Health Net®

Health Net®
LIFE INSURANCE COMPANY

Small Business Application

for Group Service Agreement/Group Policy

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

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

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

Small Business Group: 1-800-361-3366 *(English)*
1-800-331-1777 *(Spanish)*
1-877-891-9053 *(Mandarin)*

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

Existing Business/Group
PO Box 9103
Van Nuys, CA 91409-9103
www.healthnet.com

New Business/Group
Please send all completed paperwork to your designated Account Executive or Broker.

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Small Business Application

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

Groups taking multiple plans, select your package:

☐ Enhanced Choice ☐ Silver Choice ☐ SmartCare Choice ☐ SmartCare ☐ H^n Options ☐ H^n Options Silver

Mental Health Parity and Addiction Equity Act (MHPAEA)-compliant plans ☐ Yes ☐ No

Groups with a single plan, select your network:

☐ Full Network (HMO and EOA) ☐ Silver Network[1] (HMO and EOA)

SmartCare HMO[2]

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

Other plan options

HMO Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50	**HMO Value** ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50	**HMO Advantage** ☐ 25 ☐ 35 ☐ 45
HMO Standard Dual Network[3] ☐ 20 ☐ 30	**HMO Value Dual Network[3]** ☐ 30 ☐ 40	
EOA Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50	**EOA Value** ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50	**EOA Advantage** ☐ 25 ☐ 35 ☐ 45
H^n Options ☐ HMO 25 ☐ HMO 35 ☐ EOA 25 ☐ EOA 35		
PPO Standard ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45	**PPO Value** ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45	**PPO Advantage** ☐ 45
HSA[4] Value PPO ☐ 4500	**HRA PPO** ☐ 3000 ☐ 5000	**POS** ☐ 10 ☐ 20
H^n Options ☐ PPO 250 ☐ PPO 500 ☐ PPO 1500 ☐ PPO 1750 ☐ PPO 3000[4] ☐ PPO 4000[4]	**Salud con Health Net®** ☐ HMO y Más 15[5] ☐ HMO y Más 25[5] ☐ HMO y Más 35[5] ☐ Salud EPO[6] ☐ Salud Mexico[7]	**Flex Net** ☐ Indemnity *(Out of service area only)*

Ancillary options

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

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

2. Employer group information *(If adding dental or vision to your existing coverage, please complete sections 2, 3, 4, 7, 9, 11, 12, and 13; for all other changes to existing coverage, please complete only sections 2, 3, 4, and 12.)*

Company name:	DBA:	Group #:	SIC code:
Tax ID Number (TIN):	Total number of employees worldwide: ☐ 2–19 ☐ 20–99 ☐ 100 or more		
Type of business:	Type of entity *(corporation, sole prop., LLC, partnership):*	How long in business:	Effective date *(renewal date):*
Company contact:	Telephone:	Fax:	
Mailing address *(if PO Box, please provide physical address):*	City:	State:	ZIP:
Billing address *(if different):*	City:	State:	ZIP:
Email address *(print clearly):*			

2. Employer group information (continued)

Company contact for coordination of benefits *(if different from above):*			
Mailing address *(if PO Box, please provide physical address):*	City:	State:	ZIP:

3. Employer contribution *(Note: Employer contribution for health is a minimum of 50%[10] and for life is 100% (2–9 enrollees) and 25% (10–50 enrollees).)*

Employee Health: _____% or, $_____ Employee Life: _____% Employee Dental: _____% Employee Vision: _____%

Dependent Health: _____% or, $_____ Dependent Life: _____% Dependent Dental: _____% Dependent Vision: _____%

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

4. Eligibility information

1. Probationary period for new hires/rehires – First of the month following: ☐ Date of hire ☐ 1 mo. ☐ 2 mos. ☐ 3 mos. ☐ ___ mos. (6 max.)
2. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No
3. Number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30

	Medical	Life	Dental	Vision
4. Number of eligible employees (including eligible owner(s)):				
5. Total number of Health Net enrollees (excluding COBRA enrollees):				
6. Number of Health Net COBRA enrollees (applying for health coverage):				
7. Number of waivers (Please include an enrollment form with Section 7 "Declination of Coverage" indicated.):				

8. What type of COBRA[11] are you subject to? ☐ Federal COBRA ☐ Cal-COBRA

   If federal COBRA, how would you like your COBRA enrollees to be billed: ☐ Group billed ☐ Member billed
9. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No
10. Do the eligible enrollees represent a carve-out either by class, location or union affiliation? ☐ Yes ☐ No
11. Does the group file a DE-9C? ☐ Yes ☐ No[12]

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

(Note: Option A is for 2–50 employees. Options B–G vary by group size.)

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

☐ **Option B** – A flat amount higher than $15,000; maximum $100,000: $ _____.

☐ **Option C** – One (1) X annual salary; _____ or two (2) X annual salary; maximum $50,000.

☐ **Option D** – One (1) X annual salary; _____ or one and a half (1.5) X annual salary; _____ or two (2) X annual salary; maximum $100,000.

