

HMO Guaranteed Issue

Summary of Benefits

Health coverage made easy

Effective January 1, 2012



Jesus Hao
Health Net



Health Net®

Health Net Guaranteed Issue

Individual & Family Coverage

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage, regardless of pre-existing conditions, when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet requirements outlined under the “Important things to know,” “Who is eligible?” section are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net’s Guaranteed HMO plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the eligibility requirements, agree to pay the required premiums and live or work in the plan’s service area. In response, Health Net of California, Inc. offers the HMO 40 plan to eligible individuals at the Guaranteed Issue Rates listed at the end of this brochure.

If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at 1-888-HMO-2219, or visit the Department’s website at www.hmohelp.ca.gov.

This document is only a summary of your health coverage. You have the right to view the plan’s Plan Contract and Evidence of Coverage (EOC) prior to enrollment. To obtain a copy of this document, contact your authorized Health Net agent or your Health Net Sales Representative at 1-800-909-3447. The plan’s Plan Contract and EOC, which you will receive after you enroll, contain the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and the plan’s Plan Contract and EOC thoroughly once received,

especially all sections that apply to those with special health care needs. The health benefits and coverage matrix on pages 3 through 5 is included to help you compare coverage benefits.

Please read the following information so you will know from whom or what group of providers health care may be obtained.

How the plan works

Health Net requires the designation of a primary care physician. A primary care physician (PCP) provides and coordinates your medical care. You have the right to designate any primary care physician who participates in our Health Net Individual HMO network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the primary care physician. Until you make your primary care physician designation, Health Net designates one for you. For information on how to select a primary care physician and for a list of the participating primary care physicians, refer to your Health Net Individual HMO Directory. The Health Net Individual HMO Directory is also available on the Health Net website at www.healthnet.com. Your primary care physician oversees all your health care and provides the referral/authorization if specialty care is needed. Primary care physicians include general and family practitioners, internists, pediatricians and OB/GYNs. A primary care physician’s office is just like any other private doctor’s office. When you need to see your doctor, just call for an appointment. To obtain health care, simply present your ID card and pay the appropriate copayment.



Your primary care physician must first be contacted for initial treatment and consultation before you receive any care or treatment through a hospital, specialist or other health care provider, except for OB/GYN visits, as set out below. All treatments recommended by such providers must be authorized by your primary care physician.

You do not need prior authorization from Health Net or from any other person (including a primary care physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your Health Net Individual HMO Directory. The Health Net Individual HMO Directory is also available on the Health Net website at www.healthnet.com. Refer to the “Mental Health and Chemical Dependency Services” section later in this guide for information about receiving care for Mental Disorders and Chemical Dependency.

HMO advantages include:

- no paperwork or claim forms;
- emergency care covered worldwide;
- set copayments for office visits and prenatal, postnatal and newborn care;
- hospital coverage;
- no charge for X-ray and laboratory services; and
- prescription coverage.

Timely access to non-emergency health care services

The California Department of Managed Health Care (DMHC) has issued regulations (Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services.

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the Individual Conversion Plan EOC or contact the Health Net Member Services Department at the phone number on the back cover.

Out-of-pocket maximum

See the “Principal Benefits and Coverage Matrix – HMO” section for specific information about the out-of-pocket maximum and deductibles for the Guaranteed Issue HMO Plan. The copayments and the calendar year inpatient hospital services deductible that you or your family members pay for covered services and supplies apply toward the individual or family out-of-pocket maximum. After you or your family members meet your individual or family out-of-pocket maximum, you pay no additional amounts for covered services and supplies for the balance of the calendar year, except as otherwise noted. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay the copayments and the calendar year deductible for inpatient hospital facility services until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family out-of-pocket maximum, or (b) each enrolled family member individually satisfies the individual out-of-pocket maximum. You are responsible for all charges related to services and supplies not covered by the health plan. Amounts that are paid toward certain covered services and supplies are not applicable to a member’s out-of-pocket maximum. See the “Principal Benefits and Coverage Matrix – HMO” section for specific information about which amounts do not apply toward the out-of-pocket maximum. Payments for services and supplies not covered by this plan will not be applied to this yearly out-of-pocket maximum. In order for the family out-of-pocket maximum to apply, you and your family must be enrolled as a family unit.

Principal Benefits and Coverage Matrix – HMO

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The plan contract and Evidence of Coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations.

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net’s cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

<i>Benefit description</i>	<i>HMO 40 NG</i>
Deductibles	\$1,500 per calendar year for inpatient hospital services only (prescription drug deductible also applies ¹)
Lifetime maximums	Unlimited
Out-of-pocket maximum (Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum.)	\$3,000 single / \$6,000 family (includes deductible)
Professional services	
Visit to physician	\$40
Specialist consultations	\$40
Prenatal and postnatal office visits ²	\$40
Preventive care	
Periodic health evaluations and annual preventive physical examinations ³	\$0
Vision exams (for diagnosis or treatment)	\$40
Hearing exams (for diagnosis or treatment)	\$40
Immunizations – standard	\$0
Immunizations – to meet foreign travel or occupational requirements	20%
Prostate cancer screening and exam	\$0
Well-woman exam (breast and pelvic exams, cervical cancer screening and mammography) ⁴	\$0
Allergy testing	\$40
Allergy injection services	\$40
All other injections	Covered in full
Allergy serum	Covered in full
Outpatient facility services	
Outpatient services other than surgery	Covered in full
Outpatient surgery	\$250
Hospitalization services	
Semiprivate hospital room or special care unit with ancillary services (unlimited, except for non-severe mental disorder and chemical dependency treatment)	\$1,500 deductible applies per calendar year for inpatient services
Surgeon or assistant surgeon services	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	\$50 per day
Maternity care in hospital or skilled nursing facility	\$0 after inpatient hospital services deductible is met

<i>Benefit description</i>	<i>HMO 40 NG</i>
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency)	Covered in full
Emergency health coverage	
Emergency room (professional and facility charges)	\$100 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	\$40
Ambulance services	
Ground ambulance	\$80
Air ambulance	\$80
Prescription drug coverage	
\$100 prescription drug deductible per member, per calendar year applies ⁷ Prescription drugs filled at a participating pharmacy (up to a 30-day supply) ^{1,5,6}	\$15 Level I (primarily generic); \$25 Level II (primarily brand name, peak flow meters, inhaler spacers and diabetic supplies, including insulin); \$50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Prescription drugs filled through mail order (up to a 90-day supply) ^{1,5,6}	\$30 Level I (primarily generic); \$50 Level II (primarily brand name and diabetic supplies, including insulin); \$100 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com .) ^{1,5,6}	50%
Contraceptive drugs ^{5,6}	\$15 Level I (primarily generic); \$25 Level II (primarily brand name); \$50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Durable medical equipment	
Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	50%
Prosthesis ⁹	Covered in full
Mental health services⁸	
Severe mental illness and serious emotional disturbances of a child conditions	
Outpatient professional consultation	\$40
Inpatient services	Covered in full
Other mental disorders⁸	
Outpatient professional consultation (20-visit maximum each calendar year)	\$40
Inpatient services (30-day maximum each calendar year)	Covered in full
Chemical dependency services	
Chemical dependency treatment	Not covered
Acute care (detoxification)	\$100 per day (unlimited)
Home health services	
Home health services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	\$40

<i>Benefit description</i>	<i>HMO 40 NG</i>
Other	
Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear) ⁹	\$25
Laboratory procedures and diagnostic imaging (including X-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational and respiratory therapy)	\$40
Sterilizations – vasectomy	\$150
Sterilizations – tubal ligation	\$150
Organ and stem cell transplants (non-experimental and non-investigational)	Covered in full
Hospice services	Covered in full
Family planning counseling	\$40

HMO footnotes

¹Does not apply to the out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma, and diabetic supplies.

