INDIVIDUAL & FAMILY PLANS AND
CALIFORNIA FARM BUREAU MEMBERS'
HEALTH INSURANCE PLAN

FIELD UNDERWRITING AND ENROLLMENT GUIDELINES

Health coverage made easy.

Effective January 1, 2009

Health Net®
A BETTER DECISION

CONTENTS

Introduction 3

Guidelines to submitting your client's Individual & Family applications 5

Eligibility conditions 5

Addition of new dependents 6

Children attaining age 6

Continuation of coverage for dependents on CFBF plans 6

United States residency 7

Things to remember when submitting applications 7

Payment options 8

Return of applications 8

Most common reasons for delay in processing applications 8

Guidelines for obtaining supplemental information 9

Medical underwriting guidelines 9

Insurability 9

Height and weight tables 10

Ineligible occupations 10

Prescription medications 11

Substandard guidelines 12

Declinable conditions 20

Conditions requiring medical records 21

Guaranteed Issue Coverage/Health Insurance Portability and Accountability Act (HIPAA) 22

Who is eligible for HIPAA? 22

The CashNet℠ Plan 22

Short-term plans – Quick Net Daily and Quick Net Monthly 23

Important things to remember 23

Is this plan renewable? 23

Important information 23

Supplemental Term Life Insurance offered with Individual & Family Plans 23

Supplemental Term Life offered with the California Farm Bureau Member's Health Plan 24

Common terms/definitions 24

Legal requirements 27

Applicant/client responsibility 27

Broker/agent responsibility 27

Non-English speaking applications (translation) 27

Member information 27

Changing benefits/Changing plan designs 27

Adding dental and vision option 27

Reinstatement of coverage 28

Nonsufficient fund fee 28

Re-application 28

Discrimination 28

Automatic bank draft (ABD) 28

Frequently asked billing questions 28

Certification requirements for PPO plans 29

Exceptions 29

California Farm Bureau Federation 30

Agriculture's #1 Farm organization 30

Types of membership 30

Membership dues 31

Membership benefits 31

Important broker information 32

Application mailing address 32

Forms and brochures 32

Supplemental medical questionnaires 32

INTRODUCTION

The following Field Underwriting and Enrollment Guidelines were developed to assist you and your clients with questions that might arise when writing with Health Net of California and/or Health Net Life Insurance Company's (hereinafter referred to as Health Net) Individual & Family Plans (IFP) and California Farm Bureau Members' Health Insurance Plan (CFBF).

These Guidelines are a brief overview of Health Net's underwriting practices. **Only Health Net's Underwriting Department may make a final decision to accept or decline an individual and determine the rate level or an effective date. An insurance Agent/Broker cannot guarantee coverage, change terms or waive requirements.** The guidelines are not definitive and are subject to change without notice at Health Net's sole discretion. Health Net will endeavor to keep brokers informed of changes in a timely manner.

Please advise all Applicants to maintain their prior coverage until notified by Health Net of their approval.

The Evidence of Coverage (EOC) issued by Health Net to HMO members represents the contract for coverage between Health Net and its HMO members. In the event of any conflicts or inconsistencies between this document and the EOC, the EOC shall govern.

A Policy/Certificate is issued to individuals who elect PPO coverage. The PPO plans are administered and underwritten by Health Net Life Insurance Company. The Policy/Certificate issued by Health Net Life Insurance Company to insureds represents the contract for coverage. In the event of any conflicts or inconsistencies between this document and the Policy/Certificate, the Policy/Certificate shall govern.

BROKER/AGENT RESPONSIBILITIES

Health Net Agents/Brokers are required to comply with all of Health Net's rules and regulations, including those relating to the completion and submission of applications for coverage under Health Net's Group and Individual & Family Plan Programs, including California Farm Bureau Members' Health Insurance Plans.

This means that Health Net Agents/Brokers must ensure that each application, (whether it is the paper or online version of application), must be completed by the applicant. Neither the Agent/Broker, nor any other person may complete or sign the application, except that an applicant's parent or legal guardian may complete and sign the application if the applicant in under 18 years old. There are no other exceptions.

On each application, Health Net Agents/Brokers are required to complete the Agent/Broker Information Section and its Broker Certification. An application that does not have a completed Agent/Broker Information Section and Broker Certification cannot be processed by Health Net.

As part of the Broker Certification, the Health Net Agent/Broker is required to indicate whether they assisted the applicant in completing the application or submitting the application to Health Net.

If the Health Net Agent/Broker did not assist the applicant, in any way, in completing or submitting the application, then the Health Net Agent/Broker must confirm that the applicant completed all information, with no assistance or advice of any kind from the Health Net Agent/Broker. The Health Net Agent/Broker must also confirm they understand that, if any portion of their Broker Certification statement by is false, they may be subject to civil penalties, including but not limited to a fine of up to $10,000.

