FOR GROUPS 2–50

EMPLOYER MANUAL

Administrative guide for employers in California

Health Net®
A BETTER DECISION

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WELCOME TO THE EMPLOYER MANUAL

This Employer Manual is a guide to administering your Health Net Small Business Group health plans[1]. It contains updates and enhancements to our guidelines and procedures. Use the Table of Contents to find what you need quickly and easily. This guide includes:

- Enrollment procedures
- Membership information
- Billing procedures
- Instructions on how to fill out all necessary forms
- And more

Each of these sections incorporates in-depth instructions on how to address applicable situations and also helps simplify the process for you, our valued customer.

At Health Net, we strive to provide you with our best service and keep you informed on current Health Net policies. If you have any questions, please contact your Health Net Account Manager or the Health Net Small Business Group at **1-800-447-8812**.

For the purposes of this manual, the term "Health Net" means both Health Net of California and Health Net Life Insurance Company, except where specifically stated.

Thank you for your continued business.

THE HEALTH NET MISSION

Health Net's mission is to help people be healthy, secure and comfortable. Our vision is to be the recognized leader in adding value to the lives of the people we are serving by delivering:

- Access to quality health care that helps people achieve improved health outcomes.
- Understandable, reliable and affordable products.
- Service that exceeds expectations.

[1]Health Net HMO, EOA, POS and Salud con Health Net HMO plans are offered by Health Net of California, Inc. Health Net PPO, HSA-compatible PPO insurance plans, Flex Net and Salud con Health Net PPO and EPO insurance plans are underwritten by Health Net Life Insurance Company. Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc.

HEALTH NET DIRECTORY

Website: www.healthnet.com

SMALL BUSINESS GROUP

Account Management

Northern California Accounts
Phone: 1-800-447-8812, Option 2, then Option 2
Fax: 1-800-303-3110

Southern California Accounts
Phone: 1-800-447-8812, Option 2, then Option 1
Fax: (818) 676-6297

Account Service Unit
Phone: 1-800-447-8812, Option 3
Fax: 1-800-794-3988
Email: hn_account_services@healthnet.com

Membership/Accounting
Phone: 1-800-224-8808, Option 3
Fax: 1-916-935-4420
Email: enrollmentunit_north@healthnet.com

Member Services
Phone: 1-800-361-3366
Para los que hablan español: 1-800-331-1777

Address
Health Net
P.O. Box 9103
Van Nuys, California 91409-9103

ENROLLMENT PROCEDURES

In this section you will find information about:

- Your annual open enrollment.
- How to enroll new and rehired employees.
- How to enroll existing and newly acquired dependents.
- Selecting a Participating Physician Group (PPG) for HMO, EOA and POS plans.
- The Health Net ID card.

SMALL BUSINESS GROUP ENROLLMENT AND CHANGE FORM

This form can be used in the following ways:

1. To be completed by employees to initially enroll in Health Net for coverage for themselves and their dependents. You must carefully review this form for completeness before submitting it to Health Net.
2. To delete/add dependents, change address/name or make a plan change.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

For benefit plan contracts entered into or renewed on and after November 1, 2009, employers who employ on average more than fifty (50) employees during the previous calendar year are required to enroll in plan(s) with benefits in accordance to the Mental Health Parity and Addiction Act of 2008, unless otherwise exempted.

PROBATIONARY PERIOD

Probationary periods are the length of time that all employees must wait before they are covered by Health Net. The effective date of coverage is always the first of the month following the completion of the probationary period, if applicable. The probationary period is determined by the employer, not Health Net.

Probationary periods are applied to:

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

REHIRES

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

Example:
Terminated: 8/25/09
Coverage ends: 9/01/09
Rehired: 9/18/09
Coverage reinstated: 9/01/09

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

If more than 30 days have elapsed between the termination and rehire dates, the employee must again fulfill your group's probationary period as if she or he were a new hire. This will produce a coverage lapse. The probationary period varies with each group.

Example:
Terminated: 8/25/09
Coverage ends: 9/01/09
Rehired: 10/09/09
Probationary period: Two months[2]
Coverage reinstated: 1/01/10

AN IMPORTANT REMINDER

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

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

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

[2]Varies by employer group.

IRS SECTION 125

Under the IRS Section 125 rules, **individuals may not change their enrollment or benefits elections in mid-year**. The only time an individual may make a mid-year election change on a pre-tax basis is upon a change in family status if the plan allows mid-year election changes due to changes in family status. Please note: The Section 125 rule only applies if deductions for the employee's health insurance are taken out on a pre-tax basis. Even then, employees may not make changes at will except for canceling coverage. They must still wait until open enrollment unless they experience a qualified family status change as defined by HIPAA.

Under the IRS regulations, changes in family status include:

1. Marriage, divorce, legal separation or annulment of the employee.
2. Death of the employee's spouse or dependent.
3. Birth or adoption of the employee's child or placement for adoption.
4. Commencement or termination of employment of the employee's spouse.
5. A switch from part-time to full-time status by the employee.
6. An unpaid leave of absence taken by the employee or employee's spouse.
7. A significant change in the health coverage of the employee or spouse attributable to the spouse's employment.
8. Changes in work schedule for employee or any qualified dependent including strike or lockout or return from an unpaid leave of absence.
9. The dependent satisfies or ceases to satisfy the requirements for unmarried dependents. An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status or any similar circumstances as provided under the accident or health plan under which the employee receives coverage.
10. A change in the place of residence or worksite of the employee, spouse or dependent.

Section 125 also added the following three new events upon which a change in election can occur under an accident and health plan or group term life insurance component of a flex plan:

1. If a change in status occurs that results in COBRA continuation coverage by the employee, spouse or dependent, the employee may increase his or her flex plan election amount to pay for the COBRA coverage on a pre-tax basis.
2. If the employee, spouse or dependent becomes entitled to Medicare or Medicaid (other than pediatric vaccines), the employee may elect to cancel the coverage of the employee, spouse or dependent.
3. If the plan receives a qualified medical child support order (QMED) pertaining to an employee's dependent, the employee may elect to add the child to the plan (if the QMED requires coverage) or drop the child from the plan (if the QMED requires the ex-spouse to provide coverage).

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

CALIFORNIA LAW ON DOMESTIC PARTNERSHIP

California law grants registered domestic partners the same rights as a legal spouse for group health insurance coverage. The creation or dissolution of a registered domestic partnership is considered a qualified family status change where mid-year election changes are allowed.

Under California law, individuals of the same sex can register as domestic partners, as long as the requirements set forth in California law are met. Opposite sex individuals can register as domestic partners only when one or both is above the age of 62 and one or both meet specified eligibility requirements under the Social Security Act.

Based on verification of domestic partnership by the Employer, Health Net will process the enrollment of the domestic partner as a spouse for coverage under the employer-selected health plan. The eligible unmarried dependent children of the domestic partner must also be allowed to enroll under the same terms as eligible unmarried children of the employee and/or employee's legal spouse.

Additionally, Health Net's Small Business Group plans allow enrollment of domestic partners of the same or opposite sex who do not meet California's legal requirements. The Employer must determine whether to exclude this option by discussing same with the Health Net Sales Representative prior to initial enrollment. Enrollment of the domestic partner (and eligible dependent children of the domestic partner) who does not meet California's domestic partner requirements is allowed only at the time of the employee's initial enrollment or at the annual open enrollment period.

ANNUAL OPEN ENROLLMENT

Requirements

- Employers must conduct an annual open enrollment for Health Net.
- The employer determines date for first open enrollment.
- The open enrollment period must last at least ten (10) days.
- The open enrollment coincides with the employer's anniversary date and occurs during the same month each year.
- In subsequent years, the open enrollment should occur during the same month as the first open enrollment.

What is accomplished during the open enrollment period?

- Eligible employees and their dependents may join Health Net for the first time.
- Transfer from one health carrier offered by the employer to Health Net.
- Members may add or remove eligible dependents.
- Transfer from one product line to another if the employer group offers more than one product.
- Employer group may add another product line if eligible.

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

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

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

No, the probationary period is not waived because the annual open enrollment occurs. All employees must meet the probationary period as specified in your *Small Business Application for Group Service Agreement/Group Policy*.

How does Health Net help during open enrollment?

Health Net Account Managers are available to assist you during open enrollment. They can provide services ranging from supplying enrollment kits and forms, conducting conference calls with employer groups for question-and-answer sessions, or arranging for a Health Net representative to conduct an open enrollment meeting. Please contact your Account Manager in advance to arrange the best program for your company.

ENROLLING NEW EMPLOYEES

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

New employees are eligible to become Health Net members if they are full-time permanent employees working 30 hours per week or more and have satisfied the probationary period for your group. If you offer coverage to all part-time (20 hours a week or more) employees, permanent part-time employees may also become Health Net members. See the *Small Business Application for Group Service Agreement/Group Policy*. If you have any question concerning eligibility requirements, please contact your Health Net Account Manager.

How are eligible new employees enrolled?

To enroll eligible new employees you must submit an *Enrollment and Change Form*.

All new employees who wish to enroll must complete, sign and date their own *Enrollment and Change Form*. Missing or incomplete information will cause a delay in enrollment.

If a new member is receiving care from the PPG, the PPG will require that the member present their ID card before care is received. A new member may also be required to complete an *Eligibility Certification* form if his or her name does not appear on their current Eligibility Report.