²Prenatal, postnatal and newborn care office visits for preventive care are covered in full. If the primary purpose of the office visit is unrelated to a preventive service or if other non-preventive services are received during the same office visit, the above copayment will apply for the non-preventive services.

³For preventive health purposes, covered services include, but are not limited to, periodic health evaluations and diagnostic preventive procedures, based on recommendations published by the U.S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the U.S. Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

⁴Women may obtain OB/GYN physician services in their primary care physician's physician group for OB/GYN preventive care, pregnancy and gynecological ailments without first contacting their primary care physician. Mammograms are covered at the following intervals: One for ages 35–39, one every 24 months for ages 40–49, and one every year for age 50 and older.

⁵The Health Net Recommended Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the List do require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary for the nature of the member's condition, after Health Net's receipt of the information which is reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call the Customer Contact Center at the number listed on the back of your ID card, or visit our website at www.healthnet.com.

⁶Percentage copayments will be based on Health Net's contracted pharmacy rate. If the pharmacy's retail price is less than the applicable copayment, you will only pay the pharmacy's retail price.

⁷The prescription drug deductible (per member per calendar year) must be paid for prescription drug covered services before Health Net begins to pay. The prescription drug calendar year deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, and diabetic supplies and equipment dispensed through a Participating Pharmacy. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

⁸Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. See page 10 for definitions of severe mental illness or serious emotional disturbances of a child.

⁹Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed to assist the visually impaired, insulin pumps and related supplies, and corrective footwear. Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of glucose monitors and blood glucose testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems (including pen needles) for the administration of insulin, and specific brands of insulin syringes. Additionally, the following supplies are covered under the medical benefit as specified: (a) visual aids (excluding eyewear), to assist the visually impaired with proper dosing of insulin, are provided through the prostheses benefit; and (b) Glucogen, provided through the self-injectables benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

Important *Things to Know*

Who is eligible?

Applicants who meet the following requirements are eligible to enroll in Health Net's Guaranteed Issue HMO without underwriting. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

- The applicant must be under the age of 65.
- The applicant must not be eligible for Medicare.
- The applicant must reside continuously in our service area.
- The most recent coverage must have been under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage).
- The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
- If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.
- The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.

How does the monthly billing work?

Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases after the enrollment effective date, you will be notified at least 60

days in advance. For your monthly billing, you may choose to enroll in Health Net's Simple Pay option, pay by credit card or receive a monthly billing statement by mail. If there are changes to the Health Net Individual & Family HMO Plan Contract and EOC, including changes in benefits, you will be notified at least 30 days in advance.

Can benefits be terminated?

You may cancel your coverage at any time by giving Health Net written notice. In such event, termination will be effective on the first day of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:

- You do not pay your premium on time. (Health Net will issue a 30 day prior notice of our right to terminate your coverage for non-payment of premium. The 30 day prior notice will be sent on or before the first day of the month for which premiums are due and will describe the 30 day grace period, which grace period begins after the last day of paid coverage. If you do not pay your premiums by the first day of the month for which premiums are due, Health Net can terminate your coverage after the 30 day grace period).
- You and/or your family member(s) cease being eligible (see "Who is eligible?" section).
- You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement. Some examples include: misrepresenting eligibility information about you or a dependent; presenting an invalid prescription or

physician order; or misusing a Health Net Member ID Card (or letting someone else use it).

Health Net can terminate your coverage, together with all like policies, by giving 90 day's written notice. If your coverage is terminated because Health Net ceases to offer all like policies, you may be entitled to Conversion coverage. Should such a termination occur, information on Conversion coverage will be provided in the written termination notice. Members are responsible for payment of any services received after termination of coverage at the provider's prevailing non-member rates. This is also applicable to members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of coverage.

If you terminate coverage for yourself or any of your family members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

Are there any renewal provisions?

Subject to the termination provisions discussed, coverage will remain in effect for each month prepayment fees are received and accepted by Health Net. You will be notified 60 days in advance of any changes in prepayment fees. You will be notified 30 days in advance of any changes in benefits or contract provisions.

Does Health Net coordinate benefits?

There are no Coordination of Benefit provisions for individual plans in the state of California.

What is utilization review?

Health Net makes medical care covered under our Individual & Family HMO plans subject to policies and procedures that lead to efficient and prudent use of resources and, ultimately, to continuous improvement of quality of care.

Health Net bases the approval or denial of services on the following main procedures:

- Evaluation of medical services to assess medical necessity and appropriate level of care,
- Implementation of case management for long-term or chronic conditions,
- Review and authorization of inpatient admission and referrals to noncontracting providers, and
- Review of scope of benefits to determine coverage.

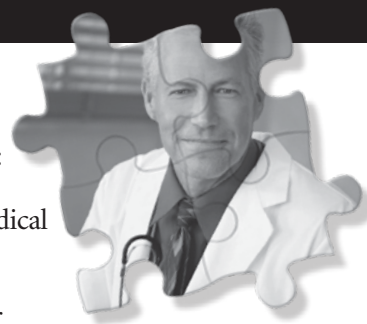
If you would like additional information regarding Health Net's Utilization Review System, please call the Customer Contact Center at **1-800-839-2172**.

Does Health Net cover the cost of participation in clinical trials?

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential to benefit the member and the trial has therapeutic intent. For further information, please refer to the Health Net Individual & Family HMO Plan Contract and Evidence of Coverage (EOC).

What if I have a disagreement with Health Net?

Members dissatisfied with the quality of care received, or who believe they were denied service or a claim in error, or subject to or received an adverse benefit determination may file a grievance or appeal. An adverse benefit determination includes: (a) rescission of coverage, even if it does not have an adverse effect on a particular benefit at the time;



(b) determination of an individual's eligibility to participate in this Health Net plan;

(c) determination that a benefit is not covered;

(d) an exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source of injury exclusion; or, (e) determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

In addition, plan members can request an independent medical review of disputed health care services from the Department of Managed Health Care if they believe that health care services eligible for coverage and payment under their Health Net plan were improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies a member's appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, members can request an independent medical review of Health Net's decision from the Department of Managed Health Care if they meet eligibility criteria set out in the Plan Contract and Evidence of Coverage.

Members not satisfied with the results of the grievance and appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice.

As a condition of enrollment, members give up their right to a jury or trial before a judge for the resolution of such disputes.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Health Net, you should first telephone Health Net at **1-800-839-2172** and use our grievance process before contacting

the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's website <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

What if I need a second opinion?

Health Net members have the right to request a second opinion when:

- The member's primary care physician or a referral physician gives a diagnosis or recommends a treatment plan with which the member is not satisfied;
- The member is not satisfied with the result of treatment received;
- The member is diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function, or a substantial impairment, including but not limited to a serious chronic condition; or

- The member's primary care physician or a referral physician is unable to diagnose the member's condition, or test results are conflicting.