If the Health Net Agent/Broker assisted the applicant in submitting the application, then the Health Net Agent/Broker must confirm that:

(1) all information in the health questionnaire was completed by the applicant;

(2) the Health Net Agent/Broker advised the applicant that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld;

(3) the Health Net Agent/Broker explained to the applicant that withholding information could result in rescission or cancellation of coverage in the future;

(4) the applicant indicated to the Health Net Agent/Broker that he or she understood these instructions and warnings;

(5) to the best of the Health Net Agent/Broker's knowledge, the information on the application is complete and accurate; and that

(6) the Health Net Agent/Broker understands that, if any portion of their Broker Certification statement is false, they may be subject to civil penalties, including but not limited to a fine of up to $10,000.

The Broker Certification also requires that whether or not the Health Net Agent/Broker assisted in applicant is completing the application or submitting the application to Health Net, the Health Net Agent/Broker must also indicate: (a) who completed the application, (b) whether the Health Net Agent/Broker personally witnessed the applicant sign the application, and (c) whether the Health Net Agent/Broker reviewed the application after the applicant signed it.

In addition, Health Net maintains the following expectations of contracted Brokers/Agents.

The Broker/Agent is expected to:

- Maintain the highest level of ethical conduct in compliance with license requirements.
- Keep informed and obey all insurance laws and regulations.
- Accurately and truthfully represent Health Net products and services.
- Provide excellent service to their client.
- Place their client's interest first.
- Identify the client's needs and recommend products and services that meet those needs.
- Stay in touch with their clients and conduct periodic coverage reviews.
- Protect the confidential information of their clients.
- Follow Health Net's Underwriting Guidelines and contact Health Net for clarification or questions.

GUIDELINES TO SUBMITTING YOUR CLIENT'S IFP AND CFBF APPLICATION

ELIGIBILITY CONDITIONS

All Applicants applying for Health Net's IFP and CFBF must meet the following requirements:

- Must be a permanent legal resident of California
- Must provide proof of legal residency if the Applicant is not a citizen of the United States (refer to United States residency requirements on page 6)
- Must be under the age of 65
- Is not eligible for Medicare Part A or Part B
- May be required to provide marriage certificate/Domestic Partner Affidavit or legal guardianship document. See following requirements.
- For IFP plans, must be at least one year old unless the child is applying with a parent or legal guardian (no dependent coverage on Subscriber Only plans)
- Child(ren) only certificates on CFBF plans:
  – Applications can be completed on most health plans to insure children ages 30 days to 18 years without either parent being on the certificate.
- Underage Applicants
  – Applicants under the age of 18: The application must be signed by the Applicant's parent or legal guardian. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in the 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 the application.
- Family coverage (no family coverage on Subscriber Only plans)
  – Spouse: Subscriber's legally married spouse
  – Domestic Partners: 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 all of the following are true:
    » Both persons have a common residence
    » Neither persons are 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
- Common Residence means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.
  – Dependent child(ren): Claimed as a dependent on the Subscriber's federal income tax return consistent with requirements of the United States Internal Revenue Service; is enrolled in an accredited school as a full-time student as defined by rules of such school; and who has not yet reached 24; or over 19 and incapable of earning his or her own living by reason of mental retardation or physical handicap incurred prior to the limiting age and who is chiefly dependent upon the Subscriber or Subscriber's spouse for support and who was insured under the Policy on the date just prior to the day his or her insurance would have ended due to age. Includes stepchild, a legally adopted child from the moment of placement in Subscriber's home, and any other child who is entirely supported by subscriber or subscriber's spouse, permanently resides in Subscriber's household and for whom Subscriber or Subscriber's spouse is court appointed guardian.
- Resides continuously in Health Net's service area
- Meet Health Net's Underwriting requirements for coverage

CFBF plans require membership with the California Farm Bureau. Refer to the Farm Bureau section for details.

ADDITION OF NEW DEPENDENTS

With the exception of policies that offer Subscriber-Only coverage, coverage for a newborn child of a subscriber, or a child adopted by or placed for adoption with a subscriber will be effective the moment of birth or the date of adoption or placement of the child. Coverage is provided for 31 days from the date of birth, adoption or placement. In order to continue coverage beyond the 31-day period, the member must complete the *Addition of Newborn or Adopted Child Enrollment Application* and enroll the child within 31 days of the date of birth, adoption or placement. The effective date will be the date of birth, adoption or placement. The subscriber will be retroactively charged for the first month's premiums.

Coverage will not be provided to a newborn during the first 31 days following birth or for a newborn dependent of a subscriber enrolled in a plan that offers Subscriber-Only coverage. A newborn dependent cannot be added to the policy of a subscriber who is enrolled in a plan that offers Subscriber-Only coverage. A newborn or any other juvenile dependent cannot be added to a Child-Only policy without underwriting approval.

