

*Quick Net Select*

# Short-Term Coverage *by the Day or Month*

*Health coverage made easy*



Jesus Hao  
Health Net

Effective July 1, 2011



Health Net®

# It's a Fast-Moving World

## Keep up with Quick Net Select from Health Net

Health Net's Quick Net Select insurance plans offer a wide-range of PPO insurance benefits, including doctor office visits, emergency care, hospitalization, surgery and generic prescription drugs. Choose coverage from 30 to 180 days or six months.

### Ideal short-term coverage for individuals who are:

- between jobs,
- new employees waiting for their health insurance benefits to begin,
- temporary employees who want health benefits,
- students,
- waiting for approval for their Individual & Family health plan or California Members' Health Plan applications, or
- no longer eligible for a parent's health plan.



### Deductible waiver for accidents

If you have an accident while you are covered on a Quick Net Select policy, we will waive the deductible for covered expenses in the emergency room or urgent care facility relating to that accident only. See page 4 for more details.

### See any doctor, including specialists!

You can receive care from any of Health Net's approximately 61,000 contracted network physicians in California. Or you can see any out-of-network physician, usually at higher out-of-pocket costs. The choice is yours! To find a PPO provider, go to [www.healthnet.com](http://www.healthnet.com) and click on *ProviderSearch*.

## Summary of PPO benefits

This chart is intended to be used to help you compare coverage benefits and is a summary only. Refer to the policy for a detailed description of coverage benefits and limitations. All benefits are subject to deductible except prescription coverage and the emergency room or urgent care visit due to an accident.

### Lifetime maximum payable: \$2 million

<i>In-Network</i>	<i>Quick Net Select 2,000</i>	<i>Quick Net Select 4,500</i>
Individual deductible <sup>1</sup>	\$2,000	\$4,500
Individual out-of-pocket maximum <sup>2</sup> (does not include deductible)	\$3,000	\$4,500
Office visits	30%	40%
Preventive care exam	not covered	not covered
Inpatient hospital care	30%	40%
Emergency room	\$100 copay + 30%	\$100 copay + 40%
X-ray and laboratory	30%	40%
Outpatient services	30%	40%
Prescription coverage	\$20 generic only	\$20 generic only

<sup>1</sup>Family deductible is met when three family members meet their individual deductible.

<sup>2</sup>Does not include deductible. Family out-of-pocket is met when three family members meet their individual out-of-pocket maximum.

## Eligibility

You and your applying family members are eligible for a short-term plan if:

- You are a U.S. citizen or permanent resident of the U.S. and have resided in the U.S. for at least six months.
- You meet the application and underwriting requirements.
- You are less than 65 years old on your policy effective date and are not totally disabled or eligible for Medicare.
- You do not have other medical or hospital coverage, including enrollment in an HMO or health care insurance plan.
- You or any family members are not pregnant at the time of application.
- You or any applying family members do not train for or participate in:
  1. a team or individual sports activity as a professional;
  2. national or international competition as an amateur; or
  3. a collegiate sports activity.
- You or any applying family members are not enrolled in training for or engaged in an occupation involving unusual hazards, and are not covered by Workers' Compensation insurance.

Dependent children are eligible to apply up to age 26 on a family plan.

## Domestic partner eligibility

A Domestic Partnership is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A registered domestic partnership is established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State and at the time of the filing it is true that:

- Both persons have a common residence.
- Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or adjudged a nullity.
- The two persons are not related by blood in a way that would prevent them from being married in California.
- Both persons are at least 18 years old.
- Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance benefits under the Social Security Act.
- Both persons are capable of consenting to the domestic partnership.

## Important information

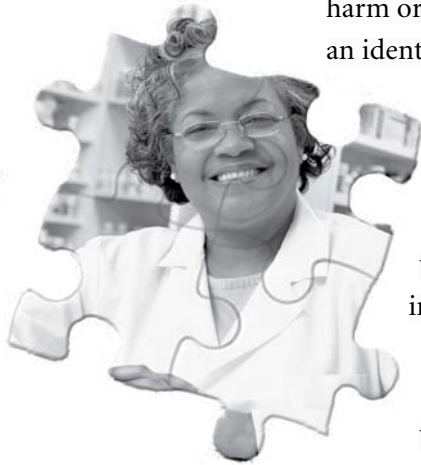
To be eligible for a Guaranteed Issue plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in addition to other requirements, an individual must have been recently covered under an employer plan. A short-term plan is not an employer plan and, therefore, acceptance of a short-term policy will impact eligibility for individual guaranteed issue health insurance under HIPAA.



**Christian Aparicio,**  
**Health Net**  
*Helping our members  
make better-informed  
health decisions.*

### **Deductible waiver for an accident**

Accidental injury is any physical harm or disability that is the result of a specific, unexpected or unintentional incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental



injury does not include illness and must be treated in an emergency room or urgent care center. The benefit period deductible will be waived only for that day's treatment in the emergency room or urgent care center for the person who sustains the accident; follow-up treatment will be subject to the benefit period deductible. A completed Accident Waiver form must be submitted within 60 days of the accident and is required for the claim to be reviewed. Once approved, the benefit period deductible will be waived only for that day's treatment in the emergency room or urgent care center. The insured will continue to pay any charges billed in excess of covered expenses. Contact the Customer Contact Center at 1-800-839-2172 for more information.

### **This is a non-renewable plan**

Health Net's Quick Net plans are non-renewable. However, if you feel there is a need to continue beyond your benefit period, you may re-apply if:

- You meet the application and underwriting requirements.
- There is no significant change in your health.

- The total days of coverage for Quick Net Select Daily plans does not exceed 360 days. The total days of coverage for Quick Net Select Monthly plans does not exceed 365 days.

A re-application fee of \$10 will be charged.

### **When does coverage begin?**

- If you are approved, your coverage will begin immediately on the effective date you choose, as long as it does not precede the postmark date of your application and is within 30 days of the signature date.
- If your chosen effective date precedes the postmark date, your coverage will become effective the day after the postmark date. If your application is faxed in by 2:00 p.m., your coverage can be effective the day of receipt.
- Applications submitted without payment or with partial payment will be pended until payment is received. If payment is not received within two weeks of the application signature date, the application will be withdrawn.
- If you apply for Health Net's permanent plan after your Quick Net plan is in effect, your Quick Net plan must expire before your permanent plan becomes effective.

### **Summary of exclusions**

Please refer to your policy for a complete list of exclusions and limitations.