To obtain a copy of Health Net's second opinion policy, contact the Customer Contact Center at 1-800-839-2172.

What are Health Net's loss ratios?

The loss ratio is the ratio of health care costs to premiums. Health Net's 2010 loss ratio for Individual & Family HMO plans was 139.8%.

What is the relationship of the involved parties?

Physician groups, contracting physicians, hospitals and other health care providers are not agents or employees of Health Net. Health Net and each of its employees are not the agents or employees of any physician group, contract physician, hospital or other health care provider. All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of your coverage option. Members are not liable for any acts or omissions of Health Net, its agents or employees, or of physician groups, any physician or hospital, or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of your plan.

What about continuity of care upon termination of a provider contract?

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracting physician group or provider and make every effort to ensure continuity of care. At least 60 days prior to termination of a contract with a physician group or acute care hospital to

which members are assigned for services, Health Net will provide a written notice to affected members. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

In addition, the member may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for:

- an acute condition;
- a serious chronic condition not to exceed twelve months from the contract termination date;
- a pregnancy (including the duration of the pregnancy and immediate postpartum care);
- a newborn up to 36 months of age not to exceed twelve months from the contract termination date;
- a terminal illness (for the duration of the terminal illness); or
- a surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Customer Contact Center at 1-800-839-2172.

What are Severe Mental Illness and Serious Emotional Disturbances of a Child?

Severe Mental Illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with professionally recognized standards including, but not limited to, the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, as amended to date), autism, anorexia nervosa, and bulimia nervosa.

Serious Emotional Disturbances of a Child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, as amended to date, other than a primary substance abuse disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home, or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue

for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's Plan Contract and Evidence of Coverage and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net's Customer Contact Center at 1-800-839-2172 to ensure that you can obtain the health care services that you need.

What is the method of provider reimbursement?

Health Net uses financial incentives and various risk-sharing arrangements when paying providers. Members may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on the back of their Health Net ID card.

When and how does Health Net pay my medical bills?

Health Net will coordinate the payment for covered services when you receive care from your primary care physician or when you are referred by your primary care physician

to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your Health Net member ID card.

Am I required to see my primary care physician if I have an emergency?

Health Net covers emergency and urgently needed care throughout the world.

If your situation is life-threatening, immediately call 911 if you are in an area where the system is established and operating. If your situation is not so severe, first call your primary care physician or physician group (medical), or the Administrator (mental illness or detoxification). If you are unable to call and you need medical care right away, go to the nearest medical center or hospital.

An emergency means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment, and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and

safety of the member or her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capacity of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital, as medically necessary.

All air and ground ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the emergency or urgency has passed and your condition is stable must be provided or authorized by your primary care physician or physician group (medical), or the Administrator (mental illness and chemical dependency); otherwise, it will not be covered by Health Net.

Am I liable for payment of certain services?

We are responsible for paying participating providers for covered services. Except for copayments and deductibles, participating providers may not bill you for charges in excess of our payment. You are financially responsible for: (a) services beyond the benefit limitations stated in the plan's Plan Contract and EOC; and (b) services not covered by the Individual & Family HMO Plan. The Individual & Family HMO Plans do not cover: prepayment fees, copayments,

deductibles, services and supplies not covered by the Individual & Family HMO Plans or non-emergency care rendered by a non-participating provider.

Can I be reimbursed for out-of-network claims?

Some non-participating providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill, evidence of its payment and the emergency room report to us for reimbursement within one year of the date the service was rendered. Coverage for services rendered by non-participating providers is limited to emergency care when a participating provider is not available.

How does Health Net handle confidentiality and release of member information?

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings. As part of the application or enrollment form, Health Net members sign a routine consent to obtain or release their medical information. This consent is used by Health Net to ensure notification to and consent from members for present and future routine needs for the use of personal health information.

This consent includes the obtaining or release of all records pertaining to medical history, services rendered or treatment given to all subscribers and members under the plan for the purpose of review, investigation or evaluation of an application, claim, appeals (including the release to an independent reviewer organization) or grievance, or for preventive health or health management purposes.



We will not release your medical records or other confidential information to anyone such as employers or insurance brokers, who are not authorized to have that information. We will only release information if you give us special consent in writing. The only time we would release such information without your special consent is when we have to comply with a law, court order or subpoena. Often, Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

Privacy practices

For a description of how protected health information about you may be used and disclosed and how you can get access to this information, please see the plan's Notice of Privacy Practices in the plan's Plan Contract.

How does Health Net deal with new technologies?

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians.

Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient's medical condition requires expert evaluation.

What are Health Net's Utilization Management processes?

Utilization Management is an important component of health care management.

Through the processes of pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure that they are medically necessary and appropriate for the setting and time. This oversight helps to maintain Health Net's high quality medical management standards.

Pre-authorization

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate that the procedure is medically necessary and planned for the appropriate setting (i.e., inpatient, ambulatory surgery, etc.).

Concurrent review

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a member's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

Discharge planning

This component of the concurrent review process ensures that planning is done for a member's safe discharge in conjunction with the physician's discharge orders and to authorize post-hospital services when needed.

Retrospective review

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where pre-authorization was required but not obtained.

Care or case management

Nurse Care Managers provide assistance, education and guidance to members (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with members and their physicians and community resources.

Exclusions *and* Limitations

No payment will be made under the Health Net Individual & Family HMO Plans for expenses incurred for, or which are follow-up care to, any of the items below. The following are selective listings only. For a comprehensive listing, see the Health Net Individual & Family Plan Contract and EOC.

- Services and supplies which Health Net determines are not medically necessary, except as set out under “Does Health Net cover the cost of participation in clinical trials?” and “What if I have a disagreement with Health Net?” on page 7.
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Custodial care. Custodial care is not rehabilitative care and is provided to assist a patient in meeting the activities of daily living such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net determines to be experimental or investigational, except as set out under “Does Health Net cover the cost of participation in clinical trials?” and “What if I have a disagreement with Health Net?” on page 7.
- Services or supplies provided before the effective date of coverage; services or supplies provided after coverage through this plan has ended are not covered.
- Reimbursement for services for which the member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to, collection, storage or purchase of sperm or ova.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs, and are only covered when a contracted physician performs a fitting examination and in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the member physician’s office, are covered as a medical benefit, and are limited to one fitting and device per year, unless additional fittings or devices are medically necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one prescription per year unless additional fittings or devices are medically necessary. Injectable contraceptives are covered as a medical benefit when administered by a physician.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.¹⁰

¹⁰When a medically necessary mastectomy has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition, when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following: improve function or create a normal appearance to the extent possible, unless the surgery offers a minimal improvement in the appearance of the member.

