PRINCIPAL BENEFITS AND COVERAGE MATRIX – PPO

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

BENEFIT DESCRIPTION	PPO SIMPLECHOICE HSA NG		PPO SIMPLEVALUE 50 NG	
	IN-NETWORK YOU PAY[1]	OUT-OF-NETWORK YOU PAY[2]	IN-NETWORK YOU PAY[1]	OUT-OF-NETWORK YOU PAY[2]
Calendar year deductible	$4,000 single / $8,000 family All benefits, including outpatient prescription drugs, are subject to the deductible except preventive care. For contracts of two or more insureds, there are no benefits until the family deductible is met.		$0 (available as an applicant-only contract)	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM Preferred providers	$4,000 single / $8,000 family combined in- and out-of-network (includes deductible)		$7,500	
Non-preferred providers	$5,000 single / $10,000 family combined in- and out-of-network (includes deductible)		$10,000	
Lifetime maximum	Unlimited		Unlimited	
VISIT TO PHYSICIAN	Covered in full after deductible is met	50%	$50	50%
X-RAY AND LABORATORY PROCEDURES[3]	Covered in full after deductible is met	50%	50%	50%
PREVENTIVE CARE SERVICES (adult and child) Routine preventative services and immunizations[4]	Covered in full	Not covered	Covered in full	Not covered
Routine physical exam[5]	Covered in full after deductible is met	Not covered	50%	Not covered
MATERNITY AND PREGNANCY Prenatal and postnatal office visits	Not covered	Not covered	Not covered	Not covered
Maternity care in hospital	Not covered	Not covered	Not covered	Not covered
EMERGENCY AND URGENT CARE Emergency room (professional and facility charges)	Covered in full after deductible is met		$50 copay plus 50%	
Urgent care center (facility charges)	Covered in full after deductible is met		50%	
Ambulance[6]	Covered in full after deductible is met		50%	
HOSPITALIZATION SERVICES (NON-EMERGENCY CARE)[6] Surgeon and anesthetics services	Covered in full after deductible is met	50%	50%	50%
Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited)	Covered in full after deductible is met	50%[7]	$400 copay per day plus 50% (4-day copay maximum)	$400 copay per day plus 50%[7] (4-day copay maximum)

BENEFIT DESCRIPTION	PPO SIMPLECHOICE HSA NG		PPO SIMPLEVALUE 50 NG	
	IN-NETWORK YOU PAY[1]	OUT-OF-NETWORK YOU PAY[2]	IN-NETWORK YOU PAY[1]	OUT-OF-NETWORK YOU PAY[2]
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full after deductible is met	50%[7]	$400 copay plus 50%	$400 copay plus 50%[7]
Outpatient facility services	Covered in full after deductible is met	50%[7]	50%	50%[7]
REPRODUCTIVE HEALTH Sterilization	Covered in full after deductible is met	Not covered	50%	Not covered
OTHER SERVICES Rehabilitative therapy includes physical, speech, occupational, respiratory and cardiac therapy (20 visits per calendar year combined in- and out-of-network)[6]	Covered in full after deductible is met	Not covered	50%	50%
Chiropractic care (12-visit calendar year maximum combined in- and out-of-network / $20 maximum payable per visit)	Covered in full after deductible is met	Not covered	50%	Not covered
Mental health services for nonsevere conditions[6,8]	Covered in full after deductible is met[9]	50% inpatient / not covered outpatient	50% inpatient / 50% outpatient	50% inpatient / not covered outpatient
Durable medical equipment (including foot orthotics)[6]	Covered in full after deductible is met	Not covered	50%	Not covered
OUTPATIENT PRESCRIPTION DRUGS[10] Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies	Covered in full after deductible is met	Not covered	$750 brand deductible applies to Levels II and III $10 Level I (generic) $35 Level II (brand) $50 or 50% Level III (whichever is greater, non-formulary)	Not covered
Filled through mail order (up to a 90-day supply)	Covered in full after deductible is met	Not covered	Twice the level of copayment	Not covered

PPO FOOTNOTES

[1] Insured pays the negotiated rate, which is the rate the participating or preferred provider has agreed to accept for providing a covered service.

[2] Percentage is a portion of the covered expense based on maximum allowable amount. You are also responsible for any charges in excess of the covered expense.

[3] Calendar year deductible waived.