## Enrollment is as easy as 1-2-3!

1. Just select when you want your coverage to start and how long you want your coverage to last, from 30 to 180 days or six months.
2. Choose either Quick Net Select Daily or Quick Net Select Monthly. There are no changes or refunds once your policy is in force.<sup>3</sup>
3. Fill out the application, include your premium payment by check or credit card<sup>4</sup> and send to Health Net. For Quick Net Select Daily, send in the full amount owed; for Quick Net Select Monthly, send in your first month's premium. You will be billed for the subsequent months until you cancel your policy or your coverage ends.

We'll let you know within a few days if your application has been approved.

Length of coverage	Quick Net Select Daily	Quick Net Select Monthly
Minimum coverage time	30 days	1 month
Maximum coverage time	180 days	6 months

### How to calculate your premium

Inside this brochure you'll find rates for your area.

To find your rate:

1. Select the regional rate page for the county where you live.
2. Find the heading that fits the number of people in your family you want to cover.

3. Select the type of coverage you want:  
Quick Net Select Daily or Quick Net Select Monthly.
4. Choose your plan.
5. Find the dollar amount on the chart that corresponds to your coverage and deductible.
6. **If you are choosing Quick Net Select Daily**, multiply the number on the chart by the number of days of coverage for which you are applying. Daily applicants need to send in a premium for their entire length of coverage.

#### Example of Quick Net Select daily premium calculation

Brian, 32 and Kimberly, 28, live in Los Angeles County (Region 1). They choose the **Quick Net Select Daily \$2,000 deductible** plan. They select 85 days of coverage.

**Subscriber + Spouse** rate, based on age of younger spouse/ domestic partner (age 28)  
**Per day rate = \$3.20**  
**\$3.20 x 85 days = \$272.00** (Total premium due)

7. **If you are choosing Quick Net Select Monthly**, the amount on the chart is your monthly premium. The first month's premium is required for processing.

### Payment options

- check
- credit card

Send your payments and application to:  
 Health Net Individual & Family Enrollment  
 PO Box 1150  
 Rancho Cordova, CA 95741-1150

Specific provisions apply to renewability. Please refer to your policy for details.

<sup>3</sup>There are no changes allowed beyond the 10-day free look period. No exceptions will be made.

<sup>4</sup>Your check will be held in trust while your application is reviewed by Health Net. Applications submitted without payment or with partial payment will be pended until payment is received. If payment is not received within two weeks of the application signature date, the application will be withdrawn. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you.

# Quick Net Select Monthly and Daily rates

Rates effective January 1, 2010

## Region 1 Los Angeles County.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	70	50	1.38	0.99
	19-24	70	50	1.38	0.99
	25-29	82	58	1.60	1.13
	30-34	93	65	1.82	1.27
	35-39	111	78	2.18	1.52
	40-44	129	90	2.53	1.76
	45-49	169	118	3.31	2.32
	50-54	208	147	4.08	2.88
	55-59	256	179	5.01	3.51
	60-64	303	211	5.94	4.14
Applicant & Spouse/ Domestic Partner	19-24	141	101	2.76	1.98
	25-29	163	115	3.20	2.26
	30-34	186	130	3.64	2.54
	35-39	222	155	4.36	3.04
	40-44	258	180	5.06	3.52
	45-49	338	237	6.62	4.64
	50-54	416	294	8.16	5.76
	55-59	511	358	10.02	7.02
60-64	606	422	11.88	8.28	
Applicant & Child	19-24	130	93	2.55	1.83
	25-29	141	100	2.77	1.97
	30-34	152	108	2.99	2.11
	35-39	171	120	3.35	2.36
	40-44	189	133	3.70	2.60
	45-49	228	161	4.48	3.16
	50-54	268	190	5.25	3.72
	55-59	315	222	6.18	4.35
60-64	363	254	7.11	4.98	
Applicant & Children	19-24	183	131	3.59	2.57
	25-29	194	138	3.81	2.71
	30-34	206	145	4.03	2.85
	35-39	224	158	4.39	3.10
	40-44	242	170	4.74	3.34
	45-49	282	199	5.52	3.90
	50-54	321	227	6.29	4.46
	55-59	368	260	7.22	5.09
60-64	416	292	8.15	5.72	
Family	19-24	253	182	4.97	3.56
	25-29	276	196	5.41	3.84
	30-34	298	210	5.85	4.12
	35-39	335	236	6.57	4.62
	40-44	371	260	7.27	5.10
	45-49	450	317	8.83	6.22
	50-54	529	374	10.37	7.34
	55-59	624	439	12.23	8.60
	60-64	719	503	14.09	9.86

## Region 2<sup>1</sup> Merced, Napa, Sacramento, San Joaquin, Sonoma, Stanislaus, Tulare, western El Dorado and western Placer counties.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	73	51	1.44	1.00
	19-24	73	51	1.44	1.00
	25-29	86	61	1.69	1.19
	30-34	99	70	1.94	1.38
	35-39	117	82	2.29	1.60
	40-44	134	92	2.63	1.81
	45-49	171	118	3.35	2.31
	50-54	207	143	4.06	2.81
	55-59	254	178	4.99	3.49
	60-64	302	212	5.92	4.16
Applicant & Spouse/ Domestic Partner	19-24	147	102	2.88	2.00
	25-29	172	121	3.38	2.38
	30-34	198	141	3.88	2.76
	35-39	234	163	4.58	3.20
	40-44	268	185	5.26	3.62
	45-49	342	236	6.70	4.62
	50-54	414	287	8.12	5.62
	55-59	509	356	9.98	6.98
60-64	604	424	11.84	8.32	
Applicant & Child	19-24	136	94	2.66	1.85
	25-29	148	104	2.91	2.04
	30-34	161	114	3.16	2.23
	35-39	179	125	3.51	2.45
	40-44	196	136	3.85	2.66
	45-49	233	161	4.57	3.16
	50-54	269	187	5.28	3.66
	55-59	317	221	6.21	4.34
60-64	364	256	7.14	5.01	
Applicant & Children	19-24	191	133	3.74	2.60
	25-29	203	142	3.99	2.79
	30-34	216	152	4.24	2.98
	35-39	234	163	4.59	3.20
	40-44	251	174	4.93	3.41
	45-49	288	199	5.65	3.91
	50-54	324	225	6.36	4.41
	55-59	372	260	7.29	5.09
	60-64	419	294	8.22	5.76
	Family	19-24	264	184	5.18
25-29		290	203	5.68	3.98
30-34		315	222	6.18	4.36
35-39		351	245	6.88	4.80
40-44		386	266	7.56	5.22
45-49		459	317	9.00	6.22
50-54		531	368	10.42	7.22
55-59		626	438	12.28	8.58
60-64		721	506	14.14	9.92

<sup>1</sup>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.