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

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

An employee may enroll with Health Net or add dependents outside of the open enrollment period due to a change in or loss of benefits or contribution levels in current coverage from another group sponsored plan. The individual must request enrollment within 30 days of the change. Your group's benefits administrator or Human Resources representative must submit an *Enrollment and Change Form*, a letter to Health Net explaining the change in benefits or contribution level, including the effective date of that change and proof of prior coverage.

Example:

Permissible: The subscriber/dependent(s) is enrolled with another carrier. That carrier's plan changes (e.g., copayment increase, contribution increase, benefit dropped, etc.) effective June 30. Due to a change in or loss of benefits, the subscriber/dependent(s) is eligible to enroll in your group's Health Net plan effective July 1 provided the member submits all documentation affirming the change no later than July 30. If submission deadline is missed, the subscriber must wait until the group's open enrollment period to enroll the dependent(s).

- The subscriber of the other plan has ceased being covered except for either failure to pay premium contribution, a "for cause" termination such as fraud or misrepresentation of an important fact or voluntary termination.
- The other group sponsored plan is terminated and not replaced with other group coverage.
- The employee loses coverage as a dependent under the spouse's plan due to divorce or legal separation.
- If an employee is enrolled as a dependent in another group sponsored health plan, and the subscriber of plan chooses a different plan.
- If an employee gains new dependents due to birth, adoption, marriage or addition of a domestic partner, the employee may enroll himself or herself, and the new dependent. For a new spouse, the effective date of coverage will be the first of the month following the date of marriage/ unionship, according to the rules established by the Group. For a newborn, coverage will commence at the moment of birth; however, the assigned effective date will be the first of the month following date of birth. For adoption, the effective date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care. Your group's benefit administrator or Human Resources representative must submit a letter to Health Net explaining the change in benefits or contribution level, including the effective date of that change. Proof of prior coverage must also be submitted with this letter.

Not permissible: The subscriber or dependent(s) are enrolled with another carrier and sees that Health Net offers a better benefit and requests to change to Health Net. Since there was no change in benefits or contribution level, the request will be denied.

ENROLLING REHIRED EMPLOYEES

Who qualifies as a rehired employee?

Former employees who have been rehired within 30 days of the last day previously worked.

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

If rehired within 30 days, the probationary period is waived. If rehired after 30 days, the probationary period must be met.

How are rehired employees enrolled?

Submit a completed *Enrollment and Change Form* for each rehire you wish to enroll. The New Hire option should be indicated.

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

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

ENROLLING FORMERLY INELIGIBLE EMPLOYEES

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

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

How are formerly ineligible employees enrolled?

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

ENROLLING DEPENDENTS

What is the definition of a dependent?

Health Net defines eligible dependents of the employee as individuals who meet the eligibility requirements for coverage listed below and who are included on the *Enrollment and Change Form* completed and signed by the subscriber.

- The subscriber's lawful spouse or domestic partner.
- An unmarried child of the subscriber, spouse or domestic partner, who is under age 19. The child may be a natural child, adopted child, legal dependent or stepchild. A case coordinator must review newly acquired adoptive and legal dependents.
- An overage dependent, defined as an unmarried child of the subscriber, spouse or domestic partner, who is between 19 and 24 years old and who depends upon either the subscriber, spouse or domestic partner for at least 50 percent of his or her economic support, or is a full-time student.[3]

[3]Students qualify for full-time status when taking 9 units or equivalent hours in a college, university or trade school.

- An unmarried child who is mentally or physically handicapped and is incapable of self-sustaining employment and remains dependent upon the subscriber, spouse or domestic partner for at least 50 percent of his or her support. The disability must have been present prior to the dependent reaching this limiting age where he or she would have ceased to be an eligible dependent.

Note: There are additional requirements. Please refer to the Overage Dependents section.

Important: Maximum ages and qualifications for dependent children vary by plan. We have highlighted some of the most common qualifications; however, your group's requirements may be significantly different. Please check your *Small Business Application for Group Service Agreement/Group Policy* for details.

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

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

How are dependents enrolled?

To enroll eligible dependents, you must submit a fully completed *Enrollment and Change Form*. The Add Dependent option must be checked, all the dependents the subscriber wishes to add must be indicated on the form, and it must be signed and dated to the subscriber. Remember that, except in the case of a loss or change in other coverage or a family status (marriage, addition of a domestic partner, birth or adoption), existing dependents may only be enrolled at initial enrollment or subsequent open enrollment periods.

ENROLLING NEWLY ACQUIRED DEPENDENTS

What is the definition of a newly acquired dependent?

A newly acquired dependent is a spouse, domestic partner or child who joins the family as an eligible dependent after the date the subscriber's coverage becomes effective.

Note: When a subscriber's covered dependent child gives birth to a child, the newborn grandchild of the subscriber is not eligible for coverage. (See the section Enrolling Dependents for additional information.)

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

- Newly acquired dependents may enroll in Health Net up to 30 days from the date of birth, or the date that the legal right to control health care is granted for adoption, the date of the court order granting guardianship, or the date of marriage or creation of the state registered domestic partnership.
- If a newly acquired dependent is not enrolled within 30 days from the date of acquisition, the newly acquired dependent is not eligible for membership until the next open enrollment period. When the employer allows enrollment of domestic partners who are not registered (filed Declaration of Domestic Partnership form in California), the domestic partner and dependent children of the domestic partner cannot be enrolled until the next annual open enrollment period.

When does coverage become effective for a newly acquired dependent?

Spouses/Domestic Partners: A new spouse or registered domestic partner must be enrolled within 30 days of marriage or domestic partner registration. Coverage begins on the date of marriage (or domestic partner registration) or on the first day of the calendar month following the date of marriage (domestic partner registration), according to the rules established by the Group.

Newborns: Newborns of the subscriber or spouse (registered domestic partner) are covered from the moment of birth. However, that coverage is automatically provided for only the first 30 days following birth. **In order for coverage to continue without a lapse, the child must be enrolled before the 31st day of life.**

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

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

Wards or subjects to guardianship: A dependent who is within the age limit and who is a legally acquired dependent (ward) of the subscriber or covered spouse (covered domestic partner) must be enrolled within 30 days of the commencement date of legal guardianship. Coverage will begin as of the first of the calendar month following Health Net's receipt of the enrollment request. Proof that the subscriber or covered spouse (covered domestic partner) is a court-appointed legal guardian will be required.

How are subscription charges/premiums affected by adding newly acquired dependents?

There will be additional subscription charges/premiums for the newly acquired dependent if his or her enrollment causes the subscriber's contract to become a two-party (employee + spouse/domestic partner [no child(ren)] or employee + child(ren) [no spouse/domestic partner]) or family (employee + spouse/domestic partner + child[ren]) contract type. The subscription charges/premiums will start on the dependent's effective date. If enrollment is completed within 30 days of this date, the effective date will be the first of the month following the month in which the dependent was acquired. If the subscriber is already on a family or employee + child(ren) contract, there will be no additional subscription charge. Some groups may not be impacted by adding dependents and should contact their account manager to verify.

How are newly acquired eligible dependents enrolled?

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

Important: Newborns and adopted children will be covered for the first 30 days, but enrollment of acquired dependents is never automatic. Completion/submission of an *Enrollment and Change Form* is required. Health Net will require that enrollment requests for children who have been placed in the subscriber's or spouse/domestic partner's custody for adoption be accompanied by a copy of the signed consent form.

A copy of the court order establishing the guardianship must accompany enrollment requests for children who have become wards.

ELIGIBLE OVERAGE DEPENDENTS (OAD)

Definition of overage dependents: Any unmarried child who is between 19 and 24 years of age, provided the child is a full-time student or dependent upon his or her parent(s) for at least half of his or her economic support. Full-time student is defined as taking nine semester units or equivalent hours in a qualified college, university or vocational school, as determined by Health Net.

In order for Health Net to determine if a child qualifies for coverage as an overage dependent, the subscriber must complete and submit an *Overage Dependent Certification* form.

If the child qualifies as an overage dependent, an *Overage Dependent Certification* form will be automatically sent to the subscriber by Health Net 90 days before the child's birthday each year. This form should be completed and returned within 15 days. You will be notified through a monthly report that your employee has been sent this form.

How it works (note: these are not "limits")

- Covered children who attain age 24 will be cancelled the first of the month following their 24th birthday. The subscriber will be notified of the cancellation in writing approximately 60 days prior the 24th birthday.
- Children who are over age 19 cannot enroll when the subscriber initially enrolls with Health Net unless the dependent meets the definition of an Overage Dependent. In order to determine if a child qualifies for coverage as an overage dependent, the subscriber must complete the *Overage Dependent Certification* form and submit it with the *Enrollment and Change Form*.
- If a covered child reaches the limiting age and is incapable of self-sustaining employment because of mental or physical handicap and is 50% dependent on the subscriber for economic support and maintenance, he or she may qualify to continue to be covered as a disabled dependent. The condition must have commenced prior to attaining the limiting age. In order to determine if a child qualifies for coverage, the subscriber must request a *Disabled Dependent Certification* form. The subscriber and the dependent's physician must complete this form. This form must be submitted to Health Net within 30 days of the date when the child reaches the limiting age. Health Net will then evaluate the information and determine whether the requirements for continued coverage are met. In addition to the steps for qualification outlined above, in order to enroll a disabled dependent, Health Net requires that the child must have been covered as a dependent of the subscriber under a previous group health plan at the time the child reached the second limiting age. Documentation in the form of a letter from the previous insurer or the employer who sponsored the health plan will be required.