If the *Addition of Newborn or Adopted Child Enrollment Application* form is not completed within the 31 days, the child's coverage will be terminated. If application is more than 31 days past the date the dependent is acquired, proof of insurability must be submitted and a full Health Insurance Application must be submitted with the dependent coverage effective according to the effective date option selected on the enrollment form. **There are no automatic additions for newborns to CFBF child(ren) only certificates.**

The 31-day non-medical rule does not apply for a dependent spouse, or registered domestic partner addition or children acquired through marriage. The Health Insurance Application should be completed indicating the appropriate additions in Section B, complete the application in its entirety and submit through normal channels.

CHILDREN ATTAINING AGE

Insurance for a dependent child terminates under the member's policy/certificate at the end of the month in which the child:

- Attains age 19 and is not a full-time student;
- Attains age 24, if full-time student (See Full-time Student Status Verification Procedures);
- Ceases to be a full-time student between the ages of 19 and 24;
- Marries or emancipates; or
- Attains age 18 (or 19, refer to the Plan COI) on a Child-Only certificate for CFBF plans.
  - Such child may request conversion to their own certificate, providing the application is made within 31 days of the date insurance as a dependent child terminates. Individuals will not be medically underwritten if covered under the same plan that they had under their child-only certificate; mandatory life insurance will also be included.

For CFBF plans, if the individual falls under any one of the following categories, they must also become a member of the County Farm Bureau to convert:

- Married child;
- Unmarried children 21 or older who live at home and are not full-time students; or
- Full-time students that attain age 24 for health coverage.

Complete the Over-age Dependent Certification, indicating conversion to their own policy/certificate. Include the member's name and Subscriber ID number. The form should be completed in its entirety and submitted following the instructions on the form.

Coverage will become effective concurrent with the date insurance as a dependent child terminates (as long as the application is made within 31 days). This will be considered a conversion and renewal commissions will apply.

CONTINUATION OF COVERAGE FOR DEPENDENTS ON CFBF PLANS

Conversion coverage for a spouse, registered domestic partner, and/or dependent child(ren) will be issued without evidence of insurability provided the conversion election form is received and the first premium is paid within 31 days of the date the Covered Person's coverage ended for the following reasons:

- The Covered Person dies;
- Written notice, signed by the Certificateholder, is received, requesting termination of coverage for any or all Covered Persons; or
- With respect to a Covered Person who is a Dependent spouse, or registered domestic partner, the last day of the calendar month in which the marriage of the Certificateholder and Dependent spouse or registered domestic partner is dissolved;

- With respect to a Covered Person who is a Dependent child, the last day of the calendar month in which the child becomes an emancipated minor or attains age 19 (age 24 if a full-time student enrolled in at least 9 semester units or equivalent at an accredited school or college), unless the child is incapable of self-sustaining employment in accordance with the terms in the definition of Dependent in the Certificate of Insurance; or
- With respect to a Covered Person who is a Dependent child, the last day of the calendar month in which the child marries.

Insurance for the surviving insured spouse or registered domestic partner of a deceased member and any surviving insured dependent children of the deceased member continues until the end of the month in which the death occurs.

To continue coverage without evidence of insurability, the dependent spouse (or dependent child) must provide a written request to convert to their own certificate within 31 days of the date insurance as a dependent terminates. The spouse, registered domestic partner, or agent should notify Health Net when an insured member has died. A copy of the death certificate is required.

UNITED STATES RESIDENCY

- Must provide proof that he or she has been a legal resident of the United States for the six consecutive months immediately prior to applying for Health Net coverage
- Health Net reserves the right to request proof of United States residency at any time
- The following are acceptable as proof of United States residency:
  - Verification of employment in the United States for the past six months
  - Rent or mortgage receipts in the United States for the past six months
  - Utility bill receipts in the United States for the past six months (the bills must be in the Applicant's name)
  - Medical records documenting treatment or residency in the United States for the past six months

