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

Small Group

2022 Renewal Election Form

Your broker and Health Net Health Plan of Oregon, Inc., "Health Net" account manager may have provided you with additional renewal proposals to help you choose the best coverage for your group. To help us serve you better, please provide the quote number of the renewal proposal you are accepting. The quote number can be found on the cover page and in the header of the renewal proposal pages.

QUOTE #: _____ **RENEWAL EFFECTIVE DATE #:** _____

1. Employee information

New hire waiting period *(Please check the waiting period for new hires. Federal law prohibits waiting periods beyond 90 days.)*
First of the month following: ☐ Date of hire ☐ 30 days ☐ 1 month ☐ 60 days

On a typical business day, how many employees are eligible for health benefit plan coverage *(count all employees throughout the U.S.)*?
Total eligible employees: _____ In-state employees: _____ Out-of-state employees: _____

Total worldwide employees: _____
(Count all employees regardless of if they are eligible for coverage. Include full-time and part-time employees. Do not include 1099 and seasonal employees.)

What type of COBRA[1] are you subject to? ☐ Federal COBRA ☐ State Continuation

Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for 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]
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 *(or # of months in business if less than 12 months)*. Round up or down to the nearest whole number – example: 30.5 = 31. Do not spell out the number – example: write 30, not thirty.

How many full-time employees were in the group during the prior calendar year? _____

How many full-time equivalent employees were in the group during the prior calendar year? _____

How many employees are there as of the effective date of coverage? _____
(For the purposes of determining eligibility, employers must have one common law employee at the time of enrollment.)

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.)

Are you a part of a controlled group *(see definition on page 3 of this form)*? ☐ Yes ☐ No
If "Yes," who is the employer for purposes of filing taxes? _____

2. Medical plan offerings (Select the plans and contribution you wish to offer. All medical plans include pediatric vision coverage.)

Employer monthly contribution percentage? Employee: _____% Dependent: _____%

COMMUNITYCARE 1T

☐ CC1T15-500-1-3000DX	☐ CC1T25-1000-2-7900DX	☐ CC1T25-3500-2-7900DX	☐ CC1T40-4500-3-8150ES
☐ CC1T20-750-2-3000DX	☐ CC1T25-2000-2-7900DX	☐ CC1T40-3000-3-8150ES	

PPO

☐ Platinum P10-250-1-4000LX	☐ Gold P0-3500-4-7900DX	☐ Gold P30-1500-2-7900DX	☐ Silver P45-3500-5-8150ES
☐ Platinum P10-500-2-4000LX	☐ Gold P20-500-3-7900DX	☐ Gold P30-3500-3-7900DX	☐ Silver P45-5000-5-8150ES
☐ Platinum P10-750-2-4000LX	☐ Gold P20-1000-2-7900DX	☐ Silver P20-5000-5-8150DX	☐ Bronze P8250-0-8250ES
☐ Gold P50-0-5-5000	☐ Gold P20-2000-2-7900DX	☐ Silver P40-3000-3-8150ES	
☐ Gold P0-1500-4-7900DX	☐ Gold P20-2500-3-7900DX	☐ Silver P40-4000-3-8150ES	

HIGH DEDUCTIBLE PPO

☐ Silver HD2800-2-5500ES	☐ Silver HD4000-3-6750ES
☐ Silver HD3000-3-6750ES	☐ Bronze HD6900-0-6900ES

HIGH DEDUCTIBLE PPO - INTEGRATED HSA

☐ Yes
☐ No

HEALTH NET OREGON STANDARD PPO

☐ Health Net Oregon Standard Gold Plan ☐ Health Net Oregon Standard Silver Plan ☐ Health Net Oregon Standard Bronze Plan

3. Supplemental renewal offering

(Select the plans you wish to offer – only 1 dental, 1 vision and 1 alternative care plan may be checked.)

REMINDER: 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 during open enrollment, then the employee must complete the *Declination of Coverage* section of the *Enrollment and Change Application*. If an employee does not wish to decline dental and/or vision coverage for their eligible dependents during open enrollment, then they will have that coverage during their plan year. Employees can only make changes to their coverage during their open enrollment period or based upon a qualifying event.

DENTAL

☐ Plus D50-1855-1500 ☐ Value D50-185-1500V ☐ Preferred Plus DP50-1855-1500 ☐ Essentials D50-16-500

VISION

☐ Elite 1010-1 ☐ Preferred 1025-2 ☐ Preferred 1025-3

ALTERNATIVE CARE

☐ Alt Care Base *(included)* ☐ 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.)*

I/We have reviewed and understand my/our medical plan renewal notification along with the following informational pieces provided by Health Net. After reviewing the renewal information, by my/our signature below, I/we confirm that I/we intend to renew my/our health benefit plan(s).

I/We understand that Health Net is relying on my/our answers to the above questions to determine if my/our group meets the definition of a small employer group as defined by the State of Oregon. I/We also understand that the final rates will be based on the actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify the eligibility of the group.

Policyholder name:		
Policyholder/Case ID *(located on the cover page and header of renewal proposal pages)*:		
Physical address:		
City:	State:	ZIP:
Billing address:		
City:	State:	ZIP:
Company authorized representative *(please print)*:	Title:	
Signature:	Date:	
Email address:	Phone:	
Broker:		

This form must be completed and returned to your Health Net account manager in order to perform renewal election changes. If the completed form is not received by Health Net by the 10th of the month prior to the effective date of your renewal, your health benefit plan(s) will be auto-renewed to the closest matching plan(s).

ADDITIONAL INFORMATION WHEN COMPLETING THE EMPLOYER GROUP QUESTIONNAIRE

If an employer has more than 50 full-time equivalent (FTE) employees, Health Net may provide the employer a quote as a large group. Health Net must treat the employer as a small group if the employer has at least one but not more than 50 FTEs.

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.

CONTROLLED AND AFFILIATED GROUPS

Controlled and Affiliated Groups means groups that are commonly controlled and/or affiliated as described in subsection (b), (c), (m), or (o) 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.

FTE EMPLOYEES

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

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.

[1]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.

[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.

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