# Quick Net Select Monthly and Daily rates

Rates effective January 1, 2010

## Region 3

Riverside, San Bernardino, Santa Barbara and Ventura counties.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	67	46	1.32	0.90
	19-24	67	46	1.32	0.90
	25-29	77	54	1.50	1.05
	30-34	86	61	1.68	1.20
	35-39	103	72	2.01	1.41
	40-44	119	83	2.34	1.62
	45-49	153	107	3.00	2.10
	50-54	187	132	3.66	2.58
	55-59	227	160	4.46	3.14
	60-64	268	188	5.25	3.69
Applicant & Spouse/ Domestic Partner	19-24	135	92	2.64	1.80
	25-29	153	107	3.00	2.10
	30-34	171	122	3.36	2.40
	35-39	205	144	4.02	2.82
	40-44	239	165	4.68	3.24
	45-49	306	214	6.00	4.20
	50-54	373	263	7.32	5.16
	55-59	455	320	8.92	6.28
	60-64	536	376	10.50	7.38
	Applicant & Child	19-24	124	85	2.44
25-29		134	93	2.62	1.82
30-34		143	100	2.80	1.97
35-39		160	111	3.13	2.18
40-44		176	122	3.46	2.39
45-49		210	146	4.12	2.87
50-54		244	171	4.78	3.35
55-59		285	199	5.58	3.91
60-64	325	227	6.37	4.46	
Applicant & Children	19-24	175	119	3.43	2.34
	25-29	184	127	3.61	2.49
	30-34	193	135	3.79	2.64
	35-39	210	145	4.12	2.85
	40-44	227	156	4.45	3.06
	45-49	261	181	5.11	3.54
	50-54	294	205	5.77	4.02
	55-59	335	234	6.57	4.58
	60-64	375	262	7.36	5.13
	Family	19-24	242	165	4.75
25-29		261	181	5.11	3.54
30-34		279	196	5.47	3.84
35-39		313	217	6.13	4.26
40-44		346	239	6.79	4.68
45-49		414	288	8.11	5.64
50-54		481	337	9.43	6.60
55-59		563	394	11.03	7.72
60-64		643	450	12.61	8.82

## Region 4

Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Santa Cruz and Solano counties.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	64	46	1.26	0.90
	19-24	64	46	1.26	0.90
	25-29	73	52	1.44	1.02
	30-34	83	58	1.62	1.14
	35-39	99	70	1.95	1.38
	40-44	116	83	2.28	1.62
	45-49	148	104	2.91	2.04
	50-54	181	125	3.54	2.46
	55-59	221	154	4.34	3.01
	60-64	262	182	5.13	3.56
Applicant & Spouse/ Domestic Partner	19-24	129	92	2.52	1.80
	25-29	147	104	2.88	2.04
	30-34	165	116	3.24	2.28
	35-39	199	141	3.90	2.76
	40-44	233	165	4.56	3.24
	45-49	297	208	5.82	4.08
	50-54	361	251	7.08	4.92
	55-59	443	307	8.68	6.02
	60-64	523	363	10.26	7.12
	Applicant & Child	19-24	119	85	2.33
25-29		128	91	2.51	1.79
30-34		137	97	2.69	1.91
35-39		154	110	3.02	2.15
40-44		171	122	3.35	2.39
45-49		203	143	3.98	2.81
50-54		235	165	4.61	3.23
55-59		276	193	5.41	3.78
60-64	316	221	6.20	4.33	
Applicant & Children	19-24	167	119	3.28	2.34
	25-29	176	125	3.46	2.46
	30-34	186	132	3.64	2.58
	35-39	202	144	3.97	2.82
	40-44	219	156	4.30	3.06
	45-49	251	177	4.93	3.48
	50-54	284	199	5.56	3.90
	55-59	324	227	6.36	4.45
	60-64	365	255	7.15	5.00
	Family	19-24	232	165	4.54
25-29		250	177	4.90	3.48
30-34		268	190	5.26	3.72
35-39		302	214	5.92	4.20
40-44		336	239	6.58	4.68
45-49		400	282	7.84	5.52
50-54		464	324	9.10	6.36
55-59		546	380	10.70	7.46
60-64		626	437	12.28	8.56

# Quick Net Select Monthly and Daily rates

Rates effective January 1, 2010

## Region 5

Orange and San Diego counties.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	67	46	1.32	0.90
	19-24	67	46	1.32	0.90
	25-29	77	54	1.50	1.05
	30-34	86	61	1.68	1.20
	35-39	103	72	2.01	1.41
	40-44	119	83	2.34	1.62
	45-49	153	107	3.00	2.10
	50-54	187	132	3.66	2.58
	55-59	227	160	4.46	3.14
	60-64	268	188	5.25	3.69
Applicant & Spouse/ Domestic Partner	19-24	135	92	2.64	1.80
	25-29	153	107	3.00	2.10
	30-34	171	122	3.36	2.40
	35-39	205	144	4.02	2.82
	40-44	239	165	4.68	3.24
	45-49	306	214	6.00	4.20
	50-54	373	263	7.32	5.16
	55-59	455	320	8.92	6.28
60-64	536	376	10.50	7.38	
Applicant & Child	19-24	124	85	2.44	1.67
	25-29	134	93	2.62	1.82
	30-34	143	100	2.80	1.97
	35-39	160	111	3.13	2.18
	40-44	176	122	3.46	2.39
	45-49	210	146	4.12	2.87
	50-54	244	171	4.78	3.35
	55-59	285	199	5.58	3.91
60-64	325	227	6.37	4.46	
Applicant & Children	19-24	175	119	3.43	2.34
	25-29	184	127	3.61	2.49
	30-34	193	135	3.79	2.64
	35-39	210	145	4.12	2.85
	40-44	227	156	4.45	3.06
	45-49	261	181	5.11	3.54
	50-54	294	205	5.77	4.02
	55-59	335	234	6.57	4.58
60-64	375	262	7.36	5.13	
Family	19-24	242	165	4.75	3.24
	25-29	261	181	5.11	3.54
	30-34	279	196	5.47	3.84
	35-39	313	217	6.13	4.26
	40-44	346	239	6.79	4.68
	45-49	414	288	8.11	5.64
	50-54	481	337	9.43	6.60
	55-59	563	394	11.03	7.72
	60-64	643	450	12.61	8.82