THINGS TO REMEMBER WHEN SUBMITTING APPLICATIONS

- Applications must be completed and signed by the Applicant in blue or black ink.
- Applications completed or signed by a broker will not be accepted.
- Health Net relies on the applicant to provide truthful, complete and accurate information in the application process.
- Coverage is not guaranteed (except for guaranteed issue HIPAA coverage; see page 21 for HIPAA requirements). Only Health Net underwriters may make a final decision to accept or decline an application.
- Retroactive effective dates are not available.
- For IFP, effective dates of either the 1st or the 15th are available. The 15th of the month is only available for our IFP PPO plans.
- CFBF plans can be effective any day of the month.
- The cut-off date is five days prior to the requested effective date.
- If the application is being faxed, the application must be completed in black ink. If the applicant authorizes Health Net and/or Heath Net Life Insurance Company to debit their account based on the facsimile copy of their premium check they can do so by completing and signing the "Check-By-Fax" form. This form can be faxed with the application for processing. Corporate checks, third-party checks, credit card checks, cashier's checks, money orders, traveler's checks, official checks and government checks cannot be accepted. Once the premium check is faxed, **DO NOT MAIL** the original application or check. A photocopy or facsimile of this application and authorization is considered as valid as the original. Health Net recommends that Brokers keep the application or a copy on file as well as the copy of the Check by Fax form for no less than seven (7) years.
- All Applicants, except newborns, require a Social Security number/Matricular Consula ID (Mexican Consulate ID). Matricular Consula ID can be accepted in place of social security numbers.
- The application must be received by Health Net within 30 days from the signature date. A new application will be required if the signature date is more than 60 days old from the effective date.
- For CFBF plans each applicant must complete the Statement of Health section. Additional forms can be requested.

- A HIPAA Authorization form will be required to be completed by the applicant if medical records are required. This form authorizes the release of medical information to Health Net. If this form is not completed and signed this can delay the processing of the application.
- All Applicants must list all prescription medications currently being taken, regardless of plan requested.
- A check must accompany the application when submitted to Health Net. The check will not be processed unless the application is approved by Health Net's Underwriting Department. The original check, submitted by the Applicant, will be returned if the application is declined. If a member of a contract (Subscriber & Spouse/Domestic Partner, Subscriber & Child, Subscriber & Children, Family) is declined, Health Net will deposit the check at the request of the Primary Applicant. Cashing the Applicant's check does not mean the application has been accepted.
- If the premium check is insufficient or not included with the application, the application will not be processed. All applications must include the first month's premium. The application must be filled out accurately and completely. Any information regarding an Applicant's medical history that is communicated to a broker, either verbally or in writing, must be included on the application form.
- CFBF applications must include payment for the Farm Bureau's Membership Dues.
- If all questions on the individual application are not answered in full, the application will be returned, which will result in a delay in processing and may result in a change in the effective date of the policy. Failure to provide information will result in a declination.
- For additional information or explanations to be submitted with the application, attach extra sheets of paper if necessary. All attachments must be signed and dated by the Applicant.
- Please see the section titled RESCISSION on page 26 for important information on rescission of membership.

PAYMENT OPTIONS

- **Preferred Payment Option**
  Automatic Bank Draft (ABD) – One month's premium and the Simple Pay Option Form. The premiums withdrawn from the account will be for future billing periods plus any past due balances. The first month's withdrawal may be for multiple bill periods, if the Applicant did not submit a binder check or due to the timing of the ABD set-up. The premium will be withdrawn from the Applicant's bank account approximately 10 days in advance of the due date.
- Credit card billing – Monthly premium will be charged directly to the Applicant's credit card account. The premiums charged to the account will be for the future bill period plus any past due balances. The premium will be charged to the Applicant's credit card about ten days in advance of the due date.
- Monthly billing – one month's premium must be remitted with the application.

RETURN OF APPLICATIONS

Applications will be returned for the following reasons:

- A missing signature of the Applicant, spouse, domestic partner, guardian and dependents age 18 or older
- Undated applications
- Applications received in Health Net's office more than 30 days from the signature date
- Applications requesting an effective date more than 60 days from the signature date
- Applications completed in pencil
- Incomplete applications

MOST COMMON REASONS FOR DELAY IN PROCESSING APPLICATIONS

- First month's premium not remitted with the application
- Plan type is not selected
- Social Security numbers are omitted
- Medical information is incomplete
- Height/weight and/or date of birth is missing
- Incomplete address information
- Broker ID is missing

GUIDELINES FOR OBTAINING SUPPLEMENTAL INFORMATION[1]

CLEAN APPLICATION

A **Clean Application** is defined as an application in which the applicant has answered No to all medical history questions. When evaluating a Clean Application, the following chart should be used to determine if supplemental information is required from the applicant:

APPLICANT AGE	REQUIREMENT
35 – 49	Supplemental Medical Attendances Questionnaire
50 – 64	Supplemental Medical Attendances Questionnaire

If an applicant age 50–64 provides no additional medical history information on the Supplemental Medical Attendances Questionnaire, as described on the questionnaire, the results of a physical examination will be required. Expenses related to that exam will be the applicant's responsibility.

The examination must include:

- height/weight, measured in the physician's office
- blood pressure readings
- results of a resting EKG
- results of a blood chemistry profile and urinalysis
- results of any other diagnostic tests the doctor may recommend.

For male applicants, the blood chemistry profile must include PSA results. For female applicants, the result of a Pap smear is required.

A copy of the physician's chart notes and test results must be submitted.

[1]The Guidelines for Obtaining Supplemental Information do not apply to Health Net Quick Net Plans.