- Treatment and services for temporomandibular joint disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework and appliances.
- This Plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility, or other properly licensed facility as specified in the plan's Plan Contract and EOC. Any institution that is primarily a place for the aged, a nursing home or any similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.
- Dental care. This plan does cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise medically necessary. See the "Dental care" exclusion above for information regarding cleft palate procedures.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses.
- Services to reverse voluntary surgically induced infertility.
- Sex change procedures or treatment.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the plan's Plan Contract and EOC.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this plan does cover durable medical equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment and supplies; (c) surgical dressings other than primary dressings that are applied by your physician group or a hospital to lesions of the skin or surgical incisions; (d) jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over the counter support devices or orthotics, and devices or orthotics for improving athletic performance or sports-related activities; (g) orthotics that are not custom made to fit the member's body; and (h) corrective footwear (such as corrective shoes or foot orthotics), that is not incorporated into a cast, brace or strapping of the foot, unless it is medically necessary for the management and treatment of diabetes.
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.

- Treatment by immediate family members.
- Drugs (including injectable medications) for the treatment of sexual dysfunction when prescribed for the treatment of sexual dysfunction.
- Services to diagnose, evaluate or treat infertility are not covered.
- Bariatric surgery provided for the treatment of morbid obesity is covered when medically necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center. Health Net has a specific network of bariatric facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your member physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained.
- Services for the treatment of Chemical Dependency (other than detoxification) are not covered.
- Treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be experimental or investigational in nature. For information regarding requesting an Independent Medical Review of a Plan denial of coverage on the basis that it is considered experimental or investigational see “What if I have a disagreement with Health Net?” on page 7.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Services or supplies that are not authorized by Health Net, the physician group (medical) or the Administrator (Mental Disorders or Chemical Dependency) according to Health Net’s procedures.
- Services and supplies rendered by a nonparticipating physician without authorization from Health Net or the physician group.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drug, medical equipment or supply that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes). If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s), will only be covered when prior authorization is obtained from Health Net. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage will be covered.
- Routine foot care, unless medically necessary for a diabetic condition.
- Acupuncture.
- Coverage for rehabilitation therapy is limited to medically necessary services provided by a Plan-contracted physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license, to treat physical or mental health conditions, subject to any required authorization from the Plan or the member’s medical group. The services must be based on a treatment plan authorized

- as required by the Plan or the member's medical group.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover medically necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
 - Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus (aversion therapy) is not covered.
 - Services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California.
 - Electroconvulsive therapy is not covered except as authorized by the Administrator.
 - The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency: (a) treatment for co-dependency; (b) treatment for psychological stress; and (c) treatment of marital or family dysfunction. Treatment of Delirium, Dementia, Amnesic Disorders (as defined in the DSM-IV) and Mental Retardation are covered for medically necessary medical services but covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment. In addition, Health Net will cover only those Mental Disorder or Chemical Dependency services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license.
 - Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of coverage see "What if I have a disagreement with Health Net?" earlier in this guide.
 - Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain.
 - Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer-based reports, unless the scoring is performed by a provider qualified to perform it.
 - Residential treatment that is not medically necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.
 - Services in a state hospital are limited to treatment or confinement as the result of an emergency or urgently needed care.
 - Treatment or consultations provided by telephone are not covered.
 - Medical mental health care or chemical dependency services as a condition of parole or probation, and court-ordered testing are limited to medically necessary covered services.

Mental Health *and* Chemical Dependency *services*

The Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Administrator) which contracts with Health Net to administer these benefits.

When you need to see a participating mental health professional, contact the Administrator by calling the Health Net Member Services Department at the phone number on your Health Net ID Card. The Administrator will help you identify a participating mental health professional, a participating independent physician or a subcontracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment. Certain services and supplies for mental disorders and

chemical dependency may require prior authorization by the Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Administrator is encouraged. Please refer to the plan's Plan Contract and EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Administrator.

Prescription Drug *Program*

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located participating pharmacy, please visit our website at www.healthnet.com or call the Customer Contact Center.

Specific exclusions and limitations apply to the Prescription Drug Program. See the Health Net Individual & Family Plan Contract and EOC for complete details. Remember, limits on quantity, dosage and treatment duration may apply to some drugs.

Mail order pharmacy program

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient mail order pharmacy program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call Health Net at 1-800-839-2172.

Note: Schedule II narcotic drugs are not covered through mail order. See the Health Net Individual & Family Plan Contract and EOC for additional information.

The Health Net Recommended Drug List: Level I drugs (primarily generic) and Level II drugs (primarily brand)

The Health Net Recommended Drug List (or Formulary or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for

Health Net members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net contracting primary care physicians and specialists that they refer to this list when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed in the Recommended Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Recommended Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. This committee's members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Recommended Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- medical and scientific publications,
- relevant utilization experience, and
- physician recommendations.

To obtain a copy of Health Net's most current Recommended Drug List, please visit our website at www.healthnet.com or call the Customer Contact Center at 1-800-839-2172.



Level III drugs

Level III drugs are prescription drugs that are listed as Level III or not listed on the Recommended Drug List and are not excluded from coverage.

What is “prior authorization”?

Some Level I, Level II and Level III prescription medications require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. Upon receiving your physician’s request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through email. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the plan’s Plan Contract and EOC for details regarding your right to appeal.

To submit an appeal:

- Call the Customer Contact Center at 1-800-839-2172,
- Visit www.healthnet.com for information on emailing the Customer Contact Center, or
- Write to:
Health Net Customer Contact Center
PO Box 10348
Van Nuys, CA 91410-0348

Health Net *of California, Inc.*

Guaranteed Issue Plan Rates effective January 1, 2012

Note: If you have a birthday during the year that moves you into a new age category, please be advised that any required rate change will be effective the first of the month following the month in which your birthday occurs.

Merced, Sacramento, San Joaquin, Sonoma, Stanislaus, Tulare, western El Dorado,¹¹ and western Placer¹¹ counties

Region 1 Los Angeles County

Tier/Age	HMO 40 NG	
Subscriber	<1	1,689
	1-4	453
	5-18	440
	19-24	544
	25-29	635
	30-34	797
	35-39	880
	40-44	924
	45-49	974
	50-54	1,152
55-59	1,346	
60-64	1,346	
Subscriber and spouse	19-24	1,088
	25-29	1,271
	30-34	1,596
	35-39	1,761
	40-44	1,849
	45-49	1,949
	50-54	2,305
	55-59	2,692
60-64	2,692	
Subscriber and child	19-24	1,057
	25-29	1,145
	30-34	1,307
	35-39	1,387
	40-44	1,431
	45-49	1,480
	50-54	1,592
	55-59	1,786
60-64	1,786	
Subscriber and children	19-24	1,506
	25-29	1,594
	30-34	1,754
	35-39	1,832
	40-44	1,876
	45-49	1,922
	50-54	2,033
	55-59	2,227
60-64	2,227	
Family	19-24	2,051
	25-29	2,230
	30-34	2,553
	35-39	2,713
	40-44	2,801
	45-49	2,898
	50-54	3,185
	55-59	3,573
60-64	3,573	

