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

Small Group

2025 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 Centene Vision Services. Health Net Health Plan of Oregon, Inc., Health Net Life Insurance Company and Centene Vision Services 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: 888-802-7001

Health Net Life: 800-865-6288

Health Net Dental: 877-410-0176

Health Net Vision: 866-392-6058

For employer use only:
New Business/Group Please send all completed paperwork to your designated account executive or broker.

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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 (All medical plans include pediatric vision coverage and alternative care benefits. Pediatric dental coverage is included with all medical plans, with the exception of the Health Net Oregon Gold and Standard PPO plans.)

PPO

Platinum	P10-250-1-3500DX PD	P10-500-1-3500DX PD	P10-750-1-3500 DX PD	
Gold	P25-500-2-8550DX PD	P15-1000-2-8500DX PD	P15-1500-2-8500DX PD	P15-2000-2-8500DX PD
	P25-2000-2-7000DX PD	P15-2500-2-8500DX PD	P15-3000-2-8500DX PD	P10-1500-4-8975DX PD
	P10-3500-4-8975DX PD			
Silver	P40-3000-3-8975ES PD	P35-4500-3-8975DX PD	P35-5000-3-8975ES PD	P40-6000-3-8975ES PD
Bronze	P8250-0-8250ES PD			

HIGH DEDUCTIBLE PPO

Silver	HD3300-3-6750ES PD	HD4000-3-6750ES PD
Bronze	HD7100-0-7100ES PD	

HEALTH NET OREGON GOLD AND STANDARD PPO
(Alternative care benefits related to this plan include chiropractic, acupuncture, and naturopathy.)

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

Dental		**Vision**		
Plus D50-1855-1500	Value D50-185-1500V	Elite 1010-1	Preferred 1025-2	Preferred 1025-3
Preferred Plus DP50-1855-1500	Essentials D50-16-500			

Pediatric Dental Coverage Acknowledgement

If purchasing the Health Net Oregon Gold Plan or an Oregon Standard PPO Plan, I confirm that I am purchasing pediatric dental coverage with another carrier as required by the 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:			
DBA name:			
Group # *(to be completed by Health Net)*:	SIC code:		
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)*:			

2. Employer group information (continued)

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.[1]

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)

5. Eligibility information (continued)

12. What type of Continuation are you subject to? Federal COBRA[2] 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. 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.)

16. Are you part of a controlled group?[3] Yes No

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

18. 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

A full-time employee for any calendar month is an employee who has on average at least 30 hours of service per week during the calendar month, or at least 130 hours of service during the calendar month.

Seasonal Work

An employer is not considered to have more than 50 full-time employees (including full-time equivalent employees) if both of the following apply:

1. The employer's workforce exceeds 50 full-time employees (including full-time- equivalent employees) for 120 days or fewer during the calendar year, and
2. The employees in excess of 50 employed during such 120-day period are seasonal workers.

FTEs – Full-time Equivalent Employees

A full-time equivalent employee is a combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee. An employer determines its number of full-time-equivalent employees for a month in the two steps that follow:

1. Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee, and
2. Divide the total by 120.

The following employees should not be included in the count of FTEs:

- Leased employees[4]
- Contracted employees
- Retired or former employees on continuation of coverage
- A sole proprietor
- A partner in a partnership
- A 2-percent S corporation shareholder
- The spouse of a person who is a sole proprietor, a partner in a partnership or a 2-percent
- S corporation shareholder
- A worker described in 26 U.S.C. Section 3508

An employer's number of full-time equivalent employees (or part-time employees) is only relevant to determining whether an employer is a large employer.

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, guardianship or placement for adoption. For spouse, domestic partner and stepchild(ren): first day of the month on or following the date of marriage or verification of domestic partnership.

[1]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.

[2]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.

[3]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 on group profile form. Controlled Groups include parent-subsidiary, brother-sister and the combination of both of the preceding.

[4]An employer may continue to offer group health insurance to it's leased workers in accordance with ORS 743.521, but the leased employees are not included in the employee count when determining group size.