ROUTINE EXAMINATION

If an applicant discloses on the application that a routine physical examination had been performed, the following chart should be used to determine if supplemental information is required.

APPLICANT AGE	DATE OF EXAM	REQUIREMENT(S)
30 – 34	Within previous year	Physical Exam Results Questionnaire
35 – 44	Within previous year	Physical Exam Results Questionnaire Medical Attendances Questionnaire
45 – 49	Within previous 2 years	Physical Exam Results Questionnaire Medical Attendances Questionnaire
50 – 54	Within previous year	Medical Records Medical Attendances Questionnaire
50 – 54	Within 1 – 3 years	Physical Exam Results Questionnaire Medical Attendances Questionnaire
55 – 64	Within 3 years	Medical Records Medical Attendances Questionnaire
55 – 64	Within 3 – 5 years	Physical Exam Results Questionnaire Medical Attendances Questionnaire

MEDICAL UNDERWRITING GUIDELINES

INSURABILITY

Because of the potential additional risk associated with certain medical conditions, some Applicants will be declined for all coverages. However, based on underwriting evaluation, certain Health Net PPO plans may be offered at a 20 percent or 50 percent additional premium. Health Net's Individual HMO plans are not available for other than preferred premiums.

HEIGHT AND WEIGHT TABLES

The height and weight tables included with these guidelines will be used to evaluate an Applicant's insurability. Certain conditions, such as high blood pressure, as well as individuals who smoke, will be taken into consideration during the application process.

FEMALES, AGES 18-64

	PREFERRED				AGE 35 & YOUNGER
	MINIMUM	MAXIMUM	+20%	+50%	+50%
4'8"	76	129	138	152	161
4'9"	79	134	143	157	166
4'10"	81	139	148	163	172
4'11"	84	144	153	168	178
5'0"	87	148	159	174	184
5'1"	90	153	164	180	191
5'2"	93	159	169	186	197
5'3"	96	164	175	192	203
5'4"	99	169	181	198	210
5'5"	102	174	186	204	216
5'6"	105	180	192	211	223
5'7"	109	185	198	217	230
5'8"	112	191	204	224	237
5'9"	115	196	210	230	244
5'10"	118	202	216	237	251
5'11"	122	208	222	244	258
6'0"	125	214	229	251	265
6'1"	129	220	235	258	273
6'2"	132	226	241	265	280
6'3"	136	232	248	272	288

MALES, AGES 18-64

	PREFERRED				AGE 35 & YOUNGER
	MINIMUM	MAXIMUM	+20%	+50%	+50%
5'0"	92	154	164	179	189
5'1"	95	159	169	185	196
5'2"	98	164	175	191	202
5'3"	102	169	181	198	209
5'4"	105	175	186	204	216
5'5"	108	180	192	210	222
5'6"	112	186	198	217	229
5'7"	115	192	204	223	236
5'8"	118	197	210	230	243
5'9"	122	203	217	237	251
5'10"	125	209	223	244	258
5'11"	129	215	229	251	265
6'0"	133	221	236	258	273
6'1"	136	227	243	265	280
6'2"	140	234	249	273	288
6'3"	144	240	256	280	296
6'4"	148	246	263	288	304
6'5"	152	253	270	295	312
6'6"	156	260	277	303	320

INELIGIBLE OCCUPATIONS

- Asbestos/toxic chemical workers
- Athletes – Semi-pro and Professional
- Explosives workers
- Deep-sea fisherman
- Off-shore oil workers
- Flight instructors
- Crop dusters
- Stunt or test pilots
- Underground miners
- Salvage and rescue underwater divers
- Stunt person
- Pyrotechnician
- Rodeo performers
- Ski patrol
- Riggers
- Jockeys
- Loggers or lumber industry

PRESCRIPTION MEDICATIONS

During the underwriting process, the cost of an Applicant's medications in relation to the monthly premium will be evaluated. Based on this evaluation, coverage may be offered with a 20 percent or 50 percent additional premium, or coverage may be declined, or a higher premium plan may be offered. The prescriptions below may result in an application being declined or rated with an additional 20 percent or 50 percent of premium, depending on the plan selected, cost of the prescription, age and contract size.

