhanced Choice or Starting Line-Up (SLU) plan options.

HERE'S HOW IT WORKS

1. Once we approve your application and enrollment package, you'll receive a welcome letter from Health Net. This letter will let you know you qualify for ID Card Express.
2. We guarantee Health Net ID cards will be mailed to your group within 10 working days from the date of the welcome letter.
3. If we don't live up to our promise, we'll pay you \$7,500!

Keeping you informed

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



Double check all the highlighted critical fields as noted in the sample shown here.

HOW TO SUBMIT YOUR ENROLLMENT PACKAGE

Here are some tips to help you meet the guarantee rules. Your broker or Health Net sales consultant will provide you with the required enrollment spreadsheet, called the Census Robotech Member Enrollment Template or Generic 349 Layouts Medical Dental Vision Life. You will need to fill out one of these spreadsheets based on your enrollment type.

- Provide all your employee enrollment forms or the required spreadsheet to Health Net as soon as possible so they can be processed with the initial submission.
 - Late or incomplete packages may be disqualified.
- Check your spreadsheet or enrollment forms. **Make sure they are complete and contain no errors.** Enrollment Packages with more than 30 percent discrepancies will delay ID cards and are not covered by this offer.

To be completed by employer

Employee name: _____
 Requested effective date: _____ Employee group number (medical): _____
 Employee eligibility date (how long only): _____
 Same as hire date Other

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (Select coverage.)

HMO HMO SmallCare HMO BasicCare HMO Initial HMO/MA EOA ExactCare EOA Select PPO Other

PPO PPO CCO PPO HSA compatible PPO POS HSA compatible PPO Integrated HSA compatible PPO Other

Dental and Vision

Dental (DHMO) Dental (DPPH) Vision (PPO)

2. Reasons for application

Plan change New hire Open Enrollment COBRA Qualifying event date: _____ Effective date: _____
 Change address/name Date dependent Other Add dependent Marriage Divorce/Adoption/Legal Guardianship/Court Order/Assignment of parent child relationship Loss of prior coverage Other (specify): _____

3. Employee personal information

Last name: _____ First name: _____ MI: _____ Sex: Male Female
 Residence address: _____ City: _____ State: _____ ZIP: _____
 Date of birth (mm/dd/yyyy): _____ Social Security #/Matricular ID # (required for all applicants): _____ Job title: _____
 Telephone #: _____ Work phone #: _____ Email address: _____
 Date of hire: _____ Dept. #: _____ Marital status: Single Married Domestic partner
 I would prefer to receive communications and plan information in: English Spanish Chinese Korean

Participating physician group: _____ Primary care physician: _____
 PPO/PCP enrollment ID # (4-digit PPO and 6-digit PCP numbers): _____ Is this your current PCP? Yes No
 Dental HMO provider name: _____ Dental HMO provider ID #: _____

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

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Employee name: _____ Last 4 digits of Social Security #: _____

4. Family information; please list all eligible family members to be enrolled.
(List dependent children if necessary)

Spouse Domestic partner Other

First name: _____ MI: _____
 Last name: _____
 Residence address: _____ City: _____ State: _____ ZIP: _____
 Date of birth (mm/dd/yyyy): _____ Social Security #/Matricular ID # (required for all applicants): _____

Participating physician group: _____ Primary care physician: _____
 PPO/PCP enrollment ID # (4-digit PPO and 6-digit PCP numbers): _____ Is this your current PCP? Yes No
 Dental HMO provider name: _____ Dental HMO provider ID #: _____

Son Daughter Other

First name: _____ MI: _____
 Last name: _____
 Residence address: _____ City: _____ State: _____ ZIP: _____
 Date of birth (mm/dd/yyyy): _____ Social Security #/Matricular ID # (required for all applicants): _____

Participating physician group: _____ Primary care physician: _____
 PPO/PCP enrollment ID # (4-digit PPO and 6-digit PCP numbers): _____ Is this your current PCP? Yes No
 Dental HMO provider name: _____ Dental HMO provider ID #: _____

Son Daughter Other

First name: _____ MI: _____
 Last name: _____
 Residence address: _____ City: _____ State: _____ ZIP: _____
 Date of birth (mm/dd/yyyy): _____ Social Security #/Matricular ID # (required for all applicants): _____

Participating physician group: _____ Primary care physician: _____
 PPO/PCP enrollment ID # (4-digit PPO and 6-digit PCP numbers): _____ Is this your current PCP? Yes No
 Dental HMO provider name: _____ Dental HMO provider ID #: _____

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Section 7 is only critical if the member wants to decline coverage for themselves or their eligible dependent(s).

