Health Net®

Large Business Application

For Oregon Groups (51+ employees)

Subscriber Group information

Full legal name of employer – hereafter known as Subscriber Group (include punctuation and abbreviations):		Group number:
DBA:	Phone:	Fax:
Physical address (street address, city, state, ZIP):		Effective date:
Billing address (if different than the above address):		Anniversary date:
Subsidiary/affiliated companies and other employer locations:		Federal tax ID/EIN:
Group benefits administrator name and title:		Administrator telephone:
Group benefits administrator address:		Administrator email address:
Billing contact name and title:		Billing contact telephone:
Billing contact address:		Billing contact email address:
COBRA administrator contact name and title:		COBRA administrator contact telephone:
COBRA administrator contact address:		COBRA administrator contact email address:
Workers' compensation carrier name:		Policy number:

Type of organization

☐ Corporation	☐ Association (as defined by ORS 743.522)*	Nature of business:
☐ Sole proprietorship	☐ Trust (as defined by ORS 743.522)*	
☐ Partnership	☐ Discretionary group (as defined by ORS 743.522)*	Date of business inception:
☐ Other (describe): _____		SIC code:

***Is the association/trust/discretionary group filed and approved with the Division of Financial Regulation as a group policyholder?**

☐ Yes, current Division of Financial Regulation Approval #: _____

☐ No ☐ N/A

(continued)

Type of organization (continued)

Is the group subject to ERISA? Generally, ERISA applies to all employer health plans. Sole proprietors or partnerships that do not have any employees may not be subject to ERISA. The Subscriber Group must notify Health Net as changes in ERISA status occur.

☐ Yes, ERISA plan year begins in the month of: _____

☐ No, government or public plan or church plan

☐ No, other reason (please specify): _____

Eligibility information

This provision may only be changed at the time of the group contract renewal each year.

Employees: Regular, active, full-time employees scheduled to work at least _____ hours/week (must be at least 17.5 hours)

☐ Dependents: Legal spouse, Registered Domestic Partner, and child(ren), from birth to age 26, of employee spouse or Registered Domestic Partner	Include non-registered domestic partners as dependents: ☐ Yes ☐ No

☐ Local government retirees

"Local government" means any city, county, school district, or other special district in this state.

"Retired employee" means a former officer or employee of a local government who is retired for service or disability, and who received or is receiving retirement benefits under the Public Employees Retirement System or any other retirement system or plan applicable to officers and employees of the local government.

Other classification, e.g., early retirees.

(Group size requirements apply. Must be approved by Underwriting.): _____

Employers' probationary period

Employees must enroll within 31 days of becoming eligible.

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

Newly hired employees: First day of the month on or following: ☐ date of hire ☐ 30 days from date of hire ☐ 60 days from date of hire.

Newly eligible employees: First day of the month following date of eligibility. ☐ Yes ☐ No

Definition of "newly eligible employees" (check all that apply):

☐ Part-time to regular, full-time employee. Specify number of hours: _____

☐ Rehired former employee. Rehired within _____ days or _____ months; cannot exceed 9 months. Employees terminated by reason of layoff are not subject to any waiting period if rehired within 9 months.

☐ Transfer

☐ Other (Must be pre-approved by Underwriting.): _____

Definition of "newly eligible dependents":

For child: Date of birth or placement for adoption.

For spouse, Registered Domestic Partner and stepchild(ren): First day of the month on or following the date of marriage or certification of Registered Domestic Partner.

Waive eligibility waiting period (for new groups only)

Do you want to waive the eligibility waiting period for all current employees?

☐ Yes, all current employees will be eligible for benefits as of the effective date.

☐ No, current employees who have not completed the probationary period must finish serving the probationary period.