PRESCRIPTION	CONDITIONS
Accutane	Skin disorders
Aciphex	Gastrointestinal/gastroesophageal
Advair	Asthma
Allegra	Allergy
Azmacort	Asthma
Celebrex	Anti-inflammatory
Celexa	Antidepressant
Concerta	ADHD
Depakote	Anticonvulsant
Effexor	Antidepressant
Famvir	Herpes
Flovent	Asthma
Imdur	Antihypertensive
Imitrex	Headache/migraines
Intal	Asthma
Lamisil	Anti-fungal
Lipitor	Cholesterol and triglyceride reduction
Lopid	Cholesterol and triglyceride reduction
Maxalt	Headache/Migraines
Mevacor	Cholesterol and triglyceride reduction
Nexium	Gastrointestinal/gastroesophageal
Parlodel	Menstrual disorders
Paxil	Antidepressant
Pravachol	Cholesterol and triglyceride
Prevacid	Gastrointestinal/gastroesophageal
Prilosec	Gastrointestinal/gastroesophageal
Proscar	Benign prostatic hyperplasia
Protonix	Gastrointestinal/gastroesophageal

PRESCRIPTION	CONDITIONS
Prozac	Antidepressant
Pulmicort	Asthma
Relafen	Anti-inflammatory
Renova	Skin disorders
Retin A	Skin disorders
Ritalin	ADHD (children only)
Serevent	Asthma
Serzone	Antidepressant
Singulair	Asthma
Tagamet	Gastrointestinal/gastroesophageal
Tambocor	Antihypertensive
Tapazole	Hyperthyroid
Temovate	Skin disorders
Tolectin	Anti-inflammatory
Topamax	Anticonvulsant
Valtrex	Herpes
Wellbutrin	Antidepressant
Xanax	Antidepressant
Zantac	Gastrointestinal/gastroesophageal
Zocor	Cholesterol and triglyceride reduction
Zoloft	Antidepressant
Zomig	Headache/migraines
Zovirax	Herpes
Zyrtec	Allergy

The prescription list is intended to serve as a guide only; other prescriptions may result in an application being declined or rated with an additional 20 percent or 50 percent of premium.

SUBSTANDARD GUIDELINES

Following is a list of commonly encountered medical impairments that may result in an additional 20 percent or 50 percent premium or declination of an application. This guide is for more common impairments and is not intended as a definitive representation of Health Net's underwriting guidelines. All underwriting decisions are subject to consideration of the facts related to an Applicant's specific medical history. The absence of any impairment from this list does not imply insurability.

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Acne	Superficial, treated with antibiotics or topical medications only.	Preferred
	Requiring Accutane or intralesional steroid treatment within past 12 months.	Decline
Allergies	No smoking and no prescription medication within past 12 months.	Preferred
	No smoking within 12 months, requires prescription medication.	+20%
	Has smoked within past 12 months, no prescription medication during past 12 months.	+50%
	Potential surgical candidate or requiring long term systemic steroid use, or desensitization injections within past 12 months, or has smoked and required prescription medication during past 12 months.	Decline
Anal Fissure	Single episode, no immune disorder symptoms, sign, symptom, treatment free for at least 2 years, or surgically corrected, sign symptom, treatment free for 12 months.	Preferred
	No more than 2 episodes in 12 months, not a surgical candidate, sign, symptom, treatment free for 12 months.	+20%
	Above criteria not met.	Decline
Anorexia Nervosa	Sign, symptom, treatment free for 10 years, normal current exam and lab results.	Preferred
	As above, sign symptom, treatment free for 5–10 years.	+50%
	Above criteria not met.	Decline
Aortic Valve Disease	Sign, symptom treatment free for at least 5 years, current exam with normal cardiac function, using prophylactic antibiotics only, no cardiac medications, no other cardiac conditions, normal kidney function studies, no smoking within previous 5 years.	+20%
	As above, smoking within previous 5 years.	+50%
	Above criteria not met.	Decline
Asthma	No emergency room visit or hospital stay within 2 years, no smoking for previous 2 years, intermittent use of single inhalant steroid or bronchodilator, regular prescription medications required.	+20%
	Requires daily inhalant steroid or bronchodilator, or child between one and twelve years old, maintained on home nebulizer treatment, not asthma-related ER or hospital visits within past two years.	+50%
	Above criteria not met.	Decline
Anxiety	See "Depression."	
Autism	Over age 10 years, never institutionalized, no seizures, self-destructive behavior, or speech therapy, controlled with single medication only for more than two years.	+50%
	Above criteria not met.	Decline