## Region 6

Fresno, Kern and Kings counties.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	70	49	1.38	0.96
	19-24	70	49	1.38	0.96
	25-29	83	58	1.62	1.14
	30-34	95	67	1.86	1.32
	35-39	112	78	2.19	1.53
	40-44	129	89	2.52	1.74
	45-49	164	113	3.21	2.22
	50-54	199	138	3.90	2.70
	55-59	245	171	4.80	3.35
	60-64	290	204	5.69	4.00
Applicant & Spouse/ Domestic Partner	19-24	141	98	2.76	1.92
	25-29	165	116	3.24	2.28
	30-34	190	135	3.72	2.64
	35-39	223	156	4.38	3.06
	40-44	257	177	5.04	3.48
	45-49	327	226	6.42	4.44
	50-54	398	275	7.80	5.40
	55-59	490	342	9.60	6.70
60-64	580	408	11.38	8.00	
Applicant & Child	19-24	130	91	2.55	1.78
	25-29	142	100	2.79	1.96
	30-34	155	109	3.03	2.14
	35-39	171	120	3.36	2.35
	40-44	188	131	3.69	2.56
	45-49	223	155	4.38	3.04
	50-54	259	180	5.07	3.52
	55-59	304	213	5.97	4.17
60-64	350	246	6.86	4.82	
Applicant & Children	19-24	183	128	3.59	2.50
	25-29	195	137	3.83	2.68
	30-34	208	146	4.07	2.86
	35-39	224	157	4.40	3.07
	40-44	241	167	4.73	3.28
	45-49	276	192	5.42	3.76
	50-54	312	216	6.11	4.24
	55-59	358	249	7.01	4.89
60-64	403	283	7.90	5.54	
Family	19-24	253	176	4.97	3.46
	25-29	278	195	5.45	3.82
	30-34	302	213	5.93	4.18
	35-39	336	235	6.59	4.60
	40-44	370	256	7.25	5.02
	45-49	440	305	8.63	5.98
	50-54	511	354	10.01	6.94
	55-59	602	420	11.81	8.24
	60-64	693	487	13.59	9.54

# Quick Net Select Monthly and Daily rates

Rates effective January 1, 2010

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, eastern El Dorado, eastern Placer, Glenn, Humboldt, Inyo, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo and Yuba counties.

## Region 7<sup>2</sup>

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	77	55	1.50	1.08
	19-24	77	55	1.50	1.08
	25-29	89	63	1.74	1.23
	30-34	101	70	1.98	1.38
	35-39	121	84	2.37	1.65
	40-44	141	98	2.76	1.92
	45-49	179	125	3.51	2.46
	50-54	217	153	4.26	3.00
	55-59	267	187	5.23	3.66
	60-64	316	220	6.19	4.31
Applicant & Spouse/ Domestic Partner	19-24	153	110	3.00	2.16
	25-29	177	125	3.48	2.46
	30-34	202	141	3.96	2.76
	35-39	242	168	4.74	3.30
	40-44	282	196	5.52	3.84
	45-49	358	251	7.02	4.92
	50-54	435	306	8.52	6.00
	55-59	533	373	10.46	7.32
60-64	631	440	12.38	8.62	
Applicant & Child	19-24	142	102	2.78	2.00
	25-29	154	110	3.02	2.15
	30-34	166	117	3.26	2.30
	35-39	186	131	3.65	2.57
	40-44	206	145	4.04	2.84
	45-49	244	172	4.79	3.38
	50-54	283	200	5.54	3.92
	55-59	332	234	6.51	4.58
60-64	381	267	7.47	5.23	
Applicant & Children	19-24	199	143	3.90	2.81
	25-29	211	151	4.14	2.96
	30-34	223	159	4.38	3.11
	35-39	243	172	4.77	3.38
	40-44	263	186	5.16	3.65
	45-49	301	214	5.91	4.19
	50-54	340	241	6.66	4.73
	55-59	389	275	7.63	5.39
60-64	438	308	8.59	6.04	
Family	19-24	275	198	5.40	3.89
	25-29	300	214	5.88	4.19
	30-34	324	229	6.36	4.49
	35-39	364	257	7.14	5.03
	40-44	404	284	7.92	5.57
	45-49	480	339	9.42	6.65
	50-54	557	394	10.92	7.73
	55-59	656	462	12.86	9.05
	60-64	754	528	14.78	10.35

## Region 8

Imperial and San Luis Obispo counties.

Tier/Age	Quick Net Select Monthly Rates		Quick Net Select Daily Rates		
	30-180 days				
	\$2,000 ded.	\$4,500 ded.	\$2,000 ded.	\$4,500 ded.	
Single	0-18	77	55	1.50	1.08
	19-24	77	55	1.50	1.08
	25-29	89	63	1.74	1.23
	30-34	101	70	1.98	1.38
	35-39	121	84	2.37	1.65
	40-44	141	98	2.76	1.92
	45-49	179	125	3.51	2.46
	50-54	217	153	4.26	3.00
	55-59	267	187	5.23	3.66
	60-64	316	220	6.19	4.31
Applicant & Spouse/ Domestic Partner	19-24	153	110	3.00	2.16
	25-29	177	125	3.48	2.46
	30-34	202	141	3.96	2.76
	35-39	242	168	4.74	3.30
	40-44	282	196	5.52	3.84
	45-49	358	251	7.02	4.92
	50-54	435	306	8.52	6.00
	55-59	533	373	10.46	7.32
60-64	631	440	12.38	8.62	
Applicant & Child	19-24	142	102	2.78	2.00
	25-29	154	110	3.02	2.15
	30-34	166	117	3.26	2.30
	35-39	186	131	3.65	2.57
	40-44	206	145	4.04	2.84
	45-49	244	172	4.79	3.38
	50-54	283	200	5.54	3.92
	55-59	332	234	6.51	4.58
60-64	381	267	7.47	5.23	
Applicant & Children	19-24	199	143	3.90	2.81
	25-29	211	151	4.14	2.96
	30-34	223	159	4.38	3.11
	35-39	243	172	4.77	3.38
	40-44	263	186	5.16	3.65
	45-49	301	214	5.91	4.19
	50-54	340	241	6.66	4.73
	55-59	389	275	7.63	5.39
60-64	438	308	8.59	6.04	
Family	19-24	275	198	5.40	3.89
	25-29	300	214	5.88	4.19
	30-34	324	229	6.36	4.49
	35-39	364	257	7.14	5.03
	40-44	404	284	7.92	5.57
	45-49	480	339	9.42	6.65
	50-54	557	394	10.92	7.73
	55-59	656	462	12.86	9.05
	60-64	754	528	14.78	10.35

<sup>2</sup>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, 95724, 95736, 96140-43, 96145-46, 96148, and 96162 only. See region 2 for additional Placer County ZIP codes.