Region 2

Tier/Age	HMO 40 NG	
Subscriber	<1	1,820
	1-4	489
	5-18	474
	19-24	583
	25-29	680
	30-34	867
	35-39	945
	40-44	997
	45-49	1,050
	50-54	1,235
55-59	1,443	
60-64	1,443	
Subscriber and spouse	19-24	1,167
	25-29	1,361
	30-34	1,734
	35-39	1,890
	40-44	1,995
	45-49	2,102
	50-54	2,473
	55-59	2,886
60-64	2,886	
Subscriber and child	19-24	1,135
	25-29	1,230
	30-34	1,417
	35-39	1,494
	40-44	1,543
	45-49	1,596
	50-54	1,711
	55-59	1,919
60-64	1,919	
Subscriber and children	19-24	1,620
	25-29	1,715
	30-34	1,898
	35-39	1,975
	40-44	2,023
	45-49	2,074
	50-54	2,187
	55-59	2,395
60-64	2,395	
Family	19-24	2,204
	25-29	2,397
	30-34	2,765
	35-39	2,920
	40-44	3,020
	45-49	3,126
	50-54	3,425
	55-59	3,838
60-64	3,838	

Region 3

Riverside, San Bernardino and Ventura counties

Tier/Age	HMO 40 NG	
Subscriber	<1	1,849
	1-4	479
	5-18	464
	19-24	588
	25-29	681
	30-34	877
	35-39	957
	40-44	1,014
	45-49	1,069
	50-54	1,256
55-59	1,468	
60-64	1,468	
Subscriber and spouse	19-24	1,178
	25-29	1,365
	30-34	1,756
	35-39	1,914
	40-44	2,029
	45-49	2,140
	50-54	2,514
	55-59	2,939
60-64	2,939	
Subscriber and child	19-24	1,132
	25-29	1,225
	30-34	1,419
	35-39	1,496
	40-44	1,552
	45-49	1,604
	50-54	1,720
	55-59	1,934
60-64	1,934	
Subscriber and children	19-24	1,608
	25-29	1,696
	30-34	1,888
	35-39	1,965
	40-44	2,019
	45-49	2,074
	50-54	2,186
	55-59	2,398
60-64	2,398	
Family	19-24	2,196
	25-29	2,380
	30-34	2,767
	35-39	2,922
	40-44	3,034
	45-49	3,145
	50-54	3,442
	55-59	3,869
60-64	3,869	

¹¹ZIP codes for western El Dorado include: 95623, 95630 and 95762 only. See Region 7 for additional El Dorado County ZIP codes. ZIP codes for western Placer County include: 95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95746-47 and 95765 only. See Region 7 for additional Placer County ZIP codes.

Health Net *of California, Inc.*

Guaranteed Issue Plan Rates effective January 1, 2012

Note: If you have a birthday during the year that moves you into a new age category, please be advised that any required rate change will be effective the first of the month following the month in which your birthday occurs.

Alameda, Contra Costa,
San Francisco, San Mateo,
Santa Clara, Santa Cruz
and Solano counties

Region 4

Tier/Age	HMO 40 NG	
Subscriber	<1	2,080
	1-4	547
	5-18	532
	19-24	663
	25-29	780
	30-34	986
	35-39	1,081
	40-44	1,133
	45-49	1,203
	50-54	1,397
55-59	1,652	
60-64	1,652	
Subscriber and spouse	19-24	1,327
	25-29	1,562
	30-34	1,973
	35-39	2,164
	40-44	2,267
	45-49	2,408
	50-54	2,794
	55-59	3,304
60-64	3,304	
Subscriber and child	19-24	1,285
	25-29	1,400
	30-34	1,603
	35-39	1,696
	40-44	1,749
	45-49	1,819
	50-54	1,929
	55-59	2,186
60-64	2,186	
Subscriber and children	19-24	1,827
	25-29	1,941
	30-34	2,145
	35-39	2,235
	40-44	2,286
	45-49	2,354
	50-54	2,463
	55-59	2,720
60-64	2,720	
Family	19-24	2,492
	25-29	2,723
	30-34	3,131
	35-39	3,318
	40-44	3,420
	45-49	3,559
	50-54	3,860
	55-59	4,372
60-64	4,372	

Region 5

Orange and
San Diego counties

Tier/Age	HMO 40 NG	
Subscriber	<1	1,858
	1-4	479
	5-18	464
	19-24	588
	25-29	681
	30-34	867
	35-39	945
	40-44	997
	45-49	1,054
	50-54	1,241
55-59	1,458	
60-64	1,458	
Subscriber and spouse	19-24	1,178
	25-29	1,365
	30-34	1,734
	35-39	1,890
	40-44	1,995
	45-49	2,108
	50-54	2,483
	55-59	2,917
60-64	2,917	
Subscriber and child	19-24	1,133
	25-29	1,225
	30-34	1,407
	35-39	1,484
	40-44	1,535
	45-49	1,591
	50-54	1,706
	55-59	1,922
60-64	1,922	
Subscriber and children	19-24	1,608
	25-29	1,696
	30-34	1,880
	35-39	1,955
	40-44	2,002
	45-49	2,057
	50-54	2,170
	55-59	2,386
60-64	2,386	
Family	19-24	2,196
	25-29	2,380
	30-34	2,747
	35-39	2,900
	40-44	3,000
	45-49	3,111
	50-54	3,413
	55-59	3,847
60-64	3,847	

Region 6

Fresno, Kern and
Kings counties

Tier/Age	HMO 40 NG	
Subscriber	<1	1,853
	1-4	506
	5-18	491
	19-24	605
	25-29	714
	30-34	907
	35-39	999
	40-44	1,038
	45-49	1,105
	50-54	1,295
55-59	1,506	
60-64	1,506	
Subscriber and spouse	19-24	1,212
	25-29	1,428
	30-34	1,815
	35-39	1,999
	40-44	2,077
	45-49	2,211
	50-54	2,592
	55-59	3,014
60-64	3,014	
Subscriber and child	19-24	1,176
	25-29	1,283
	30-34	1,475
	35-39	1,564
	40-44	1,603
	45-49	1,669
	50-54	1,788
	55-59	1,999
60-64	1,999	
Subscriber and children	19-24	1,677
	25-29	1,783
	30-34	1,975
	35-39	2,062
	40-44	2,099
	45-49	2,164
	50-54	2,281
	55-59	2,492
60-64	2,492	
Family	19-24	2,284
	25-29	2,497
	30-34	2,883
	35-39	3,063
	40-44	3,139
	45-49	3,269
	50-54	3,578
	55-59	4,000
60-64	4,000	

Health Net *of California, Inc.*

Guaranteed Issue Plan Rates effective January 1, 2012

Note: If you have a birthday during the year that moves you into a new age category, please be advised that any required rate change will be effective the first of the month following the month in which your birthday occurs.

Region 7

Eastern El Dorado,¹²
Marin, eastern Placer¹²
and Yolo counties

Tier/Age	HMO 40 NG	
Subscriber	<1	1,887
	1-4	530
	5-18	516
	19-24	642
	25-29	766
	30-34	979
	35-39	1,062
	40-44	1,113
	45-49	1,161
	50-54	1,354
55-59	1,591	
60-64	1,591	
Subscriber and spouse	19-24	1,286
	25-29	1,533
	30-34	1,958
	35-39	2,126
	40-44	2,227
	45-49	2,323
	50-54	2,711
	55-59	3,182
60-64	3,182	
Subscriber and child	19-24	1,237
	25-29	1,360
	30-34	1,570
	35-39	1,654
	40-44	1,703
	45-49	1,749
	50-54	1,871
	55-59	2,108
60-64	2,108	
Subscriber and children	19-24	1,764
	25-29	1,885
	30-34	2,094
	35-39	2,174
	40-44	2,223
	45-49	2,267
	50-54	2,388
	55-59	2,624
60-64	2,624	
Family	19-24	2,407
	25-29	2,652
	30-34	3,073
	35-39	3,238
	40-44	3,337
	45-49	3,430
	50-54	3,745
	55-59	4,216
60-64	4,216	

¹²ZIP codes for eastern El Dorado include: 95613-14, 95619, 95629, 95633-36, 95643, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95720-21, 95726, 95735, 96150-52 and 96154-58 only. See Region 2 for additional El Dorado County ZIP codes. ZIP codes for eastern Placer County include: 95631, 95681, 95701, 95703, 95713-15, 95717, 95722, 95724, 95736, 96140-43, 96145-46, 96148 and 96162 only. See Region 2 for additional Placer County ZIP codes.