HEALTH AND SAFETY CODE SECTION 1373.3, WORK AND LIVE

To comply with Health & Safety Code Section 1373.3, Health Net allows members to select a provider near[4] their home or work address.

Health Net requires the actual physical work address to accompany requests to enroll members into near-work providers. Physical work address for members must be within 30 miles of provider, and for student dependents, 30 miles from the dependent's school address.

SELECTING A PHYSICIAN GROUP AND PRIMARY CARE PHYSICIAN (FOR HMO AND THE HMO LEVEL OF BENEFITS FOR EOA AND POS)

As part of the enrollment process for HMO, EOA and POS, the subscriber and each dependent should choose a Health Net Participating Physician Group (PPG) and a Primary Care Physician (PCP) from the HMO Provider Directory. The area established by Health Net for the selected PPG by the subscriber to assure reasonable access to care (within a 30-mile radius from the residence or work address) is known as Health Net's enrollment area.

We are constantly updating our HMO Provider network, so please confirm a physician's participation and availability prior to receiving service. For up-to-date provider availability, please call the Small Business Group Customer Contact Center at 1-800-361-3366 for assistance in selecting a PPG or Primary Care Physician or to request a Health Net HMO Provider Directory. As an added convenience, you can access up-to-date directory listings over the internet by visiting us at www.healthnet.com.

Health Net PPGs are multispecialty medical groups with all physicians located at a single site. Other medical groups are structured as Independent Practice Associations that, while located in their own offices at various locations, in every other way function as a PPG. Independent Practice Associations have a central administrative office.

Each member must select his or her own PPG and Primary Care Physician. However, if members do not select a PPG and/or PCP, Health Net will assign them one. Notification will be mailed to the member reflecting the assignment, including instructions on changing the PPG or PCP, if desired.

All newborn infants are assigned to the mother's PPG for the first 30 days after birth. If the mother is not enrolled on the plan, the infant will be assigned to the subscriber's PPG.

"Split" coverage is permitted, meaning eligible members under a subscriber's coverage are not bound to select the same PPG; however, they must enroll in the same health care plan.

If a new member chooses a Primary Care Physician who is currently his or her primary care provider, please indicate "Prior Patient" on the *Enrollment and Change Form*.

How does a member transfer from one PPG to another?
Transferring from one PPG to another is allowed monthly "at will."[5]

If you have any questions concerning PPG transfers, or would like to request a list of PPGs or a map of our service area, please contact the Health Net Customer Contact Center or visit our website at www.healthnet.com. Members must request PPG transfers on or before the 15th of the month in order for the change to be effective on the first of the following month.

SELECTING A PARTICIPATING OR PREFERRED PROVIDER (FOR PPO AND THE PPO LEVEL OF BENEFITS FOR POS)

Employees and their dependents do not have to select a Participating or Preferred Provider at the time of enrollment under the PPO plan or to access benefits on the PPO level of the POS plans. However, benefits may be more cost-effective for the member under the PPO or POS plans if they choose a network Preferred Provider at the time they receive health care.

Members should check the PPO provider directory for information on contracted health care providers who are members of the PPO network. Also, members should refer to the Certificate of Insurance for information on benefits.

HEALTH NET ID CARD

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

ID cards will be issued under the following conditions:

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

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

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

[5]If the member is receiving acute care, the transfer may be allowed upon consideration of unusual or serious circumstances.

TRANSITION OF CARE (TOC)

The Transition of Care Unit for Health Net can assist members in receiving uninterrupted and coordinated care if they are eligible for the TOC benefit. This provision (when approved) allows members to continue their current treatment plan for a specific diagnosis and specified time frame with their prior provider.

To request this benefit, the member should call the Customer Care Center to obtain the Health Net of California *Transition of Care Assistance Request* form. They must completely fill out the form and return it either by mail or fax, as listed on the TOC form. If they are a new member to Health Net, they will need to attach a copy of their enrollment form.

Who is eligible for Transition of Care (TOC)?

All Health Net members can be eligible for TOC if one or more of the following conditions apply:

- If the member is pregnant or gave birth in the last six weeks.
- If the member has a planned surgery scheduled within 180 days of their effective date with Health Net or the termination of their provider group Health Net contract.
- If the member has a terminal illness.
- If the member has a newborn child (up to 36 months of age not to exceed 12 months from the effective date of coverage).
- If the member has an acute condition (not to exceed 12 months from the effective date of coverage).
- If the member has a serious chronic condition.

Cases are considered for TOC assistance based on plan benefit, medical appropriateness and clinical needs. Upon receipt of the TOC form, a Nurse Care Manager will be assigned to review members care issues. The Health Net Medical Director will determine if the TOC criteria are met. Member will be notified by telephone and/or by letter.

CANCELING EMPLOYEE/ DEPENDENT COVERAGE

When should Health Net be notified of a cancellation?

Health Net must be notified as soon as possible prior to the last day that the member is eligible for coverage, but no later than 30 days[6] after the effective date of the cancellation. Premium credit cannot be issued for more than 30 days[6] retroactively.

Why is timely notification important?

Members who are no longer eligible, but who have not, in fact, been cancelled by their employer, may incur substantial medical expenses between the time they cease to meet eligibility requirements and the time they are actually removed from the plan. According to the eligibility rules of your Health Net plan, if you notify us of a cancellation more than 30 days after what should have been the last day of coverage, Health Net will require that you pay subscription charges/premiums for the affected member up to the time that you provided us with proper notification.

How does cancellation of the subscriber's coverage affect the coverage of his or her dependents?

When the subscriber's coverage is cancelled, all covered dependents also lose eligibility and are cancelled automatically.

How is employee coverage cancelled?

The group administrator must indicate the cancellation and effective date on the Current Membership and Membership Changes pages of their monthly billing statement (membership invoice). If the billing statement has already been sent, written notification of the cancellation on the group's letterhead may be mailed to Health Net at P.O. Box 9103, Van Nuys, CA 91409-9103 or faxed to (916) 935-4420. Any written request from a group or broker will be accepted.

How can a dependent's coverage be cancelled if the subscriber continues to be covered?

Follow the same procedure as when canceling an employee, or to cancel a dependent's coverage when the subscriber continues to be covered, you must submit the following form:

Enrollment and Change Form

The Delete Dependent change option should be indicated below Reason for Change. A completed, signed and dated *Enrollment and Change Form* must be submitted for each subscriber who is canceling a dependent's coverage.

UPDATING MEMBERSHIP INFORMATION

Membership information change/correction request(s), such as name or address changes, may be accomplished by submitting a *Enrollment and Change Form* or at our website at www.eservices.healthnet.com. Employers will need to be registered users to access the services at www.eservices.healthnet.com. It's an easy process!

1. Go to *Ben Admin*.
2. Click *Register* at the bottom of page.
3. Complete the online form.
4. Click *Submit to Health Net.*
5. A user name and temporary password will be sent via email within 2 business days.

[6]Permitted days are subject to contract agreement.

COVERAGE OPTIONS FOLLOWING TERMINATION, INCLUDING CONTINUATION OF COVERAGE

In this section you will find information about:

- Individual and Conversion Plans.
- Federal COBRA.
- Cal-COBRA.
- Extension of Benefits (due to total disability).
- Disabled Overage Dependents.
- Leave of Absence.

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

Who is not eligible to continue coverage under Health Net Plans?
Continuing coverage is not available to members who have had group coverage terminated by Health Net for any of the following reasons:

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

COVERAGE OPTIONS FOLLOWING TERMINATION

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

Cal-COBRA Continuation Coverage: For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage. The subject is detailed below in the section titled "Cal-COBRA Continuation Coverage."

Cal-COBRA Extension for Former Federal COBRA Beneficiaries: For employers who must provide Federal COBRA continuation coverage for a period of less than 36 months, Health Net is required by California law to offer Cal-COBRA extension for a maximum combined period of 36 months.

CONVERSION PLAN

What is the Conversion Plan?
The Conversion Plan is non-group coverage generally available to members who lose eligibility under Health Net group plans and who continue to live within the Health Net service area.

Conversion Plan for HMO, EOA and POS plan members
Former HMO, EOA and POS plan members will be given the option to purchase an HMO plan. As in the case of coverage under a group plan, covered services must be provided by, or authorized through, a selected PPG.

Conversion Plan for PPO and Flex Net plan members
PPO and Flex Net members will be given the option of a PPO Conversion Plan. Health Net Life Insurance Company has contracted with Celtic Life Insurance Company to provide conversion coverage for those eligible for such coverage. Please contact Health Net for details.

The level of benefits and copayments will not be the same as under group plans. Members who are considering the Conversion Plan should refer to the *Disclosure Form* to compare this coverage to their existing coverage.

Who is eligible for the Conversion Plan?
California law requires that employees or dependents who have been covered under a Health Net group plan have the right to transfer to the Health Net Conversion Plan. Members of Health Net group plans who lose their coverage because they no longer meet the plan's eligibility requirements – such as when the employee terminates his or her job, there is a divorce, or a child reaches the plan's stipulated limiting age or gets married – are eligible to elect coverage under the Health Net Conversion Plan. The employee or dependent must apply for the Conversion Plan within 63 days after the last day of group coverage.

When is a member not eligible to continue coverage under the Health Net Conversion Plan?
A member is not eligible for Conversion Plan coverage if:

1. The member was not covered by the Health Net group plan for the full three-month period immediately preceding the last day of coverage under the Health Net group plan.
2. Coverage is terminated because the member did not pay any premium that he or she was obligated to pay.