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# Quick Net Select PPO Daily/Monthly Policy

## Non-Renewable Short-Term Health Insurance

# Application

Application must be typed or completed in **blue or black ink**. **The application must be completed by the applicant. Neither broker nor any other person may complete the Statement of Health or sign this application and agreement on behalf of the applicant. The Statement of Health can be completed by the applicant for minor dependents.**

**Please see Part VIII if applicant does not read/write English.** The Quick Net Select Health Insurance application is available in Chinese and Spanish language versions.

Please request your effective date (*cannot precede the postmark date of this application*).  
**Requested effective date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Part I. Tell us about yourself*

Primary applicant's last name:		First name:		MI:	<input type="checkbox"/> Male	
					<input type="checkbox"/> Female	
Home address:						
City:		State:	ZIP:	County applicant resides in:		
Billing address (If you want your bill sent to an address different from your home address; only your bill will be sent to this address.):						
Home phone number: (    )		Work phone number: (    )		Email address:		
Primary applicant's birth date (mm/dd/yy): /      /		Place of birth:	Primary applicant's Social Security number: -      -		Height:	Weight (lbs):
Please select your language preference (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese						

*Part II. Family member(s) to be enrolled*

List all eligible dependents to be enrolled. Dependents must be less than 65 years of age on the policy's effective date in order to qualify as an eligible dependent. If the last name of the dependent is different from the primary applicant, please explain on a separate sheet of paper. 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. All applicants must reside at the same address. **For additional dependents, please complete a Quick Net Select addendum.**

Relation	Last name	First name	MI	Social Security number	Date of birth	Height	Weight (lbs.)
<b>Dependent 1</b> <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic partner <input type="checkbox"/> Son <input type="checkbox"/> Daughter							
Relation	Last name	First name	MI	Social Security number	Date of birth	Height	Weight (lbs.)
<b>Dependent 2</b> <input type="checkbox"/> Son <input type="checkbox"/> Daughter							

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Primary applicant's name: \_\_\_\_\_

**Part III. Choose your plan**

Quick Net Select 2,000       Quick Net Select 4,500

Please designate your plan type:  **Daily Plan**<sup>1</sup>    **Monthly Plan**

Note: If you have applied for both a short-term and a standard Individual & Family health plan and have been simultaneously approved for each, you will *automatically be enrolled in the standard Individual & Family health plan* and this application for Quick Net coverage will be cancelled. Should you wish to not be enrolled in the standard Individual & Family health plan, please check this box.  **NO, do not enroll me in the standard health plan.**

<sup>1</sup>Please complete the Daily Policy Only section below.

**Daily Policy Only (Do not complete this section for the monthly plan.)**

Benefit coverage period: Please choose the number of days for your benefit period: \_\_\_\_\_ days (30–180 days)

**Once enrolled, there are no changes permitted and the policy cannot be renewed.**

Calculate your total premium due:

\$ \_\_\_\_\_ daily rate<sup>2</sup> (please see rates) x \_\_\_\_\_ # of coverage days = \$ \_\_\_\_\_ Total premium due

**Please remit a check payable to "Health Net" for the full amount owed for the policy benefit period.**

<sup>2</sup>Daily rate is based on the number of days selected.

**Part IV. U.S. Residency**

	Primary applicant (complete primary applicant column for child-only apps.)	Dependent 1	Dependent 2
In the past 6 months, have you been a U.S. resident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No," are applicants U.S. citizens or permanent residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part V. Special enrollment for children under 19 years of age**

Your children under 19 years of age are eligible to enroll in a Quick Net Select Short-term Health Insurance Plan during the following periods and cannot be declined due to a pre-existing medical condition. While coverage is guaranteed, the premium may vary due to health history or failure to maintain health insurance prior to open enrollment. Please complete one of the applicable sections below.		Primary applicant	Dependent 1	Dependent 2
A.	<b>My child(ren) are applying during the month of their birthday (annual open enrollment).</b> (Proof of date of birth may be required. If late enrollee, see next page.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B.	<b>My child(ren) are applying outside of an open enrollment period.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C.	<b>If "Yes" to A or B above: Throughout the previous 90 days, have your child(ren) been continuously covered by health insurance? If "Yes," proof of prior coverage is required.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Primary applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
	Plan name:	State:	Most recent coverage start date:	End date:

(continued)

□	□	□	□	□	□	□	□	□	□
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Primary applicant's name: \_\_\_\_\_

**Part V. Special enrollment for children under 19 years of age (continued)**

Dependent 1 name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Dependent 2 name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:

		Primary applicant	Dependent 1	Dependent 2
D.	<b>My child(ren) are currently without coverage and are applying during a late enrollee period. Please select the appropriate qualifying event below.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Qualifying events</b>				
If your child(ren) did not enroll during an open enrollment period, they may enroll within 63 days after any of the following qualifying events. Please select the appropriate box and attach supporting documentation.				
<b>a) The child lost dependent coverage due to:</b>				
<b>i) The termination or change in employment status of the child or the person through whom the child was covered.</b> (Proof of loss of status, such as an employer letter or collateral showing dependent criteria, will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ii) The loss of an employer's contribution toward an employee's or dependent's coverage.</b> (Proof of loss of contribution, such as an employer letter or collateral showing employer's contributions, will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>iii) The death of the person through whom the child was covered as a dependent.</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>iv) Legal separation or divorce.</b> (Proof of loss of coverage, such as a Certificate of Creditable Coverage or loss of coverage letter from the employer or insurer will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>v) The loss of coverage under the Healthy Families program, Access for Infants and Mothers (AIM) program or the Medi-Cal program.</b> (Proof of loss of coverage, such as a termination letter from one of these programs, will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b) The child became a resident of California during a month that was not the child's birth month.</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c) The child was born as a resident of California and did not enroll in the month of birth.</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d) The child is mandated to be covered pursuant to a valid state or federal court order.</b> (As proof, a copy of the court order will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>e) The child was adopted.</b> (As proof, a copy of the legal adoption document will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>f) The child exhausted COBRA or Cal-COBRA continuation coverage.</b> (As proof, a Certificate of Creditable Coverage will be required.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(continued)

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Primary applicant's name: \_\_\_\_\_

**Part VI. Prior health coverage**

For applicants age 19 and older, during the previous 63 days, have you or any applicants been covered by health insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "Yes," please complete the prior coverage information below for all periods in the last 12 months.			
Applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:

**Part VII. (A) Statement of Health**

*All questions must be answered.*

**The Statement of Health section must be completed for each family member applying for coverage. Even though your children under 19 years of age cannot be declined due to pre-existing medical conditions, you are required to complete the Statement of Health for each of your children under 19 years of age for whom you are requesting enrollment, because the monthly premium for their coverage will be determined by Health Net's review of their medical history.**

**Genetic Information Non-discrimination Act of 2008 (GINA) compliance statement:** This Statement of Health is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

		Primary applicant	Dependent 1	Dependent 2
1)	Are you, your spouse/domestic partner, female dependent or companion currently pregnant or have you, your spouse/domestic partner, female dependent or companion performed a home pregnancy test during the previous 90 days which has reacted positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
2)	Are you in the process of adoption or surrogate pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3)	During the past 12 months, have you or any applying family member experienced symptom(s) for which a health care practitioner has not been consulted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
4)	During the benefit coverage period, will you or any applying family member train for or participate in: 1) a team or individual sports activity as a professional; 2) national or international competition as an amateur; or 3) a collegiate sports activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(continued)

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Primary applicant's name: \_\_\_\_\_

**Part VII. (A) Statement of Health (continued)**

All questions must be answered.

		Primary applicant	Dependent 1	Dependent 2
5)	Within the last 5 years, have you or any applying family member ever received any medical or surgical consultation, advice, or treatment including medication for the following:			
	A. Stroke; or heart or circulatory system disorder including heart attack or chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	B. Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	C. Cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	D. Alcoholism or alcohol abuse; drug abuse or chemical dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	E. Liver or kidney disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
6)	Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and are not covered by Workers' Compensation Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7)	In the past 12 months, have you or any applying family member consulted a health care practitioner and have been recommended to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
8)	In the last 30 days have you or any applying family member been confined to a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
9)	Have you or any applying family member been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
10)	Do you or any applying family member have any hospital, major medical, group health or medical insurance coverage in force that will NOT terminate prior to the effective date of this policy? If "Yes," when will existing coverage expire?	<input type="checkbox"/> Yes <input type="checkbox"/> No  ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No  ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No  ____/____/____
	Do you or any of the applicants have a Personal Health Record (PHR)? If "Yes," please include it with this application or mail it to Health Net, PO Box 1150, Rancho Cordova, CA 95741-1150.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(continued)

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Primary applicant's name: \_\_\_\_\_

**Part VII. (B) Statement of Health**

If you answered "Unsure" to any questions in Part VII (A), please identify the question number and explain your reason.

Question #	Indicate applicant	Explanation for "Unsure" response
	<input type="checkbox"/> Prim. app <input type="checkbox"/> Dep. 1 <input type="checkbox"/> Dep. 2	
	<input type="checkbox"/> Prim. app <input type="checkbox"/> Dep. 1 <input type="checkbox"/> Dep. 2	
	<input type="checkbox"/> Prim. app <input type="checkbox"/> Dep. 1 <input type="checkbox"/> Dep. 2	
	<input type="checkbox"/> Prim. app <input type="checkbox"/> Dep. 1 <input type="checkbox"/> Dep. 2	

**Part VIII. Quick Net Select Health Insurance Plans exception to standard enrollment – Statement of Accountability**

**Instructions for Part VIII:** 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 Quick Net Select Health Insurance Application when applicable.

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.  The Statement of Health.  
 Other (explain): \_\_\_\_\_

A qualified interpreter read this application to me in the following language: \_\_\_\_\_

Signature of applicant:	Today's date:
Date application was interpreted:	Time application was interpreted:
Qualified interpreter number:	

(continued)

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Primary applicant's name: \_\_\_\_\_

**Part IX. Agent/broker information**

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

**Instructions for Part IX:** The following form is to be completed by the agent/broker (if applicable).

**Health Net broker ID:** \_\_\_\_\_

Name (print): \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ Fax number: \_\_\_\_\_

\_\_\_\_\_ Email address: \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**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: \_\_\_\_\_

(continued)

Primary applicant's name: \_\_\_\_\_

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## Part X. Conditions of enrollment

### I UNDERSTAND THAT:

- The minimum coverage time under the Health Net Life Insurance Quick Net **Daily Policy is 30 days**, and for the **Monthly Policy it is one calendar month**. The maximum length of coverage time is **180 days for the Daily Policy** and **6 months for the Monthly Policy**.
- There are no changes to this policy once it goes into force. Under no circumstances will I, or my dependents, be allowed to make changes or request a refund beyond the 10-day free look period. No exceptions will be made.
- No benefits are payable for any expenses incurred as a result of a pre-existing condition for applicants age 19 and older. Pre-existing condition means an illness, injury or condition which existed during the twelve-month period when this Policy insures one or two covered persons, or six-month period when this Policy insures three or more covered persons, immediately prior to the member's effective date. An illness, injury or condition is considered to have existed when the member: (1) sought or received professional advice for that illness, injury or condition; or (2) received medical care or treatment for that illness, injury or condition.
- If I am approved under a Health Net permanent plan, I must first exhaust my coverage under Quick Net.
- My check will be held in trust while my application is reviewed by Health Net Life Insurance Company. Applications **submitted without payment** or with **partial payment** will be **pending** until payment is received. If my payment is not received within 2 weeks of the application signature date, my application will be withdrawn.

### Additional information for Monthly Policies only:

- If my Monthly policy is terminated due to lack of payment, my policy will not be reinstated. I may terminate my policy at any time, effective the first of the following month, following Health Net's receipt of my notice to cancel.

### RESCISSION OF MEMBERSHIP FOR HEALTH NET LIFE INSURANCE COMPANY INDIVIDUAL PPO PLANS:

Health Net Life Insurance Company ("HNL") is an insurance company licensed and regulated under the California Insurance Code. HNL underwrites Individual PPO health insurance plans. Any fraudulent or willful nondisclosure or misrepresentation of material facts in written information submitted by you or on your behalf on or with your application materials may be cause for disenrollment and rescission of the Insurance Policy and HNL may recoup from the policyholder (or from you or from the applicant) any amounts paid under the Insurance Policy obtained as a result of such fraudulent or willful nondisclosure or misrepresentation of material facts. In addition, if a policyholder makes any fraudulent or willful nondisclosure or misrepresentation of material facts in written information submitted on or with the application as to the policyholder's or family member's health status or history, HNL shall have no liability for the provision of coverage under the Insurance Policy. By signing this application, you represent that all responses to the Statement of Health are true, complete and accurate to the best of your knowledge and that should your application be accepted by HNL, the application will become part of the contract between HNL and yourself. By signing this application, you further represent and agree to abide by the terms of the contract. Before the contract is rescinded, HNL will provide you written notice and an opportunity to provide information. Should the contract be rescinded, HNL will provide a written notice that will explain the basis of the decision and your appeals rights. HNL will refund all amounts paid by you, less any medical expenses that HNL paid.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, and disease or case management programs. Health Net's Notice of Privacy Practices is included in the Insurance Policy, and that I may also obtain a copy of this Notice on the website at [www.healthnet.com](http://www.healthnet.com) or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this application and for payments of premiums. If such responsible party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with this application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the Statement of Accountability (see PART VIII of this application, "Quick Net Select Health Insurance Plans exception to standard enrollment – Statement of Accountability").