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Back pain	No herniated or bulging discs, not a surgical candidate, intermittent over-the-counter medications only, sign, symptom, treatment free within previous 6 months.	Preferred
	As above, but chiropractic treatment or anti-inflammatory medication within previous 6–12 months.	+20%
	As above, but physical therapy within past 12 months.	Decline
	Above criteria not met.	Decline
Basal Cell Carcinoma	Single lesion in-situ, surgically excised, sign, symptom, treatment free for previous 12 months.	Preferred
	As above, but sign, symptom, treatment free for previous 3–12 months.	+20%
	Above criteria not met.	Decline
Breast Implants	Surgery greater than 6 months and less than 5 years prior to application date.	+20%
	Surgery greater than five years and less than 8 years prior to application.	+50%
	History of painful capsular contractures, firmness or hardness, or any other complications, surgery less than 6 months or greater than 8 years prior to Application date.	Decline
	Silicone implants.	Decline
Bunions	Surgically excised, sign, symptom, treatment free for at least 3 months.	Preferred
	Not surgically excised, not a surgical candidate and sign, symptom, treatment free for at least 12 months.	+50%
	Above criteria not met.	Decline
Cataract	Surgical correction completed for one or both eyes, sign, symptom, treatment free for at least 12 months.	Preferred
	As above, sign, symptom, treatment free for 6–12 months.	+20%
	As above, sign, symptom, treatment free for 3–6 months.	+50%
	Above criteria not met.	Decline
Cellulitis	During the previous two years, no more than 2 episodes lasting more than 3 weeks, no immune disorder symptoms, no inpatient hospital care required within the past year, sign, symptom, treatment free for at least 6 months.	Preferred
	More than 2 episodes during the previous two years, normal blood test results, no immune disorder symptoms, sign, symptom, treatment free for at least 3 months.	+50%
	Above criteria not met.	Decline
Cerebral Palsy	Over age 20, self-supporting, requires no support care.	+20%
	Over age 10, minimal spasticity, capable of independent living, all surgical corrections completed, treatment-free for 2 years.	+50%
	Above criteria not met.	Decline
Chiropractic Treatment	Maintenance treatment only, no more than once monthly, no diagnosis or symptoms of back disorder, treatment within past 6 months.	+20%
	As above, maintenance treatment no more than twice monthly.	+50%
	Above criteria not met.	Decline

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Cleft Palate	Surgically repaired, all cosmetic repairs completed, no hearing or speech impairment, sign, symptom, treatment free for at least 2 years.	Preferred
	As above, sign, symptom, treatment free 12 to 24 months.	+50%
	Above criteria not met (including ongoing speech therapy).	Decline
Crohn's Disease	Sign, symptom, treatment free for at least 10 years after intestinal resection of the affected area, no immune disorder symptoms, no use of prescription medication to treat intestinal disorder, any ostomy repaired.	+20%
	As above, but sign, symptom, treatment free from 5-10 years.	+50%
	Above criteria not met.	Decline
Cystitis	Up to two acute episodes in 2 years, sign, symptom, treatment free for at least 2 months.	Preferred
	As above, 3–4 episodes in 2 years, sign, symptom, treatment free for at least 6 months.	+20%
	As above, more than 4 episodes in 2 years, sign, symptom, treatment free for at least 6 months.	+50%
	Above criteria not met.	Decline
Depression/Anxiety	Sign, symptom, treatment free for at least 2 years.	Preferred
	Sign, symptom, treatment free for 12–24 months or one single acute incident during previous 24 months. No more than one medication prescribed at any one time. (Medical records will be required).	+20%
	Current treatment or treatment within previous 12 months. Single medication only, no more than 4 physician or counseling visits within previous 12 months. No other physical symptoms. (Medical records will be required).	+50%
	Above criteria not met.	Decline
Diverticulitis	Post surgical resection of affected area, sign, symptom, treatment free for at least 5 years.	Preferred
	As above, but sign, symptom, treatment free 3–5 years.	+50%
	Above criteria not met.	Decline
Diverticulosis	Incidental finding and sign, symptom, treatment free for at least 3 years.	Preferred
	Incidental finding and sign, symptom, treatment free for less than 3 years.	+20%
	Above criteria not met.	Decline
Eczema	Acute episode lasting no more than 3 weeks, no immune disorder symptoms, sign, symptom, treatment free for at least 3 months.	Preferred
	As above, but chronic condition, controlled by antihistamines and/or topical steroids PRN or single 10-day course of oral steroids in any 12 month period.	+20%
	Above criteria not met.	Decline
Endometriosis	Post-menopausal or treated with Lupron, or Laparoscopic ablation/fulguration of endometrium, sign, symptom, treatment free for at least 3 years, or ovaries removed, sign, symptom, treatment free for at least 6 months.	Preferred
	As above, sign, symptom, treatment free for 2–3 years.	+20%
	Above criteria not met.	Decline

