PRINCIPAL BENEFITS AND COVERAGE MATRIX – HMO

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

BENEFIT DESCRIPTION	HMO 15 NG	HMO 40 NG
Deductibles	$1,000 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies[1])	$1,500 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies[1])
Lifetime maximums	Unlimited	Unlimited
Out-of-pocket maximum (Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum.)	$3,000 single / $6,000 family (includes deductible)	$3,000 single / $6,000 family (includes deductible)
PROFESSIONAL SERVICES		
Visit to physician	$15	$40
Specialist consultations	$15	$40
Prenatal and postnatal office visits[2]	$15	$40
PREVENTIVE CARE		
Periodic health evaluations and annual preventive physical examinations[3]	$0	$0
Vision exams (for diagnosis or treatment)	$15	$40
Hearing exams (for diagnosis or treatment)	$15	$40
Immunizations – standard	$0	$0
Immunizations – to meet foreign travel or occupational requirements	20%	20%
Prostate cancer screening and exam	$0	$0
Well-woman exam (breast and pelvic exams, cervical cancer screening and mammography)[4]	$0	$0
Allergy testing	$15	$40
Allergy injection services	$15	$40
All other injections	Covered in full	Covered in full
Allergy serum	Covered in full	Covered in full
OUTPATIENT SERVICES		
Outpatient services other than surgery	Covered in full	Covered in full
Outpatient surgery	$250	$250
HOSPITALIZATION SERVICES		
Semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental disorder and chemical dependency treatment)	$1,000 deductible applies per calendar year for inpatient services	$1,500 deductible applies per calendar year for inpatient services
Surgeon or assistant surgeon services	Covered in full	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	$50 per day	$50 per day

For HMO footnotes, see page 7.

BENEFIT DESCRIPTION	HMO 15 NG	HMO 40 NG
HOSPITALIZATION SERVICES (continued)		
Maternity care in hospital or skilled nursing facility	$0 after inpatient hospital services deductible is met	$0 after inpatient hospital services deductible is met
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency and mental disorders)	Covered in full	Covered in full
EMERGENCY HEALTH COVERAGE		
Emergency room (professional and facility charges)	$75 (waived if admitted to hospital)	$100 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	$25	$40
AMBULANCE SERVICES		
Ground ambulance	$50	$80
Air ambulance	$50	$80
PRESCRIPTION DRUG COVERAGE		
$100 prescription deductible per member, per calendar year applies[1,5,6,7]		
Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[1]	$15 Level I (primarily generic); $25 Level II (primarily brand name, peak flow meters, inhaler spacers and diabetic supplies, including insulin); $50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)	$15 Level I (primarily generic); $25 Level II (primarily brand name, peak flow meters, inhaler spacers and diabetic supplies, including insulin); $50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Prescription drugs filled through mail order (up to a 90-day supply)[1]	$30 Level I (primarily generic); $50 Level II (primarily brand name and diabetic supplies, including insulin); $100 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)	$30 Level I (primarily generic); $50 Level II (primarily brand name and diabetic supplies, including insulin); $100 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com.)[1]	50%	50%
Contraceptive drugs[1]	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)

BENEFIT DESCRIPTION	HMO 15 NG	HMO 40 NG
DURABLE MEDICAL EQUIPMENT		
Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	50%	50%
Prosthesis[9]	Covered in full	Covered in full
MENTAL HEALTH SERVICES		
Severe mental illness and serious emotional disturbances of a child conditions[8]		
Outpatient	$15	$40
Inpatient	Covered in full	Covered in full
Other mental disorders[8]		
Outpatient (20-visit maximum each calendar year)	$30	$40
Inpatient (30-day maximum each calendar year)	Covered in full	Covered in full
CHEMICAL DEPENDENCY SERVICES		
Chemical dependency treatment	Not covered	Not covered
Acute care (detoxification)	$100 per day (unlimited)	$100 per day (unlimited)
HOME HEALTH SERVICES		
Home health services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	$15	$40
OTHER		
Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)[9]	$25	$25
Laboratory procedures and diagnostic imaging (including X-ray) services	Covered in full	Covered in full
Rehabilitative therapy (includes physical, speech, occupational and respiratory therapy)	$15	$40
Sterilizations – vasectomy	$150	$150
Sterilizations – tubal ligation	$150	$150
Organ and bone marrow transplants (non-experimental and non-investigational)	Covered in full	Covered in full
Hospice services	Covered in full	Covered in full
Family planning counseling	$15	$40

HEALTH NET OF CALIFORNIA, INC.

GUARANTEED ISSUE PLAN RATES EFFECTIVE JANUARY 1, 201

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.

Region 1: Los Angeles County

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,204	1,540
	1–4	438	414
	5–18	399	401
	19–24	688	496
	25–29	807	579
	30–34	997	727
	35–39	1,089	802
	40–44	1,157	843
	45–49	1,271	889
	50–54	1,419	1,050
	55–59	1,694	1,227
	60–64	1,694	1,227
SUBSCRIBER AND SPOUSE	19–24	1,377	992
	25–29	1,615	1,159
	30–34	1,995	1,455
	35–39	2,179	1,604
	40–44	2,315	1,686
	45–49	2,543	1,778
	50–54	2,839	2,101
	55–59	3,389	2,454
	60–64	3,389	2,454
SUBSCRIBER AND CHILD	19–24	1,203	963
	25–29	1,319	1,045
	30–34	1,504	1,191
	35–39	1,592	1,264
	40–44	1,657	1,305
	45–49	1,768	1,349
	50–54	1,819	1,451
	55–59	2,094	1,628
	60–64	2,094	1,628
SUBSCRIBER AND CHILDREN	19–24	1,628	1,373
	25–29	1,739	1,453
	30–34	1,922	1,599
	35–39	2,006	1,671
	40–44	2,067	1,710
	45–49	2,172	1,752
	50–54	2,218	1,853
	55–59	2,493	2,029
	60–64	2,493	2,029
FAMILY	19–24	2,317	1,870
	25–29	2,546	2,033
	30–34	2,920	2,327
	35–39	3,095	2,473
	40–44	3,224	2,553
	45–49	3,444	2,641
	50–54	3,638	2,903
	55–59	4,188	3,257
	60–64	4,188	3,257

Region 2: Merced, Sacramento, San Joaquin Sonoma, Stanislaus, Tulare, western El Dorado,[1] and western Placer[1] counties

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,478	1,659
	1–4	503	447
	5–18	447	433
	19–24	778	532
	25–29	924	620
	30–34	1,147	790
	35–39	1,249	861
	40–44	1,322	909
	45–49	1,445	958
	50–54	1,609	1,127
	55–59	1,922	1,315
	60–64	1,922	1,315
SUBSCRIBER AND SPOUSE	19–24	1,557	1,064
	25–29	1,849	1,241
	30–34	2,295	1,581
	35–39	2,499	1,723
	40–44	2,645	1,819
	45–49	2,890	1,917
	50–54	3,219	2,254
	55–59	3,845	2,631
	60–64	3,845	2,631
SUBSCRIBER AND CHILD	19–24	1,363	1,035
	25–29	1,504	1,122
	30–34	1,722	1,292
	35–39	1,817	1,361
	40–44	1,885	1,407
	45–49	2,002	1,455
	50–54	2,057	1,560
	55–59	2,369	1,749
	60–64	2,369	1,749
SUBSCRIBER AND CHILDREN	19–24	1,847	1,477
	25–29	1,982	1,564
	30–34	2,193	1,730
	35–39	2,284	1,800
	40–44	2,346	1,844
	45–49	2,458	1,890
	50–54	2,504	1,994
	55–59	2,816	2,182
	60–64	2,816	2,182
FAMILY	19–24	2,626	2,009
	25–29	2,907	2,184
	30–34	3,340	2,521
	35–39	3,534	2,662
	40–44	3,668	2,754
	45–49	3,903	2,849
	50–54	4,114	3,121
	55–59	4,739	3,498
	60–64	4,739	3,498

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

Region 3: Riverside, San Bernardino and Ventura counties

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,424	1,686
	1–4	474	436
	5–18	431	423
	19–24	742	537
	25–29	878	622
	30–34	1,084	800
	35–39	1,191	872
	40–44	1,263	924
	45–49	1,378	975
	50–54	1,552	1,145
	55–59	1,861	1,339
	60–64	1,861	1,339
SUBSCRIBER AND SPOUSE	19–24	1,485	1,074
	25–29	1,757	1,244
	30–34	2,169	1,601
	35–39	2,383	1,744
	40–44	2,526	1,849
	45–49	2,757	1,951
	50–54	3,104	2,291
	55–59	3,723	2,679
	60–64	3,723	2,679
SUBSCRIBER AND CHILD	19–24	1,302	1,031
	25–29	1,433	1,116
	30–34	1,635	1,293
	35–39	1,737	1,363
	40–44	1,805	1,414
	45–49	1,915	1,463
	50–54	1,983	1,569
	55–59	2,293	1,762
	60–64	2,293	1,762
SUBSCRIBER AND CHILDREN	19–24	1,761	1,465
	25–29	1,888	1,547
	30–34	2,085	1,722
	35–39	2,184	1,791
	40–44	2,247	1,841
	45–49	2,354	1,890
	50–54	2,415	1,992
	55–59	2,725	2,186
	60–64	2,725	2,186
FAMILY	19–24	2,504	2,002
	25–29	2,767	2,169
	30–34	3,170	2,522
	35–39	3,376	2,663
	40–44	3,510	2,765
	45–49	3,733	2,866
	50–54	3,967	3,138
	55–59	4,586	3,525
	60–64	4,586	3,525

Region 4: Alameda, Contra Costa, San Francisco, San Mateo, Santa Clara, Santa Cruz and Solano counties

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,714	1,897
	1–4	535	499
	5–18	432	486
	19–24	836	605
	25–29	997	712
	30–34	1,234	899
	35–39	1,337	986
	40–44	1,421	1,033
	45–49	1,543	1,098
	50–54	1,728	1,273
	55–59	2,075	1,506
	60–64	2,075	1,506
SUBSCRIBER AND SPOUSE	19–24	1,672	1,210
	25–29	1,995	1,424
	30–34	2,468	1,798
	35–39	2,675	1,972
	40–44	2,842	2,067
	45–49	3,087	2,196
	50–54	3,457	2,546
	55–59	4,151	3,012
	60–64	4,151	3,012
SUBSCRIBER AND CHILD	19–24	1,465	1,171
	25–29	1,621	1,276
	30–34	1,853	1,462
	35–39	1,951	1,547
	40–44	2,028	1,594
	45–49	2,145	1,657
	50–54	2,211	1,759
	55–59	2,558	1,992
	60–64	2,558	1,992
SUBSCRIBER AND CHILDREN	19–24	1,982	1,666
	25–29	2,133	1,769
	30–34	2,359	1,955
	35–39	2,451	2,038
	40–44	2,524	2,084
	45–49	2,636	2,145
	50–54	2,694	2,245
	55–59	3,041	2,478
	60–64	3,041	2,478
FAMILY	19–24	2,818	2,271
	25–29	3,131	2,482
	30–34	3,593	2,854
	35–39	3,789	3,024
	40–44	3,945	3,117
	45–49	4,180	3,243
	50–54	4,423	3,519
	55–59	5,117	3,984
	60–64	5,117	3,984

Region 5: Orange and San Diego counties

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,434	1,693
	1–4	474	436
	5–18	430	423
	19–24	739	537
	25–29	878	622
	30–34	1,082	790
	35–39	1,188	861
	40–44	1,244	909
	45–49	1,368	960
	50–54	1,543	1,132
	55–59	1,846	1,329
	60–64	1,846	1,329
SUBSCRIBER AND SPOUSE	19–24	1,479	1,074
	25–29	1,757	1,244
	30–34	2,165	1,581
	35–39	2,376	1,723
	40–44	2,488	1,819
	45–49	2,737	1,921
	50–54	3,087	2,264
	55–59	3,692	2,658
	60–64	3,692	2,658
SUBSCRIBER AND CHILD	19–24	1,298	1,033
	25–29	1,433	1,116
	30–34	1,633	1,283
	35–39	1,734	1,353
	40–44	1,785	1,399
	45–49	1,905	1,450
	50–54	1,973	1,555
	55–59	2,276	1,752
	60–64	2,276	1,752
SUBSCRIBER AND CHILDREN	19–24	1,757	1,465
	25–29	1,888	1,547
	30–34	2,082	1,713
	35–39	2,179	1,781
	40–44	2,227	1,825
	45–49	2,342	1,875
	50–54	2,403	1,978
	55–59	2,706	2,176
	60–64	2,706	2,176
FAMILY	19–24	2,497	2,002
	25–29	2,767	2,169
	30–34	3,165	2,504
	35–39	3,367	2,643
	40–44	3,471	2,735
	45–49	3,711	2,835
	50–54	3,947	3,111
	55–59	4,552	3,505
	60–64	4,552	3,505

Region 6: Fresno, Kern and Kings counties

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,400	1,689
	1–4	437	462
	5–18	443	448
	19–24	761	552
	25–29	912	651
	30–34	1,127	827
	35–39	1,230	911
	40–44	1,298	946
	45–49	1,424	1,008
	50–54	1,582	1,181
	55–59	1,892	1,373
	60–64	1,892	1,373
SUBSCRIBER AND SPOUSE	19–24	1,523	1,105
	25–29	1,825	1,302
	30–34	2,254	1,655
	35–39	2,461	1,822
	40–44	2,597	1,893
	45–49	2,849	2,016
	50–54	3,165	2,363
	55–59	3,784	2,747
	60–64	3,784	2,747
SUBSCRIBER AND CHILD	19–24	1,331	1,072
	25–29	1,479	1,169
	30–34	1,688	1,344
	35–39	1,788	1,426
	40–44	1,851	1,462
	45–49	1,972	1,521
	50–54	2,026	1,630
	55–59	2,335	1,822
	60–64	2,335	1,822
SUBSCRIBER AND CHILDREN	19–24	1,803	1,530
	25–29	1,946	1,625
	30–34	2,152	1,800
	35–39	2,247	1,880
	40–44	2,306	1,914
	45–49	2,422	1,972
	50–54	2,470	2,079
	55–59	2,779	2,271
	60–64	2,779	2,271
FAMILY	19–24	2,565	2,082
	25–29	2,859	2,276
	30–34	3,279	2,628
	35–39	3,478	2,791
	40–44	3,605	2,861
	45–49	3,847	2,980
	50–54	4,052	3,260
	55–59	4,671	3,644
	60–64	4,671	3,644

Region 7: Eastern El Dorado,[1] Marin, eastern Placer[1] and Yolo counties

TIER	AGE	HMO 15 NG	HMO 40 NG
SUBSCRIBER	<1	2,419	1,720
	1–4	513	484
	5–18	464	470
	19–24	804	586
	25–29	980	698
	30–34	1,203	892
	35–39	1,307	969
	40–44	1,373	1,014
	45–49	1,480	1,059
	50–54	1,642	1,235
	55–59	1,961	1,450
	60–64	1,961	1,450
SUBSCRIBER AND SPOUSE	19–24	1,608	1,173
	25–29	1,961	1,397
	30–34	2,407	1,785
	35–39	2,614	1,938
	40–44	2,747	2,029
	45–49	2,961	2,118
	50–54	3,284	2,471
	55–59	3,923	2,900
	60–64	3,923	2,900
SUBSCRIBER AND CHILD	19–24	1,397	1,128
	25–29	1,569	1,239
	30–34	1,788	1,431
	35–39	1,887	1,507
	40–44	1,948	1,552
	45–49	2,050	1,594
	50–54	2,106	1,706
	55–59	2,425	1,921
	60–64	2,425	1,921
SUBSCRIBER AND CHILDREN	19–24	1,893	1,608
	25–29	2,060	1,718
	30–34	2,274	1,909
	35–39	2,368	1,982
	40–44	2,424	2,026
	45–49	2,521	2,067
	50–54	2,570	2,177
	55–59	2,890	2,391
	60–64	2,890	2,391
FAMILY	19–24	2,697	2,194
	25–29	3,041	2,417
	30–34	3,478	2,801
	35–39	3,675	2,951
	40–44	3,797	3,041
	45–49	4,001	3,126
	50–54	4,212	3,413
	55–59	4,851	3,842
	60–64	4,851	3,842

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

Requested Effective Date

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

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

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT APPLYING FOR COVERAGE AND CAN BE COMPLETED BY THE APPLICANT FOR MINOR DEPENDENTS OR BY AN INTERPRETER FOR APPLICANTS WHO DO NOT READ/WRITE ENGLISH. NEITHER BROKER NOR ANY OTHER PERSON THAN 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 the last page of this application.)
- ☐ 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 the last page of this application.)

Monthly premium payments (select one)

- ☐ Automated Bank Draft (Please complete the "Simple Pay Option" section on the last page of this application.)
- ☐ Monthly bill
- ☐ Credit card (Please complete the credit card section on the last page of this application.)

C. Choice of coverage

Health Net of California – Only first-of-the-month effective date is available.

- ☐ **HIPAA HMO 15**
- ☐ **HIPAA HMO 40**

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:		
Primary care physician ID # (if applicable):	Current patient: ☐ Yes ☐ No	Physician group ID #:	In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No If "No," where was your last residence?

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

Primary's Social Security number

PART III – FAMILY MEMBER(S) TO BE ENROLLED

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

☐ Check here if supplemental page is attached.

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

Relation	Last name, First name, MI	Social Security #	Date of birth	Primary care physician ID #[1]	Current patient	Physician group ID #[1]
☐ Husband ☐ Wife ☐ Domestic partner		– –	/ /		☐ Yes ☐ No	
Relation – Child 1	**Last name, First name, MI**	**Social Security #**	**Date of birth**	**Primary care physician ID #[1]**	**Current patient**	**Physician group ID #[1]**
☐ Son ☐ Daughter		– –	/ /		☐ Yes ☐ No	
Relation – Child 2	**Last name, First name, MI**	**Social Security #**	**Date of birth**	**Primary care physician ID #[1]**	**Current patient**	**Physician group ID #[1]**
☐ Son ☐ Daughter		– –	/ /		☐ Yes ☐ No	
Relation – Child 3	**Last name, First name, MI**	**Social Security #**	**Date of birth**	**Primary care physician ID #[1]**	**Current patient**	**Physician group ID #[1]**
☐ 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: _____

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

Primary's Social Security number

PART V. 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** _____

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:	