(continued)

Coverage applied for – Please indicate name of plan chosen (for example, A15-250-2-4000).	
☐ PPO: ☐ PPO HDHP Integrated HSA: ☐ PPO Integrated HRA: Select one of the following for HRA: ☐ Option A ☐ Option B ☐ Option C	☐ Triple Option: ☐ EPO[1]: ☐ Prescription: ☐ WellNet buy-up:
☐ CommunityCare 1T: ☐ CommunityCare 3T:	☐ CommunityCare 1T HDHP: ☐ CommunityCare 3T HDHP:
☐ Dental:	☐ Vision:
☐ Other riders:	

Monthly rates (including riders)
Three-tier: ☐ Employee: _____ ☐ Employee + 1 dependent: _____ ☐ Employee + family: _____
Four-tier: ☐ Employee: _____ ☐ Employee + spouse: _____ ☐ Employee + child(ren): _____ ☐ Employee + family: _____
Employer contribution *The employer must contribute at least 50% of the cost of employee coverage.*
Employee coverage: _____ % of monthly rate OR $ _____ toward monthly rate
Dependent coverage: _____ % of monthly rate OR $ _____ toward monthly rate

Additional details

Participation requirements

Standard minimum participation and contribution requirements below apply unless modified in quote or renewal Underwriting assumptions. All enrolled employees must have a bona fide employee relationship with the Employer Group. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all eligible employees must enroll in the plan. If more than one health plan is offered, Health Net's enrollment represents at least 38% of the eligible employee population. If employer contributes 100% of the employee premium, 100% of employees must enroll in the plan. A Refusal of Coverage/Waiver must be submitted for all employees and dependents declining coverage. The employer must contribute at least 50% of the cost of the employee coverage. Eligible employees must be regular, full-time employees. Failure to maintain these minimum contribution and minimum participation requirements may result in termination or nonrenewal.

(continued)

[1]Exclusive Provider Organization.

Enrollment information

Due to Medicare Secondary Payor reporting requirements, enter the total number of worldwide employees employed by the company/companies applying for coverage: _____

Please note: Federal regulations require you to promptly notify Health Net if the number of employees changes between the ranges of 0–19, 20–99, 100+.

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. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.

If you are part of a multi-employer group health plan and you want Medicare to be primary, has CMS approved a Small Employer Exception for your group? ☐ Yes ☐ No

Number of employees who work a regular schedule of 17.5 hours or more per week on the date coverage is to take effect. (Eligible employees do not include employees who work on a temporary, seasonal or substitute basis.): _____

Number of employees eligible to enroll in the plan per eligibility provisions set by the Subscriber Group: _____

Number of employees enrolling: _____
A Refusal of Coverage/Waiver is included for all eligible employees not enrolling: ☐ Yes ☐ No

Number of dependents enrolling: _____
A Refusal of Coverage/Waiver is included for all eligible dependents not enrolling: ☐ Yes ☐ No

Total number of employees waiving coverage: _____

24-hour coverage

24-hour coverage is provided for sole proprietors, partners and corporate officers of the Subscriber Group who are not subject to mandatory workers' compensation coverage. 24-hour coverage does not extend to any family member who is not also a sole proprietor, partner or corporate officer of the Subscriber Group. The name and title of an individual eligible for 24-hour coverage must be provided at the time of group or individual enrollment.

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Other current coverages

Is this coverage replacing a current group medical plan? ☐ Yes ☐ No

If "Yes," please list the name and policy number of the current carrier: _____

Is other group coverage(s) offered? ☐ Yes ☐ No

If "Yes," please list the carriers and coverages offered: _____

If "Yes," confirm rate structure is similar amongst all carriers: ☐ Yes ☐ No

[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.

(continued)

Subscriber Group statement

1. We wish to enroll as a group account with Health Net Health Plan of Oregon, Inc. (referred to herein as the Plan). It is understood that the coverage will not be in effect until the application has been accepted by the Plan.
2. We understand the eligibility rules applicable to employee enrollment and guaranteed renewability except for nonpayment and other reasons allowed by Oregon law. Failure to maintain these minimum contribution and minimum participation requirements may result in termination or nonrenewal.
3. We agree, in the event this application is accepted, to cooperate with the Plan 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 provided by the Plan's "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder.
4. We understand premiums are prepaid and are due no later than the first day of each month.
5. We understand a member's coverage terminates the last day of the month in which that member ceases to be eligible under group eligibility provisions.
6. We understand that there will be one open enrollment period per contract year. The period will be for 30 days prior to the renewal effective date.
7. We enclose the amount of $_____ as a deposit on the first month's premium (minimum deposit of 90% of premium). Upon acceptance of the application by the Plan, we promise to pay the Plan any balance necessary to constitute full initial payment for the group benefits identified in this application.
8. Applicant's signature below confirms: a) Applicant's agreement to all the terms and conditions set out in this Application, including the Conditions of Enrollment and Underwriting Assumptions; and b) the accuracy and completeness of the information that the Applicant has entered in this Application.