☐ **Option E** – Graded benefits by job title: Class I (officers, managers, supervisors) – $25,000; Class II (all other employees) – $15,000.

☐ **Option F** – Graded benefits by job title: Class I (officers, managers, supervisors) – $50,000; Class II (all other employees) – $25,000.

☐ **Option G** – Graded benefits by job title: Class I (officers, managers, supervisors) – $100,000; Class II (all other employees) – $50,000.

Dependent Life: (choose one)

☐ High: $5,000 spouse, $2,000 child, $200 infant (14 days–6 mos.)

☐ Low: $2,000 spouse, $1,000 child, $100 infant (14 days–6 mos.)

6. Pre-tax solutions *(e.g., IRS code sections 125 and 321; premium-only plans and Flex plans.)*

If you are interested in learning about the tax savings potential for your employees and company, please contact Total Administrative Services Corporation (TASC) at 1-800-422-4661.

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

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

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

Health and/or Life: _____ Workers' compensation: _____

Will Health Net be the only carrier? ☐ Yes ☐ No If "No," name of other carrier: _____

Plan(s) offered: _____

Number of enrollees not covered by workers' compensation: _____

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

8. Health Questionnaire *(For new groups only.)*

All employer groups must answer "Yes" or "No" to the following questions. Employer groups of 6–9 enrolling employees must have each employee complete the Health Questionnaire with the Enrollment form.

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

1. To your knowledge, is there any employee, dependent of an employee, or person to be covered who has received more than $5,000 of medical care in the past two (2) years? ☐ Yes ☐ No
2. To your knowledge, is any employee, dependent of an employee, or person to be covered unable to work due to injury or illness? ☐ Yes ☐ No
3. To your knowledge, are there any current pregnancies or recent hospitalizations for any employee, dependent of an employee, or person to be covered? ☐ Yes ☐ No
4. To your knowledge, has any employee, dependent of an employee, or person to be covered ever had, consulted for, had treatment rendered, been advised to have treatment or received treatment, or been hospitalized for any of the following conditions: cardiovascular disease or heart attack; disorder of the kidney, stomach, intestines, or liver; mental or nervous condition; central nervous system disorders; diabetes; respiratory disorders or cancer? ☐ Yes ☐ No
5. To your knowledge, has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or AIDS-related complex (ARC) by a medical professional? ☐ Yes ☐ No

For each "Yes" answer, please provide the person(s) name and submit their completed employee Health Questionnaire.

_____

_____

_____

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

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

☐ Policy renewal date to coincide with medical plan. Effective: _____

10. Mailing methods

Where would you want your ID cards mailed? ☐ Member ☐ Employer

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

11. Underwriting criteria

General conditions

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

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

12. Arbitration agreement and other important terms

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement/Group Policy is subject to review and approval by the Health Net Entities, the DBP Entities and/or the Fidelity Entities and receipt of the first month's premium.

The undersigned, on behalf of Group Applicant, understands and agrees that the employer Group Policies applied for, except for the HRA 3000 and HRA 5000 HRA-compatible plans outlined in the "Health plan information" section of this Small Business Application for Group Service Agreement/Group Policy, is intended to be issued as a standalone plan(s) only or in conjunction with a Health Savings Account (HSA) banking arrangement, where applicable. Such plan(s), except for the HRA 3000 and HRA 5000 HRA-compatible plans specified above, may not be combined with any form of partial self-funding or otherwise insuring of the deductible, whether in a wraparound, addition or companion capacity, including a partially self-funded Section 105 wraparound, at any time during which the Group Policies are in force. Failure to comply is a breach of the Group Policies and Underwriting Assumptions and will result in Health Net Life Insurance Company canceling the health insurance plan coverage initially issued, and replacing it with the most similar plan from the HRA 3000 and HRA 5000 HRA-compatible plan suite offered by Health Net Life Insurance Company and available for purchase at the time of the breach. The replacement health insurance plan will be issued at the applicable premium rates in effect at that time.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. Should it be determined at the time of enrollment and/or at a future date that there are misstatements in this application, the Health Net Entities, the DBP Entities and/or the Fidelity Entities may at their respective sole options either rescind the quote or initiate termination of the respective group contract(s).

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the Group Service Agreement/Group Policy and to forward such amounts in advance of the due date to the Health Net Entities, the DBP Entities and/or the Fidelity Entities, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group, and deletions from the group. Please return this application to your Health Net of California, Inc. and/or Health Net Life Insurance Company Account Executive or Broker as specified.

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

This Small Business Application for Group Service Agreement/Group Policy and any attached Addendum, together with the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies (as referenced herein), and the employee enrollment forms form the entire agreement between the parties.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

12. Arbitration agreement and other important terms (continued)

BINDING ARBITRATION AGREEMENT: On behalf of Group Applicant, I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical services malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by the Health Net Entities, the DBP Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by the Health Net Entities, the DBP Entities and/or the Fidelity Entities to deny, reduce, terminate, or not pay for all or a part of a benefit. However, members and the Health Net Entities, the DBP Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Officer of the company signature:	Officer title:	Date:

13. Broker information

Broker name:	Health Net Broker ID #:	Broker Lic. #:		Date submitted:
Agency name:	Telephone #:	Fax #:		Email address:
Address:	City:		State:	ZIP:
Broker/consultant signature:	Date:	Account Executive name:		Date:
General Agent / ID #:				Date:
General Agent verification: Open Enrollment materials provided to the Employer included the applicable Summary of Benefits and Coverage (SBC).		General Agent Representative signature:		

14. For Health Net use only

Underwriter signature:	Date:	Approved: ☐ Medical ☐ Dental ☐ Vision Declined: ☐ Medical ☐ Dental ☐ Vision	Billing #:	Effective date:
SBG representative signature:	Date:	Group # (Health):	Policyholder # (Life):	Medical plan:

Health Net of California, Inc. offers the following products: Elect Open Access, HMO, Select POS, Salud con Health Net® HMO y Más.℠ Health Net Life Insurance Company offers the following products: Flex Net, PPO, Salud con Health Net EPO, Life and AD&D insurance. Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity. Dental Benefit Providers of California, Inc. offers the following product: Dental HMO. Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: Vision PPO.

Small Business Group submission checklist

To ensure prompt processing, please make sure to include the following documents.

Groups applying for a 1st-of-the-month effective date must be submitted to Health Net by the 5th of the month. Paperwork must be completed by the 20th of the month; otherwise, the group will be rolled to the following month.

☐ A signed original application for Group Service Agreement (GSA)/Group Policy

☐ A complete employee application for each eligible employee enrolling/waiving coverage

☐ A check or a Check-by-Fax form for the first month's premium drawn from the group account

☐ A Health Questionnaire is required for:

- All groups of 6–9 employees enrolling.
- Groups of 1–5 enrolling employees that are eligible for an industry discount.
- Any employee referenced on the GSA with a known medical condition.
- Nonguaranteed issue groups.
- All carve-out groups.

☐ The latest quarter DE-9C, reconciled:

- If the group has not been in business long enough to have a DE-9C, six weeks of payroll, including withholdings, may be submitted.
- 2 week payroll is required for all employees that don't appear on the current DE-9C.
- For wages exceeding part-time and wages below full-time status, payroll will be required.
- To reconcile the DE-9C, please indicate next to each employee's name one of the following:

  T – Terminated (including termination date)

  E – Eligible and enrolling

  W – Eligible and waiving coverage

  S – Seasonal

  WP – Waiting period (include date of hire for those in waiting period)

  TEMP – Temporary employees

  PT – Part-time

  Covered by another carrier – add carrier name.

☐ Ownership paperwork (required if owner/partners' names do not appear on the DE-9C or payroll records). Must list each person's first and last name. Paperwork must be filed with the state or county. Documentation may include:

For sole proprietor:

- California Business License
- Fictitious Business Name Statement
- Schedule C Tax Form

For partnership:

- California Business License (showing both names)
- Fictitious Business Name Statement (showing both names)
- Schedule K Tax Form (for all eligible owners)
- Tax certificate (showing both names)

For corporation:

- Articles of Incorporation
- Statement of Information
- Tax Form 1120

Note: Please consult your sales representative for acceptable ownership documentation for other business structures.

For PPO plans:

☐ Copies of EOBs for employees requesting Deductible Credit from prior carrier

☐ Groups enrolling in the HSA EZ Access Program:

- Completed Bank of America Employer Enrollment Forms
- Health Net Authorization Form (1 page)
- Bank of America Employer Group Set-Up Form (2 pages)
- Bank of America Services Agreement (3 pages)

Employees can easily enroll online for The HSA for Life® from Bank of America by following these simple steps:

1. Visit www.bankofamerica.com/benefitslogin.[13]
2. Under "New User," click *Continue.*
3. Enter the Group ID provided to them by the employer.
4. Follow the prompts to complete and submit the application.

Send all completed paperwork to your designated Account Executive or Broker.

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

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

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

[4] HSA-compatible.

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

[6] Available in Los Angeles, Orange and Ventura counties.

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

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

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

[10] Multiplan packages require a minimum of 50% of the lowest cost plan (excluding Salud) or $100 per employee. A single plan option requires a minimum of 50% or $100 per employee.

[11] Note: Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2–19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

[12] If a DE-9C is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

[13] If the employees do not have online access, contact your authorized Health Net Agent or Broker.

Health Net®

Ensure *Your Employees* Understand *Their Health Care*

Summary of Benefits and Coverage to eligible and covered persons

Instructions for reproduction and distribution.

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

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

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

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

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

SBC form and manner

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

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

(continued)

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.
[2]Such requirements can be found at 29 C.F.R. § 2520.104(b).

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

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

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

Timing of SBC distribution

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

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

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

Notice of SBC modification

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

Uniform glossary

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

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

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