Employee name: _____ Last 4 digits of Social Security #: _____

5. Do you or your dependents have other health care coverage?

No Yes Yes, please complete this section including Medicare

6. Declaring coverage (Complete this section if coverage is being declined by you or your eligible dependent.)

Last name: _____ First name: _____ MI: _____ Social Security #/Matricular ID #: _____

Declaring medical coverage for: Spouse Domestic partner Dependent Reason: Other group coverage through this employer Individual coverage Other group coverage by another group (i.e., spouse/employer/Name(s): _____

Declaring dental coverage for: Spouse Domestic partner Dependent Reason: Other group coverage through this employer Individual coverage Other group coverage by another group (i.e., spouse/employer/Name(s): _____

Declaring vision coverage for: Spouse Domestic partner Dependent Reason: Other group coverage through this employer Individual coverage Other group coverage by another group (i.e., spouse/employer/Name(s): _____

IF YOU ARE DECLINING COVERAGE - STOP AND READ CAREFULLY
 Have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependent(s) and I may have to sue to be entitled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer and I have been given the chance to apply for the available coverage. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ Date: _____
Sign only if declining coverage. If signed in error, please cross out and initial.

7. Life beneficiary information (Complete this section if you are declining life insurance coverage.)
 California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, DHP and/or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or any Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. § 1001-1161. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Employee signature: _____ Date: _____
Sign only if accepting coverage. If signed in error, please cross out and initial.

8. Group term life insurance, if applicable (omit spouse/child for additional or contingent beneficiaries.)

Life beneficiary (full name): _____ Relationship: _____ %
 Life beneficiary (full name): _____ Relationship: _____ %
 Life beneficiary (full name): _____ Relationship: _____ %
 Life beneficiary (full name): _____ Relationship: _____ %

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Employee name: _____ Last 4 digits of Social Security #: _____

5. Do you or your dependents have other health care coverage?

No Yes Yes, please complete this section including Medicare

6. Declaring coverage (Complete this section if coverage is being declined by you or your eligible dependent.)

Last name: _____ First name: _____ MI: _____ Social Security #/Matricular ID #: _____

Declaring medical coverage for: Spouse Domestic partner Dependent Reason: Other group coverage through this employer Individual coverage Other group coverage by another group (i.e., spouse/employer/Name(s): _____

Declaring dental coverage for: Spouse Domestic partner Dependent Reason: Other group coverage through this employer Individual coverage Other group coverage by another group (i.e., spouse/employer/Name(s): _____

Declaring vision coverage for: Spouse Domestic partner Dependent Reason: Other group coverage through this employer Individual coverage Other group coverage by another group (i.e., spouse/employer/Name(s): _____

IF YOU ARE DECLINING COVERAGE - STOP AND READ CAREFULLY
 Have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependent(s) and I may have to sue to be entitled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer and I have been given the chance to apply for the available coverage. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

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ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, DHP and/or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or any Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. § 1001-1161. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

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Life beneficiary (full name): _____ Relationship: _____ %
 Life beneficiary (full name): _____ Relationship: _____ %
 Life beneficiary (full name): _____ Relationship: _____ %
 Life beneficiary (full name): _____ Relationship: _____ %

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Next steps

You're all set – there's nothing else for you to do. We'll make sure your group receives their ID cards promptly, as promised.

You and your employees will be able to access benefits right away. And you'll find more helpful services online at www.healthnet.com.

- **For you:** Easy-to-use online billing and enrollment.
- **For your employees:** Online tools and resources to view benefits and claims, find doctors, and access wellness programs.

Health Net – your trusted partner
for better health



Call your broker or your Health Net sales consultant today to find out more about our ID Card Express program. We look forward to partnering with you to help your employees live and work well.