How to Apply for a Health Net Guaranteed Issue Individual HMO Plan

1. Take time to review your options and choose the coverage that best suits your health care needs. Our Health Net Individual HMO provider listings define where in California our coverage is available. If you have questions, need help choosing one of our coverage options, completing the application, or if the application is missing from your enrollment information, please call us toll-free at 1-800-909-3447 or contact your authorized Health Net agent.
 2. Complete the Health Net Individual & Family HIPAA Guaranteed Issue Enrollment Application.
 - You, the applicant, must accurately complete all applicable portions of the application. Your agent may not complete your application for you. Make sure you answer all questions – incomplete applications will be returned.
 - You must complete Part IV and attach proof of creditable coverage. If you do not have proof of creditable coverage, attach any other evidence of creditable coverage (including pay stubs, papers containing enrollment and disenrollment dates, or COBRA award termination letters).
 - Each member of your family may select a different primary care physician. Health Net requires that you and your enrolled family members select a primary care physician whose office is located within a 30-mile radius of your (or your respective family member's) residence or office. If you don't choose a doctor when you complete your enrollment application, we'll assign one to you based on your residential ZIP code. If you need help selecting a doctor, give us a call at 1-800-909-3447 or visit our website at www.healthnet.com.
- Please type or print clearly in blue or black ink.
 - Make sure you and your spouse or domestic partner (if applicable) sign and date the application. Signatures are required for all applicants over age 18, including dependents. **Note:** Domestic partner is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partner is a person eligible for coverage provided that the partnership with the subscriber meets all domestic partnership requirements under California law or other recognized state or local agencies. The domestic partner and subscriber must meet the following requirements: (a) Both persons have a common residence; (b) Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or adjudged a nullity; (c) The two persons are not related by blood in a way that would prevent them from being married in California; (d) Both persons are at least 18 years old; (e) Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance

benefits under the Social Security Act;
(f) Both persons are capable of consenting to the domestic partnership; and (g) Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document from another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

- The application must be received by Health Net within 30 days from the date of signature.
- Remember, applications received by the 25th of the month will be processed for coverage starting the 1st of the following month.
- If you need help completing the application, please call your Authorized Health Net agent or Health Net.

3. Mail the completed Health Net Individual & Family HIPAA Guaranteed Issue Enrollment Application, your certificate(s) of creditable coverage or other evidence of creditable coverage, and your personal check for the applicable first month's premium (made payable to Health Net) to your authorized Health Net agent or Health Net at the address below.

Health Net
Individual & Family Plans
PO Box 1150
Rancho Cordova, CA 95741-1150



For more information please contact

Health Net

PO Box 1150

Rancho Cordova, CA 95741-1150

Individual & Family Plans

1-800-909-3447

Assistance for the hearing and speech impaired

1-800-995-0852

Other options

Coverage for family members over 65 years of age

1-800-944-7287

Coverage for children in a low-income household

1-800-327-0502

Coverage for businesses with 50 and fewer employees

1-800-447-8812

Coverage for businesses with 50+ employees

1-800-448-4411, option 4

www.healthnet.com

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Health Net® INDIVIDUAL & FAMILY PLANS HIPAA HMO GUARANTEED ISSUE ENROLLMENT APPLICATION

Application must be typed or completed in **blue or black ink**.

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT APPLYING FOR COVERAGE AND CAN BE COMPLETED BY THE APPLICANT FOR MINOR DEPENDENTS OR BY AN INTERPRETER FOR APPLICANTS WHO DO NOT READ/WRITE ENGLISH. NEITHER BROKER NOR ANY OTHER PERSON THAN THE APPLICANT OR THE APPLICANT FOR MINOR DEPENDENTS MAY SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 1-800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 1-800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件？如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 1-800-909-3447，再按 2，洽詢免費服務。

If you need assistance in completing this application, a broker may assist you. A broker who helped you read and complete this application must sign the application (see Part V).

PART I – TELL US WHO YOU ARE ENROLLING AND SELECT THE PRODUCT

A. Reason for application Family type <input type="checkbox"/> Self <input type="checkbox"/> Self and spouse/domestic partner <input type="checkbox"/> Self and child <input type="checkbox"/> Self and children <input type="checkbox"/> Self, spouse/domestic partner and child(ren) <input type="checkbox"/> Please check box for domestic partner enrollment Enrollment type <input type="checkbox"/> New enrollment <input type="checkbox"/> Add dependent	B. Billing options First premium payment (select one) <input type="checkbox"/> Automated Bank Draft (Please complete the “Simple Pay Option” section on page 6 of this application.) <input type="checkbox"/> Pay by check (Please include completed check and send with application. Amount must match monthly premium.) <input type="checkbox"/> Credit card (Please complete the credit card section on page 6 of this application.) Monthly premium payments (select one) <input type="checkbox"/> Automated Bank Draft (Please complete the “Simple Pay Option” section on page 6 of this application.) <input type="checkbox"/> Monthly bill <input type="checkbox"/> Credit card (Please complete the credit card section on page 6 of this application.)	C. Choice of coverage Health Net of California – Only first-of-the-month effective date is available. <input type="checkbox"/> HIPAA HMO 40
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PART II – APPLICANT INFORMATION

Primary applicant's last name:		First name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home address:				
City:	State:	ZIP:	County applicant resides in:	
Home phone number: ()	Work phone number: ()	Email address:		
Primary applicant's birth date (mm/dd/yy):			Primary applicant's Social Security number:	
Primary care physician ID # (if applicable):	Current patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician group ID # ¹ :	In the past 6 months, have you been a resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If “No,” where was your last residence? _____	

¹You must select a physician group and primary care physician. You may choose the same or different physician group and primary care physician for each family member you are enrolling. If you do not select a primary care physician, one will be selected for you within your regional area. To find the most up-to-date list of Health Net contracted physicians, log on to www.healthnet.com > *ProviderSearch*. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county or doctor's name. You can also call 1-800-909-3447 to request provider information, or contact your Health Net authorized broker.