The Agreement, consisting of the Plan Contract to be issued as the description of coverage and supplemented by this Group Application, has been entered into between Health Net Health Plan of Oregon, Inc. and the Subscriber Group in order to provide eligible enrolled employees and eligible enrolled dependents with the health care benefits as specified in the Plan Contract. The Agreement may be amended with the mutual written consent of the Subscriber Group and Health Net Health Plan of Oregon, Inc. at any time, subject to state and federal regulations.

Subscriber Group	*Health Net Health Plan of Oregon, Inc.*
Executed at: _____, Oregon.	Executed at: Tigard, Oregon.
Date accepted:	Date accepted:
Signature of authorized Subscriber Group representative:	Signature of authorized Plan representative:
Print name:	Print name:
Title:	Title:

(continued)

Producer statement

I certify that all information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business establishment or is otherwise eligible to contract for insurance coverage in the State of Oregon.
2. All participation requirements have been explained, and the minimum participation requirements have been met.
3. Coverages, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer.
4. Deductibles, copayments and coinsurance (if applicable) have been fully explained and understood by the employer.
5. 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 licensed by the State of Oregon and appointed by Health Net Health Plan of Oregon, Inc., attach an executed copy of Health Net's producer agreement and your current license. Commissions will not be paid prior to licensing and formal appointment.

Producer signature: _____ **Date:** _____

Producer of record (print name): _____ Producer number: _____

Name of firm/agency: _____ Email address: _____

Commission level: _____ Telephone number: _____

Split commission – Secondary producer commission percentage:

Secondary producer (print name): _____ Secondary producer number: _____

For office use only	**AE:**	**AM:**	
	Size:	**Region:**	**RMC:**

Health Net Health Plan of Oregon, Inc., 13221 SW 68th Pkwy., Ste. 200, Tigard, Oregon 97223 • 1-888-802-7001 • www.healthnet.com

Health Net

Health Net Health Plan of Oregon, Inc. (Health Net)

Ensure Your Employees Understand *Their Health Care* Coverage

Summary of Benefits and Coverage to eligible and covered persons

Instructions for reproduction and distribution.

Affordable Care Act (ACA) requirement for employers that sponsor group health plans

As required by the ACA, health plans and employer groups must provide the *Summary of Benefits and Coverage* (SBC)[1] to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA Continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in paper or electronic form (i.e., email or Internet posting).

Paper SBC

- If you provide a paper copy, the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on *four double-sided pages*.
- If you mail a paper copy, you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.

Electronic SBC

For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.[2]

- If you email the SBC, you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- If you post the SBC on the Internet, you must advise your employees by email or paper that the SBC is available on the Internet and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request.

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.

(continued)

[2]Such requirements can be found at 29 C.F.R. § 2520.104b-1(c).

- You may use the Model Language below for an e-card or postcard in connection with a website posting of the SBC:

Availability of Summary Health Information
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a *Summary of Benefits and Coverage* (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: <[group's website.com]>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

Timing of SBC distribution

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC *by the first day the employee is eligible to enroll in the plan*.
- **Special enrollees.** For special enrollees,[3] you must provide the SBCs *within 90 days following enrollment.*
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed*. If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year*.
- If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than seven business days after issuance of new policy or the receipt of written confirmation of intent to renew your group health plan*.
- At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than seven business days following your receipt of the request.

Notice of SBC modification

Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees *no later than 60 days prior to the date on which change(s) become effective*. You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary of bolded terms used in the SBC by visiting www.cciio.cms.gov or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within seven business days after Health Net receives their request.

If you have any questions, please contact your Health Net client manager.

[3]Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6.