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Primary applicant's name: \_\_\_\_\_

**Part XI. Important Provisions**

**Notice:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**HIV testing prohibited:** California law prohibits an HIV test from being required or used by health care services, plans or insurance companies as a condition of obtaining coverage.

**Acknowledgement and agreement:** I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Insurance Policy. I, the applicant, have read and understand the terms of this application and my signature below indicates that the information entered in this application is complete, true and correct to the best of my knowledge, and I accept these terms.

Acceptance of a short-term policy will impact eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996.

**Binding arbitration:** I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Applicant or parent or legal guardian's signature if applicant is under 18 years old:	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of spouse/domestic partner or applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:

The application and this Arbitration Clause must be signed by the applicant. The applicant must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Insurance Policy in order for this application to be processed. For this application to be considered, neither the broker nor any other person may sign this application and Arbitration Clause.

Primary applicant's Social Security number:

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Primary applicant's name: \_\_\_\_\_

**Part XII. Credit card payment information (optional)**

Your premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.

**First payment** (daily and monthly policies)    **Monthly payment** (monthly policies)

First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard
Account number (16 digits, complete):		Expiration date (mm/yyyy):	
Billing address:	City:	State:	ZIP <sup>1</sup> :

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. I understand that the premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw / charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)* I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, **I will be charged a \$25 service charge for each occurrence. My credit card account will be charged approximately the 20th of every month, for the following month's premium.**

Signature of credit card account holder (required to process):	Date:
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<sup>1</sup>The ZIP code must match the cardholder's address, otherwise the credit card cannot be processed.

**Fax your completed application and payment to:      1-800-977-4161 (toll free)**

**Or mail your completed application and payment to:    Health Net Individual & Family Enrollment  
PO Box 1150  
Rancho Cordova, CA 95741-1150.**



# Authorization *for Use or* *Disclosure of Information for* Enrollment

By signing this authorization,

1. I authorize the following to disclose medical information to Health Net: Any medical professional, hospital, or other health care facility, clinic, pharmacy, insurer or health benefit plan administrator, MIB, Inc., (“MIB”), or any other health care provider or health plan that has medical information, to include diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, alcohol or substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex), about me or my dependent(s); health care providers or health plans indicated in my application for coverage or on my dependents’ applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other health care provider or health plan referred to in my medical records or my dependent’s(s’) medical records.

Information regarding your insurability will be treated as confidential. Health Net or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

I also authorize Health Net, and its reinsurers, to release information from their file to other insurance companies to whom I may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph one above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied: Health Net and its affiliates including, but not limited to, its agents, underwriting operations, including independent contractors who have executed business associate contracts to conduct underwriting activities on behalf of Health Net or do post enrollment review of any information for determination of whether a policy should be rescinded for intentional misrepresentation, of material facts, who have agreed to safeguard protected health information from unauthorized use or disclosure.
3. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected by federal privacy rules governing the privacy of health information.
4. I understand that my or my dependent’s(s’) enrollment in Health Net’s health plan may be conditioned on signing this authorization. As described in the “Notice of privacy practices,” I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Health Net or its business associates in reliance on this authorization. I may send a written and dated revocation to Health Net at the address below. This authorization will become effective immediately and shall remain valid for thirty (30) months from the date the authorization form is signed, except that, for California residents, this authorization will remain in effect for one year from the date of the authorization.
5. If the person completing this authorization is the personal representative of the applicant or dependent, describe your authority to act on this person’s behalf: \_\_\_\_\_

*(continued on back page)*

A photocopy of this form is as valid as the original. You have the right to receive a copy of this authorization upon request.

**Signatures (required in ink):**

_____ Printed name of applicant	_____ Signature of applicant or his or her personal representative	_____ Date
_____ Printed name of spouse or dependent child (age 18 or older)	_____ Signature of spouse or dependent child (age 18 or older) or his or her personal representative	_____ Date
_____ Printed name of dependent child (age 18 or older)	_____ Signature of dependent child (age 18 or older) or his or her personal representative	_____ Date
_____ Printed name of dependent child (age 18 or older)	_____ Signature of dependent child (age 18 or older) or his or her personal representative	_____ Date
_____ Printed name of dependent child (age 18 or older)	_____ Signature of dependent child (age 18 or older) or his or her personal representative	_____ Date
_____ Printed name of dependent child (age 18 or older)	_____ Signature of dependent child (age 18 or older) or his or her personal representative	_____ Date

**PLEASE RETURN THIS FORM TO:**  
**Health Net Individual & Family Plans**  
**PO Box 1150**  
**Rancho Cordova, CA 95741-1150**

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA regulations, 45 C.F.R. § 164.508.

# HEALTH NET QUICK NET SELECT PLANS

*Outline of Coverage and Exclusions and Limitations*



Health Net®  
A BETTER DECISION

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# Outline of coverage

## *Health Net Life Insurance Company Individual & Family Health Insurance Plans short-term major medical expense coverage*

### **READ YOUR POLICY CAREFULLY**

This outline of coverage provides a brief description of the important features of your Health Net PPO Policy (Policy). This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and Health Net Life Insurance Company. It is, therefore, important that you read your Policy carefully!

### **MAJOR MEDICAL EXPENSE COVERAGE**

This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out of hospital care and prosthetic appliances subject to any deductibles, copayment provisions or other limitations which may be set forth in the Policy.

### **PRINCIPAL BENEFITS AND COVERAGES**

Please refer to the list below for a summary of each plan's covered services and supplies. Also refer to the Policy you receive after you enroll in a plan. The Policy offers more detailed information on the benefits and coverage included in your health insurance plan.