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PART III – FAMILY MEMBER(S) TO BE ENROLLED

List all dependent family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

Check here if supplemental page is attached.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State. **To be processed under one subscriber, all family members must reside at the same address.**

Relation – Dep. 1	Last name, first name, MI	Social Security #	Date of birth	Primary care physician ID # ¹	Current patient	Physician group ID # ¹
<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic partner <input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Relation – Dep. 2	Last name, first name, MI	Social Security #	Date of birth	Primary care physician ID # ¹	Current patient	Physician group ID # ¹
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Relation – Dep. 3	Last name, first name, MI	Social Security #	Date of birth	Primary care physician ID # ¹	Current patient	Physician group ID # ¹
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Relation – Dep. 4	Last name, first name, MI	Social Security #	Date of birth	Primary care physician ID # ¹	Current patient	Physician group ID # ¹
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

PART IV – HIPAA GUARANTEED ISSUE COVERAGE

If you do not qualify for the Individual HMO or PPO plans, you may be considered for coverage under the HIPAA Guaranteed Issue plans. The HIPAA Guaranteed Issue plans do not require underwriting (medical history review and determination of coverage) and the rates are higher compared to the other Individual Plans. If you qualify for coverage under the HIPAA Guaranteed Issue plans, please request the complete benefit details and rates for those plans. To be eligible for HIPAA Guaranteed Issue coverage, you must meet every condition below.

1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer-imposed waiting periods) in coverage? Please note that you must apply for HIPAA coverage within the 63-day break after your group health care coverage (including COBRA or Cal-COBRA, if applicable) ended. Yes No
2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)? Yes No
3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid? Yes No
(If "Yes," you are not eligible for HIPAA coverage.)
4. Was your most recent coverage terminated because of nonpayment or fraud? Yes No
5. Were you eligible under COBRA or Cal-COBRA? Yes, start date: _____; end date: _____ Yes No
If "Yes," did you accept and use up all benefits that were available? Yes No
If "No," please explain: _____

You must select a physician group and primary care physician. You may choose the same or different physician group and primary care physician for each family member you are enrolling. If you do not select a primary care physician, one will be selected for you within your regional area. To find the most up-to-date list of Health Net contracted physicians, log on to www.healthnet.com > *ProviderSearch*. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county or doctor's name. You can also call 1-800-909-3447 to request provider information, or contact your Health Net authorized broker.

PART V. AGENT/BROKER INFORMATION

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker. Instructions for Part V: The following is to be completed by the Applicant's agent/broker (if applicable).

Health Net broker ID: _____

Name (print): _____ Phone number: _____ Fax number: _____

Address: _____ Email address: _____

X **Broker signature/number (required)** **X** **Date signed (required)**

Broker certification

I _____ (name of broker),

(NOTE: You must select the appropriate box. You may only select one box.)

(____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to \$10,000.

OR

(____) assisted the applicant(s) in submitting this application. All information in the health questionnaire(s) was completed by the applicant(s). I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to \$10,000.

Please answer all questions 1 through 4:

1) **Who filled out and completed the application form?** _____

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

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

4) Are you aware of any information, including but not limited to medical history, not disclosed in this application, that might have a bearing on the risk? Yes No

If "Yes," please explain: _____

PART VI – INDIVIDUAL & FAMILY PLANS EXCEPTION TO STANDARD ENROLLMENT – STATEMENT OF ACCOUNTABILITY

Instructions for Part VI: The following process is to be used when the applicant cannot complete the application because he or she cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must employ the services of a qualified interpreter. Please contact Health Net at 1-800-909-3447, option 2, for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan HIPAA Guaranteed Issue Enrollment application when applicable.

Health Net qualified interpreter – Please complete the following when assisted by a Health Net qualified interpreter.

I, _____, was assisted in the completion of this application by a qualified interpreter authorized by Health Net because I:

Do not read the language of this application. Do not speak the language of this application. Do not write the language of this application.

Other (explain): _____.

A qualified interpreter assisted me with the completion of: The entire application.

Other (explain): _____.

A qualified interpreter read this application to me in the following language: _____.

SIGNATURES AND DATE (REQUIRED IN INK)

Signature of applicant: _____	Today's date: _____
Date application was interpreted: _____	Time application was interpreted: _____
Qualified interpreter number: _____	

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PART VI – (continued)**Qualified interpreter other than a Health Net qualified interpreter – Please complete the following when assisted by a qualified interpreter other than a Health Net qualified interpreter.**

If a qualified interpreter, other than a qualified interpreter provided by Health Net, assisted you in completing this application, the interpreter must complete the following:

I, _____, understand that a qualified interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a qualified interpreter, I personally read and completed the application for the applicant named above because:

- Applicant does not read the language of this application.
 Applicant does not speak the language of this application.
 Applicant does not write the language of this application.

Other (explain): _____.

Under the penalty of perjury, I declare that I read to the applicant:

- The entire application. Other: _____.

I read this application to the applicant in the following language: _____.

Please provide the following information regarding the qualified interpreter who assisted the applicant and who is not a Health Net qualified interpreter:

Last name:	First name:
Address of qualified interpreter:	City, State and ZIP:
Phone: ()	Date:
Qualified interpreter signature:	

PART VII – CONDITIONS OF ENROLLMENT

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment if the applicant is not eligible for HIPAA guaranteed issue coverage. Health Net may selectively reject the applicant or a dependent who is not eligible for HIPAA guaranteed issue coverage. There is no coverage unless this application is accepted by Health Net's Underwriting Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. The applicant's agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

Rescission of a Plan Contract: Any act or practice which constitutes fraud, or any intentional misrepresentation of material fact in written information submitted by the applicant or on the applicant's behalf on or with the applicant's application materials may be cause for disenrollment and rescission of the Plan Contract but such rescission is limited to the first 24 months of coverage. Health Net may recoup from the applicant any amounts paid under the Plan Contract obtained as a result of such act or practice, or intentional misrepresentation of material fact. By signing the application the applicant represents and agrees to abide by the terms of the contract. Before the contract is rescinded Health Net will provide the applicant written notice and an opportunity to provide information. Should the contract be rescinded, Health Net will provide a written notice that will explain the basis of the decision and the applicant's appeals rights. Health Net will refund all amounts paid by the applicant, less any medical expenses that Health Net paid.

Cancellation of a Plan Contract: Health Net may cancel a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the Plan Contract. If this Plan Contract is cancelled, you will be sent a notice of cancellation and cancellation will be effective upon the date the notice of cancellation is mailed.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Plan Contract. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this application and for payments of premiums. If such responsible party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with this application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the **Statement of Accountability** (see Part VI of this application "Individual & Family Plans exception to standard enrollment – Statement of Accountability").

PART VIII – IMPORTANT PROVISIONS

NOTICE: 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.

HIV TESTING PROHIBITED: 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.

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: 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 you may be at risk.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Plan Contract (to obtain a copy of the Plan Contract, call Health Net at 1-800-909-3447, option 2). I, the applicant, 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, and I accept these terms.

BINDING ARBITRATION: I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, 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 Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have 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. A more detailed arbitration provision is included in the Plan Contract. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Applicant or parent or legal guardian's signature if applicant is under 18 years old:	Date signed:
Spouse/domestic partner's signature:	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:

The application and this arbitration clause must be signed by the applicant(s). The applicant(s) must personally sign his or her name in ink and agree to comply with the arbitration clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither broker nor any other person may sign this application and arbitration clause.

**Make personal check payable to "Health Net."
 Return completed application to: Health Net Individual & Family Enrollment
 PO Box 1150, Rancho Cordova, CA 95741-1150**

You may submit a photocopy or facsimile of the application and authorizations. Health Net recommends that you retain a copy of this application and authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this enrollment application applies. "Plan Contract" refers to the Health Net of California, Inc. combined Contract and Evidence of Coverage.