3. Coverage is terminated only because the employer agreement with Health Net was terminated, by the employer or Health Net, and was replaced by the employer with other coverage within 60 days.

4. The member is covered by any other group or individual (private pay) policy. If other coverage is obtained after the member becomes covered under the Health Net Conversion Plan, eligibility will end, and the member's Health Net coverage will be terminated.

5. Health Net terminated the member's group coverage because:

   - The member knowingly omitted or misrepresented a material fact on the *Enrollment and Change Form*;
   - The member failed to pay on demand copayments or other charges owed to Health Net, the PPG or other health care provider, provided the subscriber was duly notified and billed, and at least 45 days elapsed after the date of notification;
   - The member persisted in conduct that interfered with effective rendition of health care;
   - The member utilized fraud or deception in the use of Health Net coverage or the PPG's services or facilities, or knowingly permitted such fraud or deception by another; or
   - For HMO, EOA and POS, the member no longer lives in the Health Net service area.

Who pays for the Conversion Plan?

The subscriber is obligated to pay for conversion coverage on a monthly basis. California law requires that there be no lapse in coverage. This means that the subscriber must pay premiums for the period beginning on the date of termination of the prior Health Net group coverage.

What is the employer's responsibility?

California law stipulates that it is the sole responsibility of employers to notify their employees of the availability, terms and conditions of Conversion Plan coverage. This responsibility is satisfied if the former group plan subscriber is informed within 15 days after the last day of coverage under the group plan.

To assist employers in the process of notifying former members about the availability of the Conversion Plan, Health Net will provide employers with a supply of Conversion Plan Disclosures and Conversion Enrollment/Change forms upon request.

HEALTH NET INDIVIDUAL & FAMILY PLANS

Health Net offers an option for enrolling overage dependents and employees leaving your company wishing to explore options other than COBRA or Cal-COBRA or conversion coverage.

Should employees wish to apply for coverage under our Individual & Family Plans for any reason, they may contact their agent or broker, or call 1-800-909-3447. The requestor will need to apply for coverage and will be required to answer a health questionnaire. Application for an individual policy may also be made at our website at www.healthnet.com.

Health Net IFP plans require medical underwriting. If a person chooses an IFP plan instead of COBRA or Cal-COBRA, he or she will lose his or her continuation rights.

Individual plans may also be available on a guaranteed issue basis as mandated by HIPAA to certain COBRA and Cal-COBRA beneficiaries who have exhausted COBRA or Cal-COBRA. Please contact our Individual Sales Department at 1-800-909-3447 for more information.

DIVORCE OR DISSOLUTION OF DOMESTIC PARTNERSHIP

How does a divorce or dissolution of domestic partnership affect the dependent coverage of an employee's former spouse/domestic partner?

When a divorce or dissolution of domestic partnership occurs, the employee's former spouse/domestic partner loses eligibility under the group plan (in addition to enrolled children who are not natural or adopted childeren of the employee). However, the former spouse/domestic partner and/or their dependent(s) have the right to elect the Conversion Plan or COBRA/ Cal-COBRA coverage.

How does a divorce/dissolution of domestic partnership affect the dependent coverage of an employee's children?

Natural and adopted children of the employee do not lose eligibility because of divorce or dissolution of domestic partnership and may continue to be covered as dependents of the subscriber.

Employers are obligated by law to enroll an employee's dependent if the divorce court orders the employee to provide medical coverage. The employer must allow enrollment even if the employee does not have custody of the dependent, if the dependent was not already enrolled, and currently lives outside of the Health Net service area. A copy of the court order must be given to Health Net along with the enrollment request.

Health Net will comply with a Medical Child Support Order

A Medical Child Support Order is any judgement, decree or order from a court having jurisdiction, and includes a court-approved settlement agreement. The order must:

- Require the subscriber or former spouse/domestic partner through his or her health plan to provide health coverage for the child.
- Name the employer's plan, and include the name and address of the subscriber or former spouse/domestic partner and that of the qualifying child.

- Specify the time period for which the order applies.
- Contain a "reasonable description" of the coverage to be provided, or the manner by which coverage is determined.

A Medical Child Support Order does not require Health Net or employer to expand benefits
The child is entitled to the same coverage available to other dependent children under the plan. A Medical Child Support Order does not require Health Net (or the employer) to add or expand benefits.

Note: even if the child moves out of the service area, he or she may still be covered, but only for emergency services, unless they travel into the service area for routine care. However, the employee's stepchildren and legal wards of the ex-spouse/ domestic partner would lose eligibility in the event of a divorce.

Alternate recipients are entitled to coverage
An alternate recipient is any child of a participant who is recognized under a medical child support order as having a right to enrollment in a group health plan.

Additional conditions for Medical Child Support Order enrollment:
For HMO, EOA and POS:

- If the child lives in the Health Net service area, he or she will be enrolled in the same manner, and receive the same coverage, as any other dependent child.
- Health Net will not apply service area restrictions. If the child lives outside our area, Health Net will enroll the child. The out-of-area child should be enrolled using the in-area parent's address. The PPG selected should be based on the parent's address. Emergency care outside of our area will be covered only on the same basis as other out-of-area emergency care.
- A custodial parent or guardian may file a claim for emergency care on the child's behalf. With proof of payment, Health Net will reimburse that individual instead of the subscriber. The custodian or guardian may also assign benefits directly to the provider.
- The out-of-area child may travel into Health Net service area for non-emergency services at the selected PPG. Health Net will not cover out-of-area services that are not normally covered through our plan.

For all products:

- Health Net must enroll the child in accordance with the effective date specified in the order, even if it is a midterm enrollment. If the subscriber fails to complete the necessary application, Health Net must accept the application from the custodial parent or guardian.
- Health Net may not disenroll the child due to age restrictions. The child remains eligible for the entire period the order is in effect. Coverage ends on the date specified in the order; on the date the employer reasonably determines that the order is no longer in effect; on the date the child becomes covered by a comparable plan; or on the date the subscriber ceases to be eligible.

EXTENSION OF BENEFITS DUE TO TOTAL DISABILITY

What is the definition of totally disabled?
For purposes of this benefit, the following definitions of total disability will apply:

The subscriber shall be considered totally disabled when, as a result of bodily injury or disease, such subscriber is unable to engage in any employment or occupation for which he or she is, or becomes, qualified by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit.

The family member shall be considered totally disabled when such member is prevented from performing substantially all regular and customary activities usual for a person of that age and family status.

Who is entitled to benefit extension because of total disability?
When an entire group agreement is terminated, the Health Net member who is totally disabled on the day employer-sponsored group health plan ends, whether he or she is or was an active employee, retiree or COBRA beneficiary, is entitled to benefit extension because of total disability.

To activate this right, the member must request an extension of benefits in writing within 90 days of the last day of coverage. Written certification of disability provided by the attending physician must accompany this request (the certification must be signed by the member's Primary Care Physician for HMO, or for the HMO benefit levels of EOA or POS. Members should call the Customer Contact Center for information on how to apply for an extension of benefits.

Which benefits are extended?
Extended benefits are limited to services and expenses related to the disabling condition that existed at the time coverage ended.

Who pays for the extended benefits?
Health Net will provide eligible members with an extension of the benefits that were available under the former group plan, without charge to the former group or the member.

How long are benefits provided?
Benefits are provided until whichever of the following occurs first:

- The member is no longer totally disabled.
- The member becomes covered under another group health plan that does not have a limitation regarding a disabling condition that existed prior to the new plan's effective date.

- A period of 12 consecutive months has passed since the date group coverage has ended.
- Benefits are exhausted.

Benefits are also extended when a member is hospitalized and the member's coverage is terminated, but the group's coverage remains in effect.

Can the total disability extension be combined with the Conversion Plan?

The extension of group plan benefits for total disability may coexist with Conversion Plan coverage. This combination may be advantageous to the member. However, if a member does not purchase Conversion Plan coverage within 63 days after the last day of group coverage, he or she may not do so at a later date.

When the Conversion Plan and a disability extension are combined, the benefit structure is as follows:

- The benefits of the prior group plan will apply to the totally disabling condition. In many cases, these benefits will be more comprehensive than Conversion Plan benefits.
- Conversion Plan benefits will apply to all other medical conditions.

LEAVE OF ABSENCE

How does an employee leave affect a member's Health Net coverage?

Health Net typically encounters employee leave policies that permit absences of between three to six months. If an employee is on a leave of absence consistent with your personnel policy, Health Net does not require you to take any special action. If it is your policy to require that the person on leave pay for his or her coverage during the leave period, please be aware that such a transaction will remain transparent to Health Net. You will need to continue to pay Health Net for that person's coverage in the usual manner.

Health Net expects that employers will terminate the employment and Health Net coverage of employees on leave if there is no reasonable expectation that they will return to work within a reasonable period of time. If we become aware that a Health Net subscriber has not been at work for an extended period of time, we will inquire further about the specific details.

If an employee who is on a leave of absence is terminated from your employment, he or she qualifies for all forms of continuation coverage for which he or she is eligible. Please read the detailed description of each of our continuation coverage plans presented in this section.

Family Medical Leave Act (FMLA). The employer may continue the coverage of any subscriber during a leave of absence by documenting for Health Net the employer's leave policy. The policy must be in accordance with the FMLA. If contributions are required, and the subscriber therefore waives coverage during the leave, the employer may re-enroll the subscriber and family on the date the leave ends, without a waiting period.