[4] Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); and comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents.

[5] For annual routine physical exams, the maximum payable per calendar year is $200.

[6] Certain services require prior certification from Health Net. Without prior certification, the benefit is reduced by 50%.

[7] Maximum allowable charges are $600 per day.

[8] Inpatient is $300 maximum allowable per day. Outpatient maximum payable is $30 per visit.

[9] Limited to $2,000 maximum payable per year.

[10] The Recommended Drug List is a list of the prescription drugs that are covered by this plan. It is prepared by Health Net and given to insured physicians and participating pharmacies. Some drugs require prior authorization from Health Net. Also, if your condition requires the use of a drug that is not in the Recommended Drug List, your physician may request the drug through the prior authorization process. Urgent prior authorization requests are handled within 72 hours. For a copy of the Recommended Drug List, call the Customer Contact Center at the number listed on your ID card or visit our website at www.healthnet.com.

HEALTH NET LIFE INSURANCE COMPANY

GUARANTEED ISSUE PLAN RATES EFFECTIVE FEBRUARY 1, 2011

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

(1 or +2 refers to the applicant's spouse and/or dependent children as defined in the Health Net Life Insurance Company PPO Policy.)

Region 1: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba counties

TIER	AGE	PPO SIMPLEVALUE 50 NG COMBO	PPO SIMPLECHOICE HSA NG
APPLICANT	under 15	316.00	316.00
	15–29	446.25	446.25
	30–34	559.00	559.00
	35–39	623.25	623.25
	40–44	673.50	673.50
	45–49	721.25	721.25
	50–54	888.50	888.50
	55–59	1,045.50	1,045.50
	60–64	1,045.50	1,045.50
APPLICANT + 1	under 15		608.00
	15–29		904.25
	30–34		1,037.25
	35–39		1,134.25
	40–44		1,257.50
	45–49		1,415.25
	50–54		1,686.50
	55–59		1,976.75
	60–64		1,976.75
APPLICANT + 2	under 15		892.00
	15–29		1,362.50
	30–34		1,627.75
	35–39		1,729.75
	40–44		1,767.25
	45–49		1,930.50
	50–54		2,177.25
	55–59		2,398.75
	60–64		2,398.75

Region 2: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma and Stanislaus counties

TIER	AGE	PPO SIMPLEVALUE 50 NG COMBO	PPO SIMPLECHOICE HSA NG
APPLICANT	under 15	285.75	285.75
	15–29	389.25	389.25
	30–34	475.25	475.25
	35–39	523.00	523.00
	40–44	575.00	575.00
	45–49	618.75	618.75
	50–54	745.25	745.25
	55–59	868.75	868.75
	60–64	868.75	868.75
APPLICANT + 1	under 15		566.25
	15–29		801.25
	30–34		911.00
	35–39		999.25
	40–44		1,103.50
	45–49		1,222.75
	50–54		1,459.75
	55–59		1,680.00
	60–64		1,680.00
APPLICANT + 2	under 15		883.75
	15–29		1,238.75
	30–34		1,487.00
	35–39		1,543.75
	40–44		1,573.25
	45–49		1,669.75
	50–54		1,873.75
	55–59		1,998.00
	60–64		1,998.00

Region 3: Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara counties

TIER	AGE	PPO SIMPLEVALUE 50 NG COMBO	PPO SIMPLECHOICE HSA NG
APPLICANT	under 15	296.00	296.00
	15–29	396.00	396.00
	30–34	490.50	490.50
	35–39	538.50	538.50
	40–44	590.50	590.50
	45–49	637.75	637.75
	50–54	768.25	768.25
	55–59	893.00	893.00
	60–64	893.00	893.00
APPLICANT + 1	under 15		562.00
	15–29		810.25
	30–34		941.25
	35–39		1,025.25
	40–44		1,125.00
	45–49		1,198.00
	50–54		1,426.50
	55–59		1,636.50
	60–64		1,636.50
APPLICANT + 2	under 15		888.75
	15–29		1,284.00
	30–34		1,502.75
	35–39		1,554.50
	40–44		1,623.50
	45–49		1,694.00
	50–54		1,893.50
	55–59		2,024.75
	60–64		2,024.75