- Inpatient hospital services
- Outpatient hospital services
- Ambulatory surgical center
- Skilled nursing facility
- Professional services
- Diagnostic imaging (including X-ray) and laboratory procedures
- Home health care agency services
- Outpatient infusion therapy
- Ambulance services – ground ambulance transportation and air ambulance transportation
- Diabetes education
- Radiation therapy, chemotherapy and renal dialysis treatment
- Bariatric (weight loss) surgery
- Prostheses
- Medically necessary corrective footwear
- Rental or purchase of durable medical equipment
- Implanted lens which replaces the organic eye lens
- Cardiac rehabilitation therapy
- Pulmonary rehabilitation therapy
- Self-injectable drugs
- Surgically implanted drugs
- Diabetic equipment
- Reconstructive surgery
- Dental injury
- Phenylketonuria (PKU)
- Care for complications of pregnancy
- Organ, tissue and bone marrow transplants
- Clinical trials
- Mental health care

## REPRODUCTIVE HEALTH SERVICES

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Life's Customer Contact Center at 1-800-839-2172 to ensure that you can obtain the health care services that you need.

## COST SHARING

Coverage is subject to deductible, coinsurances and copayments. Please consult the Policy for complete details.

## CERTIFICATION (PRIOR AUTHORIZATION OF SERVICES)

Some services require pre-certification from Health Net prior to receiving services. Please refer to your Policy for details on what services and procedures require pre-certification.

Health Net Life does not require pre-certification for dialysis services or maternity care.

## EXCLUSIONS AND LIMITATIONS

The following is a list of services that are not generally covered. For complete details on any plan's exclusions and limitations, please see the Policy for complete details.

- Contraceptive drugs and/or certain contraceptive devices are covered as specified in the Policy. Vaginal contraceptive devices are only covered when a physician prescribes the device and performs a fitting examination as specified in the Policy.
- Dental services except as specified in the Policy.
- Treatment and services for temporomandibular (jaw) joint disorders (TMJ).
- Surgery and related services for the purposes of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are medically necessary.
- Food or dietary, nutritional supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Vision care including certain eye surgeries to replace glasses, except as specified in the Policy.
- Optometric services or eye exercises, except as specifically stated elsewhere in the Policy.
- Eyeglasses or contact lenses, except as specified in the Policy.
- Sex changes.
- Services to reverse voluntary surgically induced infertility.
- Services or supplies that are intended to impregnate a woman are not covered.
- Certain genetic testing.
- Experimental or investigative services.
- Routine physical exams and preventive care services (e.g., physical exam for insurance, licensing, employment, school or camp.) Any physical, vision or hearing exams which are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Policy.
- Immunizations or inoculations for adults or children, except as described in the "Medical Benefits" section or for foreign travel or occupational purposes.
- Services not related to a covered illness or injury.
- Custodial or domiciliary care.
- Services or supplies that are not medically necessary.
- Any amounts in excess of the maximum amounts specified in the Policy.
- Pregnancy or maternity services, except as specified in the Policy.
- Cosmetic surgery except as specified in the Policy.

- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility, primarily for diagnostic tests which could have been performed safely on an outpatient basis.
  - Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.
  - Any services or supplies furnished by a non-eligible institution, which is other than a legally operated hospital or medicare-approved skilled nursing facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated.
  - Expenses in excess of a hospital's (or other inpatient facility's) most common semi-private room rate.
  - Infertility services.
  - Private duty nursing.
  - Mental and nervous disorder and substance abuse treatment, except as specified in the Policy.
  - Hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation unless due to severe mental illness or serious emotional disturbances of a child.
  - Over-the-counter medical supplies and medications.
  - Personal comfort items.
  - Orthotics, unless custom made to fit the covered person's body and as specified in the Policy.
  - The Policy does cover certain medically necessary diabetic equipment.
  - Educational services or nutritional counseling, except as specified in the Policy.
  - Hearing aids.
  - Obesity related services.
  - Any services received by Medicare benefits without payment of additional premium.
  - Services received before your effective date of coverage.
  - Services received after coverage ends.
  - Services for which no charge is made to the covered person in the absence of insurance coverage, except services received at a charitable research hospital which is not operated by a governmental agency.
  - Physician self-treatment.
  - Services provided by immediate family members.
  - Conditions caused by the covered person's commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition.
  - Conditions caused by release of nuclear energy, when government funds are available.
  - Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.
  - Services for conditions of pregnancy for a surrogate parent are covered, but when compensation is obtained for the surrogacy, we shall have a lien on such compensation to recover its medical expense.
  - Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting except as stated in the Policy.
  - Sexual dysfunction drugs.
  - Rehabilitative services rendered in an outpatient facility are not covered.
  - Psychosocial speech delay (includes delayed language development).
  - Mental retardation or dyslexia.
  - Attention deficit disorders and associated behavior problems.
  - Developmental articulation and language disorders.
- However, some of the above conditions shall be covered as shown in the "Schedule of Benefits" section, if Medically Necessary as described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness," and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

- Outpatient speech therapy, except as specified in the Policy.
- Services and supplies obtained while in a foreign country with the exception of emergency care.
- Home birth.
- Reimbursement for services for which the covered person is not legally obligated to pay the provider in the absence of insurance coverage.
- Physical exams for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Policy.
- Amounts charged by out-of-network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Treatment of chronic alcoholism, drug addiction and other chemical dependency problems, including detoxification services, except as specifically stated in the Policy.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the covered person's residence to accommodate the covered person's physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- Disposable supplies for home use.
- Services performed by a person who lives in the covered person's home or who is related to the covered person by blood or marriage.

## PRE-EXISTING CONDITIONS

Services or supplies received for the treatment of a pre-existing condition during the first 6 consecutive months during which the covered person is covered (including any waiting period). Except that:

1. This exclusion shall not apply to a child newly born to, or newly adopted by, an enrolled policyholder or his or her spouse or domestic partner, or to a child under 19.

2. If a covered person becomes eligible for coverage under this Policy within 63 days of the termination of any creditable coverage, that covered person will be given credit toward the 6-month waiting period for time covered by the creditable coverage.

## RENEWABILITY OF THIS POLICY

Subject to the termination provisions described in the Policy, coverage will remain in effect for up to the amount of days specified in the acceptance letter.

Policyholders may apply for one additional Health Net short-term insurance plan under the following circumstances:

- No short-term claims were incurred under a previous short-term medical Policy;
- There has been no significant change in health;
- The total days of coverage for all plans does not exceed 365 days.

A renewal fee of \$10 will apply if approved.

## PREMIUMS

Premiums may be changed by HNL on at least 30 days' written notice to the policyholder prior to the date of such change. Any change in premium shall take effect on the first day of the next month following the expiration of the notice period.

If the Policy is terminated for any reason, the policyholder shall be liable for all premiums for any time the Policy is in force during a grace period and any notice period.

## LOSS RATIO

Health Net Life's 2010 ratio for the Quick Net Select PPO insurance plans was 76 percent.