OVERVIEW OF COBRA LEGAL REQUIREMENTS

This section explains what the law requires of employers. We have included their website, www.access.gpo.gov/nara/cfr/cfr-table-search.html [26CFR Part 54], where you can go to access the most recent federal COBRA regulations.

CAL-COBRA CONTINUATION COVERAGE (APPLIES TO GROUPS WITH 2 TO 19 ELIGIBLE EMPLOYEES)

Employer Obligations

Employers must perform certain services to assist Health Net in carrying out its legal obligation to provide Cal-COBRA continuation coverage for the employees and dependents of small employers with fewer than 20 employees. Related text appears in your *Group Service Agreement*. Please note that while state law defines a small employer as an employer with 2 to 50 eligible, for Cal-COBRA, a small employer is defined as an employer with 2 to 19 employees during 50 percent of the preceding year.

Cal-COBRA Obligations

When the employer employs fewer than 20 employees, the employer must do the following:

Notify Health Net of Certain Qualifying Events: The employer must notify Health Net in writing within 31 days of an employee's losing eligibility for coverage through this plan due to (1) termination of employment for reasons other than gross misconduct or (2) reduction in hours worked.

Notify Current Cal-COBRA Qualified Beneficiaries of Employer's Intent to Terminate This Group Service Agreement: If the employer intends to terminate this *Group Service Agreement* with Health Net and replace it with coverage through another California HMO or disability (health) insurer, the employer must, at least 30 days prior to the termination, inform all existing Cal-COBRA qualified beneficiaries of this action. The employer must also inform qualified beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of the period that they could have continued coverage through the Health Net plan. Health Net will provide the employer the names and last known addresses of enrolled Cal-COBRA qualified beneficiaries.

Further, in relation to a time period when the employer's employees are subject to Cal-COBRA coverage, and when a qualifying event occurs during this period, Health Net will provide coverage according to the section titled "Cal-COBRA Continuation Coverage" which follows.

Cal-COBRA Continuation Coverage

Employers who have 20 or more employees are generally subject to federal COBRA continuation coverage law. For smaller employers, California law requires that insurers and HMOs provide continuation coverage that is known as Cal-COBRA. If a member loses or is about to lose coverage, and is interested in choosing continuation coverage, you will need to inform the member if you are subject to federal COBRA law. If you are a small employer with 2 to 19 employees, notify Health Net on the Current Membership and Membership Changes pages of your billing statement or in writing on your group's letterhead of the termination. Health Net will notify the member of his or her Cal-COBRA rights and if he or she enrolls, will bill the member directly.

Who Is Eligible for Cal-COBRA Continuation Coverage?

Qualifying Event: If the member is validly enrolled through this plan, and he or she experiences a qualifying event (as described above), and as a result of that event loses coverage through this plan, that member has the right to choose to continue to be covered by this plan.

If the Employer Replaces the Previous Plan: If a member was enrolled in Cal-COBRA continuation coverage through a previous plan that is replaced by this plan, this plan will provide Cal-COBRA continuation benefits for the balance of the period that he or she could have continued to be covered by the prior group plan (unless the member terminates the Cal-COBRA continuation coverage, or otherwise ceases to be eligible for Cal-COBRA continuation coverage).

If the Employer Group Replaces This Plan: If the agreement between Health Net and your employer group terminates, all active and Cal-COBRA coverage with Health Net will end. However, if your group obtains group coverage from another carrier or HMO, members may choose to continue to be covered by that new plan for the balance of the period that they could have continued to be covered by the Health Net plan.

Newborns and Adoptions During Cal-COBRA Continuation Coverage: If a child is born to or placed for adoption with the former employee during the 36 month period of Cal-COBRA coverage, the child shall have the status of qualified beneficiary. This means the child will have the same rights as all other qualified beneficiaries. The maximum coverage period for a child born to or placed for adoption with the former employee is 36 months from the date of the original qualifying event.

The same eligibility rules that apply for newborn or adopted children of active employees and spouses/domestic partners of active employees will apply to newborn or adopted children of former employee or spouses/domestic partners of former employees covered by Cal-COBRA.

Who May Choose Cal-COBRA Continuation Coverage?

If a subscriber experiences a qualifying event, he or she may choose Cal-COBRA for himself or herself alone, or for any one or all of the other family members who are enrolled at the time of the qualifying event. In other words, the subscriber does not have to be among the persons who choose Cal-COBRA continuation coverage as a subscriber may choose coverage for the spouse/domestic partner or one or more minor children without an adult being included.

Who May Not Choose Cal-COBRA Continuation Coverage?

Individuals may not choose Cal-COBRA if the individual:

- Is enrolled in Medicare.
- Is covered by another group health plan that does not contain a pre-existing condition limitation that prevents the individual from receiving the full benefits of such plan. (A Conversion Plan is not a group health plan.) If the individual is covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, the individual may choose Cal-COBRA continuation coverage. Coordination of Benefits will apply, and this Cal-COBRA plan will be the primary plan.
- Is covered or could become covered by any federal laws regarding continuation of group health plan coverage.
- Fails to notify Health Net of a qualifying event according to the requirements described under "Notify Health Net of Cal-COBRA qualifying event."
- Fails to submit the initial premium payment in the correct amount as described below under "Payment for Cal-COBRA."

Health Net Will Offer Cal-COBRA to Members

If a member notifies Health Net in writing within 60 days of a qualifying event, Health Net will send that member by U.S. mail information about his or her Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms, and instructions to formally choose Cal-COBRA continuation coverage.

Notify Health Net of Cal-COBRA Qualifying Event

The employer group must notify Health Net of a cancellation in writing on the Current Membership and Membership Change pages of the Membership Invoice (monthly billing statement) or in writing on the employer group's letterhead within 30 days of the effective date of the cancellation.

Choosing Cal-COBRA

If the member loses coverage through the active plan due to a qualifying event, and wishes to enroll in Small Business Cal-COBRA continuation coverage, he or she must apply for coverage within the election period described below. The member must deliver the application to Health Net by first class mail, personal delivery, express mail or private courier company.

The member must deliver the enrollment form to Health Net within 60 days of the later of (1) the qualifying event or (2) the date he or she was sent a notice from Health Net that he or she has the right to continue Cal-COBRA continuation coverage or (3) the date that coverage through the employer plan terminated.

If the member fails to apply for Cal-COBRA within the election period described above, that member will be disqualified from receiving small business Cal-COBRA continuation coverage.

Payment for Cal-COBRA

The member must pay Health Net 110 percent of the applicable group rate charged for employees and their dependents.

The member must submit the first payment within 45 days of submitting the completed enrollment form to Health Net. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA continuation coverage.

All subsequent payments must be made on the first day of each month. If the payment is late, the member will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), Health Net will send a letter warning that coverage will terminate 15 days from the date on the letter.

When Does Cal-COBRA Continuation Coverage End?

Coverage will end due to any of the following reasons:

1. 36 months from the date employer group coverage ended due to:
   - Reduction in work hours resulting in loss of eligibility for employer group coverage.
   - Death of the covered employee or subscriber.
   - Divorce or separation of the covered employee or subscriber from his or her spouse/domestic partner.

- Loss of dependent status by a covered dependent child.
- The employee or subscriber becomes entitled to Medicare; that is, enrolls in the Medicare program. (This affects only the other covered dependents.)

2. The member becomes or could become covered, in accordance with any federal laws regarding continuation of group health plan coverage.
3. The member fails to pay the correct premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
4. The member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan. If the member becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this plan will continue. Coordination of Benefits will apply, and this Small Business Cal-COBRA plan will be the primary plan.
5. The member moves outside the Health Net Service Area.

Under no circumstances may a qualified beneficiary be covered under Cal-COBRA continuation coverage for more than 36 months.

FEDERAL COBRA CONTINUATION COVERAGE

When a covered member loses eligibility under an employer-sponsored health plan because of a qualifying event (see below), he or she has the legal right to elect continuation of coverage under the plan without a lapse in coverage. The coverage that must be provided is generally the same coverage that was in force at the time of the qualifying event. Covered members who lose their coverage because of a qualifying event take on the status of qualified beneficiary, and as such have essentially the same rights under the plan as do active employees.

HEALTH NET'S COBRA PROCEDURES

1. Cancellation of members

Members whose Health Net coverage ends because of one of the qualifying events should be cancelled by indicating the cancellation and effective date on the Current Membership and Membership Changes pages of the monthly Membership Invoice (billing statement). If the invoice is not available, Health Net may be notified in writing using the employer group's letterhead.

2. Notifying Health Net of an election

When a qualified beneficiary elects continuation coverage, please do the following:

First, ask the qualified beneficiary to fill out and return to you an *Enrollment and Change Form* (see Enrollment Procedures section). In the event that the member is becoming a Health Net subscriber for the first time, such as when a former dependent becomes a subscriber, it is mandatory that this Health Net form be completed and signed by the new subscriber or parent or legal guardian if the subscriber is a minor.

Second, indicate the cancellation and effective date on the Current Membership and Membership Changes pages of the monthly Membership Invoice (billing statement). If the invoice is not available, Health Net may be notified in writing using the employer group's letterhead.

Second Qualifying Events – This same process should be followed when a COBRA continuation member experiences an additional qualifying event within his or her 18-month period of coverage and elects to continue his or her COBRA coverage.