Region 4: Orange, Santa Barbara and Ventura counties

TIER	AGE	PPO SIMPLEVALUE 50 NG COMBO	PPO SIMPLECHOICE HSA NG
APPLICANT	under 15	270.00	270.00
	15–29	373.00	373.00
	30–34	454.00	454.00
	35–39	497.75	497.75
	40–44	552.50	552.50
	45–49	591.75	591.75
	50–54	708.75	708.75
	55–59	826.75	826.75
	60–64	826.75	826.75
APPLICANT + 1	under 15		531.00
	15–29		767.25
	30–34		880.00
	35–39		951.75
	40–44		1,048.75
	45–49		1,182.00
	50–54		1,430.75
	55–59		1,647.00
	60–64		1,647.00
APPLICANT + 2	under 15		861.00
	15–29		1,225.00
	30–34		1,410.25
	35–39		1,465.00
	40–44		1,494.00
	45–49		1,587.25
	50–54		1,792.75
	55–59		1,919.25
	60–64		1,919.25

Region 5: Los Angeles County

TIER	AGE	PPO SIMPLEVALUE 50 NG COMBO	PPO SIMPLECHOICE HSA NG
APPLICANT	under 15	279.00	279.00
	15–29	379.50	379.50
	30–34	467.25	467.25
	35–39	514.50	514.50
	40–44	563.75	563.75
	45–49	608.50	608.50
	50–54	732.50	732.50
	55–59	854.50	854.50
	60–64	854.50	854.50
APPLICANT + 1	under 15		528.25
	15–29		781.00
	30–34		895.50
	35–39		983.50
	40–44		1,086.00
	45–49		1,186.50
	50–54		1,401.00
	55–59		1,610.75
	60–64		1,610.75
APPLICANT + 2	under 15		873.25
	15–29		1,272.25
	30–34		1,451.00
	35–39		1,499.50
	40–44		1,549.25
	45–49		1,631.75
	50–54		1,826.50
	55–59		1,946.25
	60–64		1,946.25

Region 6: Riverside, San Bernardino and San Diego counties

TIER	AGE	PPO SIMPLEVALUE 50 NG COMBO	PPO SIMPLECHOICE HSA NG
APPLICANT	under 15	266.75	266.75
	15–29	365.25	365.25
	30–34	443.00	443.00
	35–39	486.50	486.50
	40–44	538.50	538.50
	45–49	578.50	578.50
	50–54	692.75	692.75
	55–59	806.50	806.50
	60–64	806.50	806.50
APPLICANT + 1	under 15		513.50
	15–29		741.75
	30–34		853.50
	35–39		938.00
	40–44		1,035.00
	45–49		1,119.00
	50–54		1,327.50
	55–59		1,507.25
	60–64		1,507.25
APPLICANT + 2	under 15		827.75
	15–29		1,224.25
	30–34		1,399.00
	35–39		1,435.50
	40–44		1,479.50
	45–49		1,560.50
	50–54		1,731.75
	55–59		1,850.00
	60–64		1,850.00

Health Net®

Requested Effective Date

INDIVIDUAL & FAMILY PLANS
HIPAA PPO GUARANTEED ISSUE ENROLLMENT APPLICATION

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

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

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

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

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

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

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

A. Reason for Application

Family type

- ☐ Self
- ☐ Self and spouse/domestic partner
- ☐ Self and child
- ☐ Self and children
- ☐ Self, spouse/domestic partner and child(ren)
- ☐ **Please check box for domestic partner enrollment**

Enrollment type

☐ New enrollment ☐ Add dependent

B. Billing options

First premium payment (select one)

- ☐ Automated bank draft (Please complete the Simple Pay Option section on page 6.)
- ☐ Pay by check (Please include completed check and send with application. Amount must match monthly premium.)
- ☐ Credit card (Please complete the credit card section on page 6.)

Monthly premium payments (select one)

- ☐ Automated bank draft (Please complete the Simple Pay Option section on page 6.)
- ☐ Monthly bill
- ☐ Credit card (Please complete the credit card section on page 6.)

C. Choice of coverage

Health Net Life Insurance Company – 1st and 15th of the month effective dates are available.