HEALTH NET'S PAY OPTION – MONTHLY AUTOMATIC PAYMENT FOR INDIVIDUAL & FAMILY PLANS AND CALIFORNIA FARM BUREAU MEMBER'S HEALTH INSURANCE PROGRAM

SIMPLE PAYMENT OPTION (Automatic Bank Draft) First month's payment Monthly premium payment

Your premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: Checking Savings

Transit routing number (9 digits):	Account number:
Bank name:	State:

As a convenience, I request and authorize Health Net to charge to the above account checks drawn on that account by and payable to the order of **"Health Net"** provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the premium withdrawn from my account will be for the future bill period plus any past due balances and my first month's withdraw may be for multiple periods if I did not submit a check or due to the timing of the setup. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)*

Automatic Bank Draft (ABD) transmissions are withdrawn from your bank on approximately the 20th of every month, for the following month's premium. It can take upwards of 6 weeks to process an ABD request. Therefore, your premium should be submitted with your request for ABD.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, I will be charged a \$25 service charge for each occurrence. I understand Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

Signature of account holder (required to process):	Date:

CREDIT CARD First month's payment Monthly premium payment

The monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date. Your card will be charged for the first month's premium on the day your application is approved by underwriting.

First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Account number (16 digits):	Expiration date (MM/YYYY):		
Billing address:	City:	State:	ZIP ¹ :

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. I understand that the premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw/charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)* I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a \$25 service charge for each occurrence. My credit card account will be charged on approximately the 20th of every month, for the following month's premium.

Signature of credit card account holder (required to process):	Date:

¹The ZIP code must match the cardholder's address; otherwise, the credit card cannot be processed.



No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call Health Net’s Commercial Contact Center at 800-522-0088. Individual and Family Plan (IFP) or Farm Bureau applicants please call 800-909-3447, option 2. Medicare Supplemental applicants please call 800-926-4178. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in an HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 800-522-0088. Los solicitantes del Plan Individual y Familiar (IFP, por sus siglas en inglés) o de la Oficina Agrícola, deben llamar al 800-909-3447, opción 2. Los solicitantes de un Plan Suplementario a Medicare deben llamar al 800-926-4178. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥打您會員卡上所列的電話號碼，雇主團體申請人請致電 Health Net 的商業聯絡中心，電話 800-522-0088。個人和家庭計畫 (IFP) 或農業局申請人請撥打 800-909-3447，請按 2。Medicare 附加保險申請人請撥打 800-926-4178。若您投保 PPO 計畫，請致電 1-800-927-4357 與加州保險局聯絡，詢求額外協助。若您投保 HMO 計畫，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm theo nhóm do hãng sở đài thọ xin gọi Trung Tâm Liên Lạc Thương Mại của Health Net tại số 800-522-0088. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP) hoặc Farm Bureau, xin gọi số 800-909-3447, bấm số 2. Những người nộp đơn xin Medicare Supplemental (Medicare Phụ Trợ) vui lòng gọi số 800-926-4178. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 상업 (Commercial) 고객 서비스 센터, 안내번호 800-522-0088 번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 혹은 Farm Bureau 가입 신청자님은 안내번호 800-909-3447번, 옵션 2를 이용해 주십시오. Medicare 보조 보험 가입 신청자님은 안내번호 800-926-4178번으로 전화해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC(보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa employer group applicants, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 800-522-0088. Para sa Individual and Family Plan (IFP) o Farm Bureau applicants, mangyaring tumawag sa 800-909-3447, opsyon 2. Para sa Medicare Supplemental na mga aplikante, mangyaring tumawag sa 800-926-4178. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 800-909-3447 համարով, ընտրանք 2: Լրացուցիչ Medicare-ի դիմորդներից խնդրվում է զանգահարել 800-926-4178 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в коммерческий контактный центр компании Health Net по телефону 800-522-0088. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP), а также планов страхования Фермерского бюро: пожалуйста, звоните по номеру 800-909-3447, добавочный 2. Участников плана Medicare Supplemental просим звонить по номеру 800-926-4178. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.

Russian

LANGUAGE PREFERENCE FORM
FORMULARIO DE PREFERENCIA DE IDIOMA
慣用語言資料表

TALK TO US – WE SPEAK YOUR LANGUAGE

Is English your second language? Is it easier to read and speak in a language other than English?

If yes, please complete this form and return it with your Enrollment Application. If you are accepted for enrollment, our records will be updated with this information. This information will help:

- Allow those whose preferred language is one of the two most prevalent non-English languages in Health Net's enrollment to receive certain plan documents in your preferred language.
- Provide you with interpreter assistance for health services in your preferred language.

Health Net is required to collect written and spoken language information in order to comply with California Department of Managed Health Care and California Department of Insurance language assistance regulations, however, you are not required to provide this information. Health Net will protect your information, including race, ethnicity, and your language choices.

HABLE CON NOSOTROS, HABLAMOS SU IDIOMA

¿Es el inglés su segundo idioma? ¿Le resulta más fácil leer y hablar en un idioma distinto del inglés?

Si la respuesta es sí, llene este formulario y devuélvalo junto con su Formulario de Inscripción. Si su solicitud de inscripción es aceptada, actualizaremos nuestros registros con esta información, la que nos servirá para:

- Permitir que aquellas personas cuyo idioma preferido es uno de los dos idiomas extranjeros más comunes entre todos los que se inscriben en Health Net, reciban ciertos documentos del plan en su idioma preferido.
- Brindarle la asistencia de un intérprete para servicios de salud en su idioma preferido.

A Health Net se le exige recopilar información sobre el idioma escrito y hablado para cumplir con los reglamentos sobre asistencia del idioma del Departamento de Cuidado Médico de California y el Departamento de Seguros de California, sin embargo, no es obligación que usted proporcione esta información. Health Net protegerá su información, incluidos su raza, origen étnico y sus alternativas de idioma.

請與我們交談 — 我們會說您的語言

英語是您的第二語言嗎？您是否覺得用英語以外的另一種語言來閱讀和溝通比較容易？

如果是的話，請您填寫這份表格，並連同您的投保申請書一併繳回。如果您的投保申請獲准，我們會把本表的資料更新到紀錄中。這些資料能幫助：

- 慣用語言為康寧保健投保時最通用的兩種非英文語言者，得以收到其慣用語言版本的部分計畫文件。
- 在您取得保健服務時以您慣用的語言提供您口譯員協助。

按加州醫療保健計畫管理局和加州保險局的語言協助法令規定，康寧保健必須收集書寫和口語使用語言的資訊，但是您無須提供這些資訊。康寧保健會保護您所提供的資訊，包括種族、族裔和您的語言選擇。

Name/ Nombre/ 姓名：_____

Social Security Number/ Número del Seguro Social/ 社會安全號碼：_____

Written Language/ Idioma Escrito/ 書寫語言：_____

Spoken Language/ Idioma Hablado/ 口說語言：_____

Race (optional)/ Raza (opcional)/ 種族 (非必填)：_____

Ethnicity (optional)/ Origen Étnico (opcional)/ 族裔 (非必填)：_____