For those individuals asking for the additional 11 months of coverage because of a total disability, a copy of the *SSA Disability Certification* that verifies that the individual was disabled during the first 60 days of the period of COBRA coverage will be required.

3. Adding newly eligible dependents at the time of election.

Once continuation coverage is in force, all eligibility rules of the Health Net *Group Hospital and Professional Service Agreement* will apply in the usual manner. For instance, newly acquired spouses and children can be added as covered dependents when they meet the eligibility rules. The COBRA applicant should fill out an *Enrollment and Change Form*.

4. Enrolling COBRA dependent(s), without the original subscriber.

If, independent of the subscriber, more than one qualified beneficiary in a family elects COBRA, then the applicable group rate will be determined as if the oldest family member is a "subscriber" for the purposes of COBRA, and other family members are dependents of that individual. Only qualified beneficiaries may elect COBRA.

5. Payments to Health Net

102%

Health Net will bill COBRA members directly (called direct bill COBRA) unless you request they be billed on the group billing (group administrative billing). If you prefer group administrative billing, the law permits you to charge continuation members 102 percent of the amount you pay for their coverage. The additional 2 percent is intended to offset administrative costs for maintaining continuation coverage. Health Net will charge you for COBRA coverage at its regular rate structure: single-party, employee + spouse, employee + child(ren) and family. You may contact your

Health Net Account Manager to determine the amounts that are currently being charged under the regular four-tier structure.

When you choose group administrative billing:

- COBRA members will be assigned a COBRA suffix but will retain your group number.
- The word "COBRA" will be included in the group name on the member's new ID card.
- The subscriber ID number will remain the same.
- The COBRA enrollees will be consolidated with the active group bill.

150%
If a qualified beneficiary is a disabled individual and has satisfied the requirements as indicated under the section titled "When Does Cal-COBRA Continuation Coverage End" and has requested 11 additional months of coverage for all qualified beneficiaries, then premiums of 150 percent of the ordinary amount may be charged for the 11 additional months of coverage beyond the additional 18 months for all of the enrolled members.

6. Receiving HMO, EOA and POS Services During the Period of COBRA Election
Former Health Net members who are COBRA-qualified beneficiaries and who need medical care during their COBRA period of election, but before the qualified beneficiary has made an election, will receive all necessary covered medical care from their former PPG.

The IRS Final Regulations establish certain requirements for the provision of medical services by HMOs to COBRA-qualified beneficiaries.

The following is description of the procedures Health Net and the PPG follow. We believe this procedure satisfies your obligations under this federal law.

What happens at the PPG?

If a former Health Net member requests medical services from a Health Net PPG, the provider will ask whether or not the person has made a COBRA election through his or her former group health plan employer/sponsor.

If a COBRA election has been made:

- The patient will be asked to sign a *COBRA Eligibility Certification Form (CLM 218)*. In signing this form, this patient is confirming that he or she has made a COBRA election through the former employer/ sponsor or the health plan – or that such an election has been made on his or her behalf. Further, he or she agrees to pay in full for any services provided by the PPG in the event that the former coverage is not reinstated.
- The PPG will then provide necessary covered professional medical services and require that the person pay only any copayments that are required under their former Health Net plan.
- Any necessary hospitalization would be the member's responsibility from the onset. If coverage is reinstated because of a COBRA election during or after the hospitalization, the covered hospital charges would become Health Net's responsibility. Any money paid to the hospital by the member would then be refunded to the member as quickly as possible.
- If COBRA continuation coverage is not in place within 60 days from the date of termination from active coverage or 60 days from the date member received notification from Health Net of the right to continuation coverage, whichever is later, the PPG will require that the member pay in full for any services that have been provided.

If no COBRA continuation coverage has been elected:

- The PPG will require that the patient pay for all services in the same manner as they would for any private patient.
- If the member subsequently carries out a COBRA election and coverage is reinstated, payment made by the former member to PPG or any hospital for covered services will be refunded as quickly as possible.

7. About copayments for general care
Members must pay any copayments that are required for care directly to the health care professional who has provided services. Copayments are in addition to premiums.

Important
The IRS COBRA regulations establish certain requirements for the provisions of medical services by HMOs to COBRA-qualified beneficiaries. (See the COBRA section for details.)

8. Conversion Option When conversion coverage is available, the employer must inform the COBRA beneficiary that conversion coverage is available. This notice must be given during the last six months of the period of COBRA coverage.

If continuation coverage ends before its full potential life span of 18 or 36 months, a conversion offering must be made in the usual manner required by California law.

9. **Conversion Notice** You must notify a member whose continuation coverage is ending that conversion coverage is available. The timing considerations are as follows:

   • If continuation coverage appears to be running its full course of 18 or 36 months, the notice must be made prior to the end of coverage, but not prior to the last six months of continuation coverage. This is required by COBRA.

   • If continuation coverage ends prior to its maximum span of 18 or 36 months, COBRA does not stipulate any requirements. California law will apply, however. Consequently, you must notify the terminating member of the availability of conversion coverage, within 14 days of the end of continuation coverage.

10. **Termination of the Health Net Group Hospital and Professional Service Agreement** If you terminate your agreement with Health Net or if it is terminated by Health Net, all members, including those who have elected COBRA continuation coverage, will be terminated. Your obligation to the COBRA qualified beneficiaries is to provide them with whatever coverage you are currently providing your active employees.

11. **Retirement as a Qualifying Event** Retirement, a qualifying event under COBRA, may present some confusion because Medicare is frequently involved. In view of this, we have included a description of how continuation coverage might unfold following retirement, should the retired employee subsequently become entitled to Medicare coverage.

MEDICARE COVERAGE

• When former employees elect COBRA coverage for themselves and their covered dependents, they are entitled to 18 months of coverage. If within the 18-month period of COBRA coverage, the former employee becomes covered by Medicare, the former employee loses coverage pursuant to plan rules. The former employees' Medicare entitlement is a second qualifying event for the covered dependents and they are entitled to a total of 36 months of COBRA coverage from the date of the original qualifying event.

Given that (1) loss of group plan coverage due to retirement is a qualifying event, and (2) enrollment in Medicare after the election of COBRA coverage is a reason to end COBRA coverage, the age of a retiree and his or her spouse is very significant.

• A person who is 65 at the time of retirement will usually be enrolled in Medicare. COBRA coverage may be terminated for members who are enrolled in Medicare after electing COBRA continuation coverage. However, members who enroll in Medicare before the date that COBRA is elected are qualified to make a COBRA election as well as their dependents who lose coverage as a result.

• When the retiring employee or a covered dependent is under age 65 and elects COBRA continuation coverage, he or she will lose the COBRA coverage upon reaching age 65, that is, if he or she becomes entitled to Medicare benefits.

Examples:

A. Former employee is 65/spouse is 63. It is confirmed that the former employee is covered under Medicare. The spouse, who is not yet 65, is not covered under Medicare for any other reason. Both the former employee and the spouse have the right to make a COBRA election.

B. Former employee is 65/spouse is 63. Social Security advises that the former employee does not qualify for Medicare coverage. The spouse, who is not yet 65, is not covered under Medicare for any other reason. Both the former employee and the spouse have the right to make a COBRA election.

C. Former employee is 64/spouse is 63. Neither person is over age 65, and neither has Medicare coverage for any other reason. Both can make a COBRA election.

In example A above, COBRA continuation coverage for the former employee will end after 18 months. COBRA continuation coverage for the spouse will end either 36 months from the former employee's entitlement to Medicare or 18 months from the former employee's reduction in work hours, whichever is longer.

In example B above, COBRA continuation coverage for the former employee and spouse will end after 18 months.

In example C above, COBRA continuation coverage for the former employee will end after one year, that is, if he or she becomes covered under Medicare at age 65. COBRA continuation for the spouse will end after two years, once again, if he or she becomes covered under Medicare at age 65.

Health Net offers a selection of Medicare Supplement plans. Eligible members who are interested in these plans may contact Health Net's Customer Contact Center.

BILLING PROCEDURES

MONTHLY BILLING

Your Group Number

Your company has been assigned a group number that has two or more suffixes as shown below. If your company has selected more than one type of product (i.e., HMO and PPO), generally, you will have a different group number assigned for each product.

Example:

34567A	Active Single, Employee + Spouse/Domestic Partner and Family contracts
34567B	Active Employee + Child(ren) contracts
34567C	COBRA members
34576S	Group Seniority Plus members

Every month your company will receive a Membership Invoice that consolidates all suffixes.

Please Note: as you look at the group numbers shown above, notice that the actual sequence of numbers is the same for each group within this company. In the Health Net accounting system, these numbers indicate the name and products selected by this company. Please notice that a separate letter of the alphabet designates each type of group within this company. Normally we will drop the last digit of the group number to insert S.P. for Seniority Plus.

How should payment be submitted?

Please make your check payable to Health Net. In addition, we ask that you provide us with the following information:

On the face of the check:

- Write Group Bill ID. This will allow Health Net to properly credit your company with your payment. In the example above, 34567 would be written on the front of the check.
- Write the billing period for which payment is being submitted.

On the check stub:

- Write Group Bill ID if you are paying for more than one invoice.
- Next to each letter, indicate the portion of the total check you want to apply to each of your groups.

What should be submitted with payment?

- A copy of your membership invoice along with any documentation that supports your payment amount.
- The Membership Changes and Current Membership pages from your Membership Invoice identifying changes to your current billing.

In this example, the total amount of the check Health Net received from this company was $4,000. The following information was provided on the check stub:

A $1,000

B $1,000

C $1,000

SP $1,000

Health Net would credit each of this company's four groups with $1,000.

Please mail monthly payments to the address on your Membership Invoice:

Health Net
File #52617
Los Angeles, CA 90074-2617

Enrollment and Change forms should be included with the check at this address, but please do not send *Enrollment and Change* forms by themselves (without a check) to this address. If you have already mailed payment and must submit a new *Enrollment and Change Form*, mail it to:

Health Net
P.O. Box 9103
Van Nuys, CA 91409

or

Fax to (916) 935-4420

DO NOT MAIL PAYMENTS TO THE VAN NUYS ADDRESS as it will delay credit to your account.

Please make your payments to Health Net before the due date indicated on your Membership Invoice.

What happens if payments are submitted late?

As a prepaid carrier, Health Net prepays each of our medical groups on a monthly basis for the care of all our subscribers and their covered dependents. We depend on your cooperation in making your payment on or before the due date indicated on your Membership Invoice.

Premium payment is due on the first of each month while the Group Agreement is in effect. If payment is not made by the due date, Health Net will send a reminder notice in hopes that this will result in immediate payment. If however, we have not received payment by the dates outlined in the reminder, the account may be subject to cancellation. If a termination is required, Health Net will send a written notice of termination effective on the last day of the month for which full premiums were paid. If the delinquent amount is paid within 15 days of the date of the notice, the Group Agreement will be considered for reinstatement. However, a reinstatement fee will be added to the outstanding charges. Health Net will review requests for reinstatement if an account has not been previously cancelled as a result of nonpayment within a 12-month period. To be considered for reinstatement, all outstanding balances through the current month plus a reinstatement fee will be required to be paid in full. Health Net values your business and Health Net representatives are available to assist you with any questions.

Health Net allows retroactive eligibility changes and premium adjustments up to 1–2 months prior to the current month depending on terms of your contract. Employer groups are required to provide Health Net with advance notice of their intent to cancel per the contract.

ELECTRONIC FUNDS TRANSFER (EFT)

Employer groups may have the option of Electronic Funds Transfer, or EFT, wire transfer for remitting payment.

When a group requests Electronic Funds Transfer to remit payment for premiums due, the Membership Accounting Representative supplies the following information which is then provided by the employer group to their bank:

- Health Net's Bank Name and Address
- Bank Contact
- Account Name, (Health Net)
- Health Net's Account Number
- ABA Number

The name and group number of the requesting employer group must be referenced on the transmittal.

Should you have further questions about Electronic Funds Transfer, please contact your Health Net Membership Accounting Representative.

E-SERVICES

Health Net's free internet services for group-paid medical eligibility and/or billing.

E-SERVICES – ENROLLMENT AND BILLING VIA THE INTERNET

Health Net's e-Services is a free, user-friendly, password-protected web portal for enrolled employer groups and their employees. The e-Services website is available seven days a week, 24 hours a day, excluding pre-scheduled downtime necessary for system maintenance (usually posted on the online Message Board in advance).

EMPLOYER CAPABILITIES

Billing

- View your bill.
- Print your bill.
- Adjust the total amount due shown on the bill.
- Download your current membership to your own PC as an EXCEL spreadsheet.
- Print a remittance coupon to submit a check, or pay via an online bank account.

Eligibility

- Process enrollments, changes or cancellations via the internet. You keep the form!
- Process current activity for group-paid Actives, COBRA or Retirees.
- Most updates are available to view online within 24–48 hours.
- Reduce or eliminate faxes for rush enrollments.
- Allow employees to process their own enrollment and personal information changes.
- Review, approve or reject requests submitted by employees prior to acceptance by Health Net.

To register for e-Services, go to: eservices.healthnet.com. Or, if you have any questions, please call 1-800-909-6362 and ask to be transferred to the eService team.

HOW TO ORDER FORMS

Health Net is pleased to provide you with the forms necessary to manage your Health Net Small Business Group Plans.

You may use the supply order request worksheet included with your group administrative kit to let Health Net know which forms you would like to receive and in what quantity. Please note, employers or employees may print most forms from a PDF format available under the *I'm an Employer* tab, at www.healthnet.com. Fax or mail the completed worksheet to your Account Manager. Health Net will ship your order to you promptly and without charge. More worksheets may be obtained from your Account Manager or, as an added convenience, you may simply call your Account Manager to request supplies.

ACCESSING EVIDENCE OF COVERAGE/ CERTIFICATE OF INSURANCE ONLINE

Your employees will be able to access their *Evidence of Coverage/Certificate of Insurance* online at www.healthnet.com.

It's easy to do:

1. Members log on to www.healthnet.com with their assigned user name and password. If they have not logged on before, the site will prompt them to register. When following the steps they will be logged in within just a few minutes.
2. Click on *My Medical Benefits* then *My Evidence of Coverage* or *My Certificate of Insurance* to retrieve the *Evidence of Coverage/Certificate of Insurance*. We have conveniently listed the *Evidence of Coverage/Certificate of Insurance* documents related to the specific products you have purchased.

The information is completely protected. We take the utmost care to maintain a secure website that ensures the confidentiality of the *Evidence of Coverage/Certificate of Insurance*.

A letter will be sent to your employees once the *Evidence of Coverage/Certificate of Insurance* documents are available. The *Evidence of Coverage/Certificate of Insurance* will remain on the website for the duration of the plan year. Members can print the document or save an electronic version directly from the website.

Your participation in our electronic document retrieval program is voluntary. A member letter regarding this new access will be sent to your covered employees. If you require your employees to receive their *Evidence of Coverage/Certificate of Insurance* by mail, please contact your Account Manager as soon as possible prior to your effective date to ensure timely delivery.

APPEALS AND GRIEVANCES

OVERVIEW

Health Net's appeal and grievance process allows members 180 days to file a grievance following any incident or action that is the subject of the member's dissatisfaction. The member, his or her doctor, or authorized representative, may request that Health Net conduct a review of a concern under the appeal and grievance process described in the *Evidence of Coverage* or *Certificate of Insurance*, in the section titled "General Provisions." The plan will work with the member to arrive at a mutually satisfactory solution. If the member remains unsatisfied with the outcome of the review, Health Net offers binding arbitration as the final step to resolve grievances. However, if the employer's plan is subject to ERISA, the member has the right to bring civil action under ERISA Section 502 (a) following an adverse benefit determination on review, as further discussed below.

Health Net's Appeal and Grievance Department is our established unit dedicated to addressing members' issues in a timely manner. A grievance is a type of dissatisfaction. An appeal is the member's right to challenge a denial decision made either by their health plan practitioner/provider group or Health Net concerning health care benefits. Information about this process is also available in the member handbook, under the section entitled "Understanding your plan," and, as always, our Customer Contact Center representatives are available to assist members.

APPEALS – REQUEST FOR RECONSIDERATION

An appeal is a written or oral request to change a previous decision or adverse determination. These can be categorized as: Pre-Service, Post-Service, Expedited, and External Review. The member, or his or her authorized representative's request for a review of the denial will be handled in a timely manner. When an appeal is requested, the plan will send the member a written acknowledgement letter within five (5) calendar days. This letter indicates the A&G Department has received the request and that a Health Net Appeals and Grievances Case Coordinator has been assigned to the case. We will review the member's appeal and send the member a decision within thirty (30) calendar days from receipt of their appeal. If we are unable to reach a decision within the timeframe, we will write to the member and tell them why there is a delay and when we hope to resolve their appeal. This process is known as the **Standard Appeal Process.**

An appeal can also be expedited if a member has a terminal illness and the appeal involves an experimental or investigational

issue. Another type of expedited appeal is for cases involving an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. When Health Net determines that an HMO case meets these expedited criteria, the member has the right to notify the Department of Managed Health Care (DMHC) of the complaint. Health Net will provide the member a written statement on the disposition or pending status of the expedited issue no later than three (3) days from receipt of the issue. In these situations, we encourage the member to speak with his or her doctor to discuss this process. This process is known as an **Expedited Review.**

GRIEVANCES – EXPRESSION OF DISSATISFACTION

A grievance is an oral or written statement, expressing dissatisfaction regarding any aspect of Health Net or its provider's operations, contractual issues, activities or behavior. These are generally further classified as either quality of service or quality of care. An example of a quality of service grievance is excessive waiting time in a doctor's office. A quality of care grievance would concern the health care the member is receiving. To express a grievance, the member or his or her authorized representative may contact Health Net by telephone, mail or email. The member can call our Customer Contact Center at the toll-free number printed on their Identification (ID) Card.

The Customer Contact Center will help to address the members' grievance, but it is important to note that some information may be protected by peer review laws and Health Net may not be able to legally give the member details of our actions taken to address the grievance.

GRIEVANCE FORMS

Health Net, through its website, began providing members a form used to file an online grievance with the plan. The website has an easily accessible online grievance submission procedure that is accessible through a hyperlink on the plan's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process is provided through a secure server. The online grievance submission process has an HTML format that allows the user to enter required information directly into the form. It allows the member to preview and edit the grievance prior to submission. Members may also download a hard copy of the form and fax it to the Appeal and Grievance Department directly.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

Members may request an independent medical review (IMR) of a disputed health care service from either the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) if they believe that health care services have been improperly denied, modified or delayed by Health Net or one of our contracting providers. A 'disputed health care service' is any health care service eligible for coverage and payment under the plan that has been denied, modified or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to the member. Members pay no application or processing fee of any kind for IMR. Members have the right to provide information in support of the request for IMR. Health Net will provide members with an IMR application form with any appeal resolution letter that denies, modifies or delays health care services. A decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

Eligibility: Members' applications for IMR will be reviewed by the DMHC/CDI to confirm that:

1. (A) The provider has recommended a health care service as medically necessary, or (B) The member has received urgent care or emergent services that a provider determined was medically necessary, or (C) The member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which they seek independent review;

2. The disputed health care service has been denied, modified or delayed by the plan or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary; and

3. The member has filed a grievance with the plan and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If the member's grievance requires expedited review, the member may bring it immediately to the Department's attention. The DMHC/CDI may waive the requirement that the member follow the plan's grievance process in extraordinary and compelling cases.

If the member's case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. The member will receive a copy of the assessment made in their case. If the IMR determines that the service is medically necessary, the plan will provide coverage for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC/CDI must provide its determination within thirty (30) days of receipt of the member's application and supporting documents. For urgent cases involving imminent and serious threat to the member's health, including, but not limited to, severe pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

BINDING ARBITRATION

Sometimes disputes or disagreements may arise between the member (including the enrolled family members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the *Evidence of Coverage* or *Certificate of Insurance*, or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to become a Health Net member, members agree to submit all disputes they may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both the member and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Litigation Administrator
P.O. Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage* or *Certificate of Insurance*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent the state or federal laws provide for judicial review or arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorney's fees. In cases of extreme hardship to a member, Health Net may assume all or portion of a member's share of the fees and expenses of the arbitration. Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations"

made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, the member and Health Net may voluntary agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

DEPARTMENT OF MANAGED HEALTH CARE DISCLAIMER

The California Department of Managed Health Care is responsible for regulating health care service plans (HMO, ELECT Open Access, POS and HMO Silver Network). If you have a grievance against your health plan, you should first telephone your health plan at 1-800-361-3366 and use your health plan's 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 your health plan, 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 (1-800-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website http://www.hmohelp.ca.gov has complaint forms, IMR applications and instructions online.

CALIFORNIA DEPARTMENT OF INSURANCE

The California Department of Insurance (CDI) is responsible for regulating health insurers, including Health Net Life Insurance Company (PPO and FlexNet). If you have been unable to resolve a problem concerning your insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, you may contact:

California Department of Insurance
Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013

1-800-927-HELP

HEALTH NET LIFE INSURANCE COMPANY

HOW TO APPLY FOR GROUP TERM LIFE INSURANCE

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

If you wish to add life insurance to your portfolio of coverages after the original effective date of your medical coverage, you will need to complete a *Small Business Application for Group Service Agreement/Group Policy* and forward it to Health Net for underwriting at that time.

As a new account, all of the eligible employees will need to complete section 5, Group Term Life Insurance, of the *Small Business Group Enrollment and Change Form*. Some contracts require that all employees participate in the life insurance coverage, even if they have declined medical coverage through Health Net. Please see your Policy regarding this requirement.

Employees may be added to your plan throughout the year as they become eligible. They may use the same enrollment form, as for medical: *Small Business Group Enrollment and Change Form*. If employees wish to make changes to their beneficiary designation throughout the year, they may complete and sign that section of this form and forward to Health Net Life Premium Accounting and Eligibility department at any time.

PROBATIONARY PERIOD

As with medical, there are probationary periods before coverage is effective. A probationary period is the length of time that employees must wait before they have coverage. You can find the specific probationary period in your *Small Business Plans Group Service Agreement* and in your Health Net Life Insurance Company policy.

CONTRIBUTION

Your policy requires that you, the employer, contribute 100 percent of the premium for term life insurance products. You will find this in section 3 of the *Small Business Application for Group Service Agreement/Group Policy* and in your Health Net Life Insurance Company policy for group term life insurance.

ENROLLMENT/DISENROLLMENT

To provide the financial security that your employees desire, Health Net Life Insurance Company needs some basic information. For new employees, you will need to complete section 5 and the employee will need to complete section 6 on the *Small Business Group Enrollment and Change Form*. This may be forwarded to Health Net Life Insurance Company as part of the medical coverage application, or may be sent separately via fax or mail.

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

BILLING PROCEDURES

Monthly billing

Your Group Number

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

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

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

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

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

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

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

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

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

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

CLAIMS

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

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

GLOSSARY OF TERMS

This list of definitions covers terms and phrases used frequently in this book. It is important that you understand the meaning of these words.

Certificate of Insurance: The certificate describes the benefits underwritten by Health Net Life Insurance Company, issued in connection with the *Group Hospital and Professional Service Agreement/Group Policy*. This booklet provides the subscriber with a complete statement of his or her benefits. (This term is used for PPO, Life Insurance and indemnity plans.)

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A law that allows individuals leaving the company to buy health insurance from the company at the employer's group rate rather than an individual rate.

continuation coverage: Extended coverage for a qualified beneficiary following loss of coverage due to a qualifying event.

However, if a member's former employer or Health Net terminates the policy, and it is replaced with other group coverage, the continuation coverage is provided by the replacement group health carrier.

Also, if, during Cal-COBRA continuation coverage, the member selects a different health plan offered by the employer during open enrollment, the continuation coverage will be transferred to the new plan.

copayment: The patient's part of the bill paid at the time of service. Copayments are usually flat fees for a particular service.

dependent: Any eligible member of a subscriber's family who is enrolled in Health Net and for whom monthly subscription charges/premiums are paid. Your Health Net *Group Hospital and Professional Service Agreement/Group Policy* will contain important limitations based on a dependent's age. Please read the document to fully understand your group's coverage.

effective date: In this manual, the effective date refers to the date on which a transaction becomes effective.

eligibility: The conditions which entitle an individual to enroll for coverage.

enrollment area: That portion of Health Net's service area established by Health Net for each PPG selected by the subscriber to assure reasonable access to care.

Evidence of Coverage (EOC): The *Evidence of Coverage* describes the benefits provided by Health Net, issued in connection with the *Group Hospital and Professional Service Agreement/Group Policy*. This booklet provides the subscriber with a complete statement of his or her benefits. (This term is used for HMO and point-of-service plans.)

existing dependent: An employee's spouse or child who is already a family member of the employee on the date of hire, or the date that the employee met any required probationary period or at the time of an open enrollment.

family member: For the purposes of enrolling in Health Net, a family member is defined as the subscriber, and any of the following: Legally married spouse or domestic partner. Unmarried dependent child including natural or adopted children, stepchildren, and other children for whom you or your spouse is the court-appointed guardian.

Group Hospital and Professional Service Agreement/Group Policy: The health care service agreement that exists between Health Net (or HNL) and the employer. This contract sets forth the terms and conditions between Health Net (or HNL) and the employer.

Health Net of California, Inc.: A federally qualified health maintenance organization, a California health care service plan and a subsidiary of Health Net, Inc.

Health Net Life Insurance Company (HNL): A disability (health) insurance carrier, and a subsidiary of Health Net.

hospital: A legally operated facility defined as a hospital and an institution licensed by the state and approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Medicare program.

Medicare: The name commonly used to describe Health Insurance Benefits for the Aged and Disabled provided under Public Law 89-97 as amended to date or as later amended.

member: Either a subscriber or dependent who is enrolled.

newly acquired dependent: A newly acquired dependent is a spouse or child who joins the employee's family after the employee was hired or met any required probationary period.

overage dependents: All Health Net *Group Hospital and Professional Service Agreements/Group Policies* contain provisions that limit the age to which children of the subscriber are eligible for coverage. Please check your *Group Hospital and Professional Service Agreement/Group Policy* for the specifics of your plan.

Participating Physician Group (PPG): A group of physicians, organized as a legal entity, that have an agreement in effect with Health Net to furnish medical care to Health Net members.

policyholder: The employer to which a policy has been issued.

qualified beneficiary: Anyone who, on the date of a qualifying event, is or was validly enrolled in this plan or any other group health plan your employer group sponsors.

service area (for HMO, EOA and POS): A PPG's service area is defined as a 30-mile radius from the PPG. Covered services outside the PPG service area are limited to emergency services only. Health Net's service area is the geographic area in the continental United States where Health Net has been authorized by the California Department of Corporations to provide HMO, EOA and POS benefits.

service area (for PPO): the United States.

small employer: An employer that meets the definition of small employer as described in Section 1357 of the California Health and Safety Code or Section 10700 of the California Insurance Code.

For Cal-COBRA Continuation, the following must also be true of the employer:

Employed fewer than 20 eligible employees who were eligible to enroll in the company's health plan on at least 50 percent of its working days during the preceding calendar year, has contracted for health care coverage through a group benefit plan offered by a health care service plan or a disability insurer, and is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C., Section 1161 et seq. (these describe federal COBRA).

subscriber: The employee whose employment allows eligibility under the plan. The subscriber is the person who is financially responsible for copayments, deductibles, coinsurance and charges for ineligible services for both him/herself and his or her dependents.

totally disabled: For the purposes of Health Net, the following definitions of total disability will apply:

A subscriber shall be considered totally disabled when, as a result of bodily injury or disease, such subscriber is unable to engage in any employment or occupation for which he or she is, or becomes, qualified by reason of education, training or experience and not, in fact, engaged in any employment or occupation for wage or profit.

A family member shall be considered totally disabled when such member is prevented from performing all regular and customary activities usual for a person of his or her age and family status.

We, us, our: Refers to Health Net.

Contact us

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