- ☐ **HIPAA PPO SimpleChoice HSA**
- ☐ **HIPPA PPO SimpleValue 50**

PART II – APPLICANT INFORMATION

Primary Applicant's last name:	First name:	MI:	☐ Male ☐ Female
Home address:			
City:	State:	ZIP:	County Applicant resides in:
Home phone number: ( )	Work phone number: ( )	Email address:	
Primary Applicant's birth date (mo/day/year):	Primary Applicant's Social Security Number:		
In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No If "No," where was your last residence? _____			

Primary's Social Security Number

PART III – FAMILY MEMBER(S) TO BE ENROLLED

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

☐ Check here if supplemental page is attached.

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

Relation	Last Name, First Name, MI	Social Security #	Date of Birth	Primary Care Physician ID #	Current Patient	Physician Group ID #
☐ Husband ☐ Wife ☐ Domestic partner		– –	/ /		☐ Yes ☐ No	
Relation Child 1	**Last Name, First Name, MI**	**Social Security #**	**Date of Birth**	**Primary Care Physician ID #**	**Current Patient**	**Physician Group ID #**
☐ Son ☐ Daughter		– –	/ /		☐ Yes ☐ No	
Relation Child 2	**Last Name, First Name, MI**	**Social Security #**	**Date of Birth**	**Primary Care Physician ID #**	**Current Patient**	**Physician Group ID #**
☐ Son ☐ Daughter		– –	/ /		☐ Yes ☐ No	
Relation Child 3	**Last Name, First Name, MI**	**Social Security #**	**Date of Birth**	**Primary Care Physician ID #**	**Current Patient**	**Physician Group ID #**
☐ Son ☐ Daughter		– –	/ /		☐ Yes ☐ No	

PART IV – HIPAA GUARANTEED ISSUE COVERAGE

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

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

Primary's Social Security Number

PART V. APPLICANT'S AGENT/BROKER INFORMATION

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Health Net Broker ID: _____

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

Address: _____ Email address: _____

X _____ **X** _____

Applicant's Broker signature/number (required) **Date signed (required)**

Broker Certification

I, _____ (Name of Broker),

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

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

OR

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

Please answer all questions 1 through 4:

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

2) Did you personally witness the Applicant(s) sign the Application? ☐ Yes ☐ No

3) Did you review the Application after the Applicant(s) signed it? ☐ Yes ☐ No

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

If "Yes," please explain: _____

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

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

Health Net Qualified Interpreter – Please complete the following when assisted by a Health Net Qualified Interpreter.

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

☐ Do not read the language of this Application. ☐ Do not speak the language of this Application. ☐ Do not write the language of this Application.

☐ Other (explain): _____

A Qualified Interpreter assisted me with the completion of: ☐ The entire Application.

☐ Other (explain): _____

A Qualified Interpreter read this Application to me in the following language: _____

SIGNATURES AND DATE (REQUIRED IN INK)

SIGNATURE OF APPLICANT:	Today's date:
Date Application was interpreted:	Time Application was interpreted:
Qualified Interpreter number:	

Primary's Social Security Number

PART VI – continued

Qualified Interpreter other than a Health Net Qualified Interpreter – Please complete the following when assisted by a Qualified Interpreter other than a Health Net Qualified Interpreter.

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

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

As a Qualified Interpreter, I personally read and completed the Application for the Applicant named above because:

☐ Applicant does not read the language of this Application.
☐ Applicant does not speak the language of this Application.
☐ Applicant does not write the language of this Application.
☐ Other (explain): _____

Under the penalty of perjury, I declare that I read to the Applicant:
☐ The entire Application ☐ Other: _____

I read this Application to the Applicant in the following language: _____

Please provide the following information regarding the Qualified Interpreter who assisted the Applicant and who is not a Health Net Qualified Interpreter:

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

PART VII – CONDITIONS OF ENROLLMENT

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

Any fraudulent or willful nondisclosure or misrepresentation of material facts in Application materials is cause for disenrollment and rescission of the Insurance Policy, and Health Net may recoup from the Policyholder (or from you or from the Applicant) any amounts paid for covered services obtained as a result of such fraudulent or willful nondisclosure or misstatement of material fact. In addition, if a Policyholder makes a fraudulent or willful nondisclosure or misrepresentation of material facts on Application materials, Health Net shall have no liability for the provision of coverage under the Insurance Policy.

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

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

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an Applicant does not read the language of this Application and an interpreter assisted with the completion of the Application, the Applicant must sign and submit the **Statement of Accountability** (see PART VI of this Application "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability").