*Health Net Health Plan of Oregon, Inc., "Health Net"*

Small Group

# Group Plan Contract Application

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

Medical insurance plans are offered by Health Net Health Plan of Oregon, Inc., "Health Net." Life/AD&D insurance plans are underwritten by Health Net Life Insurance Company. Dental PPO insurance plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by Dental Benefit Providers, Inc. (DBP). Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and serviced by Envolve Vision, Inc. Health Net Health Plan of Oregon, Inc., Health Net Life Insurance Company and Envolve Vision, Inc. are subsidiaries of Centene Corporation.

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

## WELCOME TO HEALTH NET

Simple steps for completing the form:

1. Carefully review and select the plan option(s) that is best for your business.
2. Make a copy of the completed application for your records. If a correction is needed, cross out and initial each correction. Please do not use a white-out product.
3. **Note:** Health Net auto-enrolls the employee and their eligible dependents who elect medical coverage into dental and/or vision coverage, if offered by their employer group. If an employee wishes to decline dental and/or vision coverage for an eligible dependent, the employee must complete the ***Declination of Coverage*** section of the ***Enrollment and Change Application***.

**Health Net Medical:** 1-888-802-7001

**Health Net Life:** 1-800-865-6288

**Health Net Dental:** 1-877-410-0176

**Health Net Vision:** 1-866-392-6058

| FOR EMPLOYER USE ONLY: |
| --- |
| **New Business/Group**<br>Please send all completed paperwork to your designated account executive or broker. |

health net

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**Important: If adding Dental or Vision to your existing coverage, please complete sections 2, 3, 4, 5, 6, 8, and 10; for all other changes to existing coverage, please complete only sections 2, 3, 4, and 8.**

## 1. Health plan information

| COMMUNITYCARE 1T[1] | PPO |
|---|---|
| **Platinum** ☐ CC1T15-500-1-3000DX ☐ CC1T20-750-2-3000DX | **Platinum** ☐ P10-250-1-4000LX ☐ P10-500-2-4000LX ☐ P10-750-2-4000LX |
| **Gold** ☐ CC1T25-1000-2-7900DX ☐ CC1T25-2000-2-7900DX ☐ CC1T25-3500-2-7900DX | **Gold** ☐ P50-0-5-5000 ☐ P0-1500-4-7900DX ☐ P0-3500-4-7900DX ☐ P20-500-3-7900DX ☐ P20-1000-2-7900DX ☐ P20-2000-2-7900DX ☐ P20-2500-3-7900DX ☐ P30-1500-2-7900DX ☐ P30-3500-3-7900DX |
| | **Silver** ☐ P20-5000-5-8150DX ☐ P40-3000-3-8150ES ☐ P40-4000-3-8150ES ☐ P45-3500-5-8150ES ☐ P45-5000-5-8150ES |
| **Silver** ☐ CC1T40-3000-3-8150ES ☐ CC1T40-4500-3-8150ES | **Bronze** ☐ P8250-0-8250ES |

| HIGH DEDUCTIBLE PPO | HEALTH INTEGRATION *(Only available with High Deductible PPO plans)* | HEALTH NET OREGON STANDARD PPO |
|---|---|---|
| **Silver** ☐ HD2800-2-5500ES ☐ HD3000-3-6750ES ☐ HD4000-3-6750ES | ☐ Yes ☐ No | ☐ Health Net Oregon Standard Gold Plan ☐ Health Net Oregon Standard Silver Plan ☐ Health Net Oregon Standard Bronze Plan |
| **Bronze** ☐ HD6900-0-6900ES | | |

| DENTAL | VISION | ALTERNATIVE CARE BUY-UP |
|---|---|---|
| ☐ Plus D50-1855-1500 ☐ Value D50-185-1500V ☐ Preferred Plus DP50-1855-1500 ☐ Essentials D50-16-500 | ☐ Elite 1010-1 ☐ Preferred 1025-2 ☐ Preferred 1025-3 | ☐ Alt Care Buy-Up 1 ☐ Alt Care Buy-Up 2 ☐ Alt Care Buy-Up 3 w/OON |

**PEDIATRIC DENTAL COVERAGE**

Purchasing pediatric dental coverage with Health Net? ☐ Yes ☐ No *(I confirm that I am purchasing pediatric dental coverage with another carrier as required by ACA mandate.)*

**LIFE AND AD&D OPTIONS (IF HEALTH NET LIFE IS SELECTED, ALL FULL-TIME EMPLOYEES ARE ELIGIBLE.)**

☐ $15,000 *(all employees)* ☐ $25,000 *(15–50 employees)* ☐ $50,000 *(25–50 employees)*

## 2. Employer group information

| | | | |
|---|---|---|---|
| Company name: | Group #: | | SIC code: |
| DBA name: | | | |
| Tax ID number *(TIN)*: | Type of business: | | |
| Type of entity *(corporation, sole prop., LLC, partnership)*: | How long in business: | | Effective date: |
| Company contact *(administrative contact)*: | Telephone: | Fax: | |
| Administrative email: | | | |
| Physical address: | City: | State: | ZIP: |
| Billing contact name *(list 'same' if the same as administrative contact)*: | | Telephone: | |
| Billing address *(if different from physical address)*: | City: | State: | ZIP: |
| Billing contact email *(if different from administrative)*: | | | |
| Company contact for coordination of benefits (COB) *(if different from above)*: | Telephone: | Email: | |
| COB address *(if different from physical address)*: | City: | State: | ZIP: |

## 3. Employer contribution (Note: Employer contribution for Health is a minimum of 50% of the lowest cost plan and for Life is 100% (2–9 enrollees) and 50% (10–50 enrollees).)

| | | | |
|---|---|---|---|
| Employee Health: _____% or $_____ | Employee Dental: _____% or $_____ | Employee Vision: _____% or $_____ | Employee Life: _____% or $_____ |
| Dependent Health: _____% or $_____ | Dependent Dental: _____% or $_____ | Dependent Vision: _____% or $_____ | |

**Note:** If you select Dental and/or Vision with no contribution, indicate "0."

## 4. Monthly rates. Please attach a copy of the sold rates.

Oregon Small Employer Group rates are guaranteed for 12 months from the effective date, except for any government mandated benefits or tax changes. Rates are also based on actual group enrollment and may differ from quoted rates if there is a change in group composition.

## 5. Eligibility information

1. Will there be eligibility conditions that will apply prior to the probationary period *(e.g., being in an eligible job classification, achieving job-related licensure requirements, or satisfying a "reasonable and bona fide employment-based orientation period")*? ☐ Yes ☐ No

2. Employer's probationary period for new hires/rehires – first of the month following: ☐ Date of hire ☐ 1 mo. ☐ 30 days ☐ 60 days*

   *Health Net will adjust the effective date for new enrollees if needed to ensure that the waiting period does not exceed 90 days.

3. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No

4. Average number of hours worked per week required to be eligible for medical insurance coverage: _____

5. How many employees are there as of the effective date of coverage?_____
   *An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.*[2]

6. Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: _____
   *To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.*

7. Total number of employees worldwide: _____
   *Count all employees throughout the U.S. regardless of if they are eligible for coverage, including full-time, part-time, leased, etc. Do not include 1099 employees or seasonal workers.*

| | MEDICAL | LIFE | DENTAL | VISION |
|---|---|---|---|---|
| 8. Number of eligible employees *(including eligible owner(s))*: *(Note: question 8 should equal questions 9 + 10+ 11)* | _____ | _____ | _____ | _____ |
| 9. Number of active enrollees *(excluding COBRA enrollees)*: | _____ | _____ | _____ | _____ |
| 10. Number of COBRA enrollees *(applying for health coverage)*: | _____ | **N/A** | _____ | _____ |
| 11. Number of waivers *(Please include an enrollment form with Section 7 "Declination of Coverage" indicated.)*: | _____ | _____ | _____ | _____ |

*(continued)*

## Eligibility information (continued)

12. What type of Continuation are you subject to? ☐ Federal COBRA[3] ☐ State Continuation

13. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No

14. Do the eligible enrollees represent a carve-out either by location or union affiliation? ☐ Yes ☐ No

15. Does the group file a Form 132? ☐ Yes ☐ No

16. Is the group subject to ERISA? ☐ Yes, month: _____ ☐ No

*(Note: Federal, state and local governments, as well as church plans, are not subject to ERISA requirements.)*

17. Are you part of a controlled group?[4] ☐ Yes ☐ No

18. If you are a part of a controlled group, who is the employer for purposes of filing taxes? _____

19. How many full-time equivalent employees were in the group during the prior calendar year? _____
*(For the purposes of determining eligibility, employers must have one common law employee at the time of enrollment.)*

## 6. Current carrier (List current carrier if any.)

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

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

Current health insurance carrier:_____ Current carrier policy number: _____

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

Plan(s) offered: _____

Name of workers' compensation carrier: _____

Number of enrollees not covered by workers' compensation: _____

List the names of enrollees not covered by workers' compensation: _____

*(Employers required to have workers' compensation must have a policy in effect to be eligible with Health Net. 24-hour coverage is provided for sole proprietors, partners and corporate officers of the Employer Group who are not subject to mandatory workers' compensation coverage.)*

## 7. Underwriting criteria

**General conditions**

The subscriber group must employ at least one eligible employee for enrollment and must be an Oregon small employer as defined by Oregon and/or federal regulations. Eligibility rules must be the same for medical and dental enrollment. All enrolled employees must have a bona fide partnership, independent contractor, or employer-employee relationship with the subscriber group. If the subscriber group includes leased employees and independent contractors under the health plan, all leased employees and independent contractors must be covered.

Health Net is not required to be sole carrier as long as participation guidelines are met. Eligible employees waiving coverage due to group coverage through another employer *(e.g., spousal coverage)* will not count against participation.

The issuance of coverage and a Group Plan Contract is subject to underwriting review and approval by Health Net and receipt of the first month's premium. The initial quoted rates are subject to Health Net's review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by Health Net as appropriate within specified time requirements. A member's coverage terminates the last day of the month in which that member ceases to be eligible under group eligibility provisions. There will be one open enrollment period per contract year. The period will be for 30 days prior to the renewal effective date.

## 8. Subscriber group statement and other important terms

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

This is an application only. Coverage and the issuance of a Group Plan Contract is subject to review and approval by Health Net and receipt of the first month's premium.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to Health Net. Should it be determined at the time of enrollment or during the 24-month period after the Group Plan Contract is issued that there has been an intentional misrepresentation of material fact, as prohibited by the terms of this Group Plan Contract, the Group Plan Contract may be canceled with 30 days' advance notice of such cancellation.

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

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the Group Plan Contract and to forward such amounts in advance of the due date to Health Net, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group and deletions from the group. Please return this application to your Health Net account executive or producer as specified.

Applicant, in the event this application is accepted, agrees to cooperate with Health Net in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information for obtaining the Health Net "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" by going to www.healthnetoregon.com/sbc and agrees to assume the responsibilities assigned to the "Group" thereunder. The undersigned hereby acknowledges responsibility for sending an electronic or printed copy of the Summary of Benefits and Coverage document (SBC) to plan participants and beneficiaries.

The following standard minimum participation and contribution requirements apply unless modified in quote or renewal Underwriting Assumptions.

Minimum contribution is defined as: The employer contribution toward Health Net's premium must be equal to or greater than 50%.

Minimum participation is defined as: For groups of 1–5 eligible employees, a minimum of 66% participation is required. For groups of 6–50 eligible employees, a minimum of 50% participation is required.

Failure to maintain these minimum contribution and minimum participation requirements may result in termination or non-renewal.

This Application for Group Plan Contract and any attached Addendum, together with the Health Net Plan Contract or Insurance Policy (as referenced herein), and the employee enrollment forms form the entire agreement between the parties in order to provide eligible enrolled employees and eligible enrolled dependents with the health care benefits as specified in the Plan Contract or Insurance Policy. The Agreement may be amended with the mutual written consent of the Subscriber Group and Health Net at any time, subject to state and federal regulations.

| Officer of the company signature: | Officer of the company printed name: | Officer title: | Date: |
|---|---|---|---|
| | | | |

**Applicant's signature above confirms to the best of their knowledge or belief:**
**1) Applicant's agreement to all the terms and conditions set out in this Application, including the conditions of enrollment and Underwriting Assumptions; and 2) the accuracy and completeness of the information that the Applicant has entered in this Application.**

## 9. Producer information and certification

**PRODUCER 1**

| | | | |
|---|---|---|---|
| Producer name: | | Health Net Producer ID #: | |
| Department of Insurance license #: | | Tax ID #: | Agent NPN #: |
| Agency name: | Phone #: | Fax #: | |
| Address: | City: | State: | ZIP: |
| Email: | | | |
| Producer commission split: | | | |

**PRODUCER 2 (ONLY REQUIRED IF SPLITTING COMMISSION)**

| | | | |
|---|---|---|---|
| Producer name: | | Health Net Producer ID #: | |
| Department of Insurance license #: | | Tax ID #: | Agent NPN #: |
| Agency name: | Phone #: | Fax #: | |
| Address: | City: | State: | ZIP: |
| Email: | | | |
| Producer commission split: | | | |

I certify that all information contained in this application is correct to the best of my knowledge. I also certify that this firm is a bona fide business establishment or is otherwise eligible to contract for insurance coverage in the State of Oregon. All participation requirements have been explained and the minimum participation requirements have been met. Coverages, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer. Deductibles, copayments and coinsurance *(if applicable)* have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

**Note: If you are not currently appointed by Health Net, commissions will not be paid. An active license confirmation and formal appointment with Health Net, prior to the group plan's effective date, is required to receive commissions payment.**

Producer 1 signature: _____ Date: _____

Producer 2 signature *(if applicable)*: _____ Date: _____

## 10. For Health Net use only

| | | |
|---|---|---|
| Account executive signature: | Name: | Date: |

## SMALL BUSINESS GROUP SUBMISSION TIMELINE

We must receive fully-completed new group applications in-house by **the 20th of the month** in order to set up a group's coverage to be effective the first of the following month.

## FULL-TIME EMPLOYEES (FTES)

The total number of employees, full-time and part-time, who work an average of 30 hours or more a week.

When counting employees to determine group size, temporary, seasonal, leased, and contracted employees are excluded.

In answering the questions about employees, an owner is generally not considered an employee even if the owner performs services for the business for compensation; however, an owner may participate in a group plan as long as the group employs at least one common law employee. An owner includes:

- **A sole proprietor and the sole proprietor's spouse;**
- **A member of a single-member limited liability company and the member's spouse;**
- **The owner of a wholly owned corporation and the owner's spouse.**

**FTE counting instructions:**

**A.** Count each employee working 30 hours or more as 1 FTE.

**B.** Total the hours worked per week by all employees working less than 30 hours, and divide by 30.

**C.** Add the numbers from A and B together. This is your FTE count.

You may also use the FTE calculator at healthcare.gov: **https://www.healthcare.gov/shop-calculators-fte/**

## BENEFIT-ELIGIBLE EMPLOYEES

The total number of employees eligible for coverage as determined by the employer.

**Dependents:** Legal spouse, domestic partner, and child(ren), from birth to age 26, of employee, spouse or domestic partner.

**Newly eligible employees – first day of the month following date of eligibility**

Definition of "newly eligible employee":

- **Part-time employee who has been employed for the length of the probationary period and is moving to regular, full-time employee**
- **Transfer who has been employed for the length of the probationary period**
- **Laid-off employee rehired within 9 months**
- **Other (must be pre-approved by Underwriting)**

**Definition of "newly eligible dependents":** For child: date of birth or placement for adoption. For spouse, domestic partner and stepchild(ren): first day of the month on or following the date of marriage or certification of domestic partnership.

[1]Available to employer groups located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties. Available to employees in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.

[2]This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.

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

[4]Controlled and Affiliated Groups means groups that are commonly controlled and/or affiliated as described in subsection (b), (c), (m), or (0) of section 414 of the Internal Revenue Code of 1986. If a group is a controlled or affiliated group of employers, a carrier must treat the group as a single group, and the controlled group must complete one group profile form. Controlled Groups include parent-subsidiary, brother-sister and the combination of both of the preceding.