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Epilepsy	No hospitalization or emergency room visit within 2 years, controlled on no more than two prescription medications for at least 12 months.	Preferred
	No hospitalization or emergency room visit within 2 years, seizure-free on medication for at least 6 months.	+20%
	Above criteria not met.	Decline
Ganglion	Surgically excised and sign, symptom, treatment free for at least 3 months.	Preferred
	Not surgically excised and sign, symptom, treatment free for at least 12 months.	+50%
	Above criteria not met.	Decline
Gastroenteritis	Fully recovered from incident lasting no more than 7 days, no immune disorder system, sign, symptom treatment free for at least 2 months since incident.	Preferred
	Above criteria not met.	Decline
Gastroesophageal Reflux Disease (GERD)	Well controlled on over-the counter medications only for at least 12 months, all medical evaluations completed, no immune disorder symptoms, no pulmonary or cardiac symptoms, including asthma, sign, symptom, and treatment free for at least 12 months	Preferred
	As above, but isolated prescription medication usage within the previous 6-12 months.	+20%
	Above criteria not met or prescription medications within the most recent 6 months.	Decline
	Medical records will be required if prescription medications have been used during the previous two years.	
Glaucoma	Maintained on non-steroidal topical drops for at least 2 years and not a surgical candidate, or surgically repaired and sign, symptom, treatment free for at least 12 months.	+20%
	Maintained on non-steroidal topical drops for 1–2 years and not a surgical candidate, or sign, symptom, treatment free for at least 6 months.	+50%
	Above criteria not met.	Decline
Gout	Never hospitalized, no significant deformity, no steroid treatment, sign, symptom, treatment free for at least 2 years.	Preferred
	As above, but maintained on NSAID medication within past 12 months.	+20%
	As above, but intermittent steroid treatment only, no more than 2 10-day course in 24 months.	+50%
	Above criteria not met.	Decline
Hemorrhoids	Sign, symptom, treatment free for at least 6 months and either surgically corrected or not a surgical candidate.	Preferred
	As above, but sign, symptom, treatment free for 3–6 months prior to application.	+20%
	Above criteria not met.	Decline
Herpes Genitalis	Genital, non-anal, no other STD in 10 years, no immune disorder symptoms, sign, symptom, treatment free for at least 2 years.	Preferred
	As above, but sign, symptom, treatment free for at least one year.	+20%
	As above, but sign symptom, treatment free for at least 6 months or requiring prophylactic medications.	+50%

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Hepatitis A	Single episode, normal liver function tests, sign, symptom, treatment free for 12 months.	Preferred
	As above, sign, symptom, treatment free for 6–12 months.	+20%
	Above criteria not met.	Decline
Hodgkin's Disease	Stage 1 or 2, at least 10 years after treatment completed, current normal CBC sign, symptom, treatment free, or Stage 3 or 4, at least 15 years after treatment completed, current normal CBC & chest x-ray, sign, symptom, treatment free.	+20%
	Above criteria not met.	Decline
Hypercholesterolemia/ high cholesterol or high triglycerides	Within preferred weight for minimum 12 months, no smoking for minimum 12 months, cholesterol or triglycerides controlled with one medication for at least 12 months, no other cardiac risk.	Preferred
	As above, but controlled with one medication and tobacco use.	+50%
	Above criteria not met.	Decline
Hypertension	Within preferred weight for at least 12 months, no smoking for at least 12 months, blood pressure controlled at 140/90 or less for at least 12 months no more than two medications plus diuretic, normal lipid profile and kidney function studies, no other cardiac risk.	Preferred
	As above, no more than two medications plus diuretic or currently smoking and no other health issues.	+50%
	Any of above criteria not met.	Decline
Hyperthyroidism	Surgically corrected or treated with radioactive medication or antithyroid agents and sign, symptom, treatment free for at least 1 year.	Preferred
	As above, but sign, symptom, treatment free for 6–12 months.	+20%
	Above criteria not met.	Decline
Hypothyroidism	Taking thyroid replacement only and stable and under treatment for at least 6 months.	Preferred
	As above, but stable and under treatment for 3–6 months.	+20%
	Above criteria not met.	Decline
Irritable Bowel Syndrome	Sign, symptom, treatment free for at least 2 years.	Preferred
	Sign, symptom, treatment free for at least 12–24 months.	+20%
	Above criteria not met.	Decline
Kidney Stone	Single episode, normal kidney function studies, sign, symptom, treatment free for at least 24 months.	Preferred
	As above, but 12–24 months since episode.	+20%
	Above criteria not met.	Decline
Leukemia	No immune disorder symptoms, normal current blood tests, sign, symptom, treatment free for at least 10 years.	+20%
	Above criteria not met.	Decline
Lyme Disease	Sign, symptom, treatment free (with no residuals) for at least 5 years.	Preferred
	Sign, symptom, treatment free (with no residuals) for 3–5 years.	+20%
	Sign, symptom, treatment free (with no residuals) for 2–3 years.	+50%
	Above criteria not met.	Decline

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Malignant Melanoma	Surgically excised, in-situ depth of less than 0.76 mm, sign, symptom, treatment free for at least 10 years.	Preferred
	As above, sign, symptom, treatment free from 5–10 years.	+50%
	Above criteria not met.	Decline
Meniere's Disease	Single episode, full recovery, no hearing loss, sign, symptom, treatment free for at least 6 months.	Preferred
	3 episodes in 2 years, sign, symptom, treatment free for at least 6 months.	+20%
	As above, but sign, symptom, treatment free for 3–6 months.	+50%
	Above criteria not met.	Decline
Migraine Headache	No emergency room visits for at least 2 years, no prescription medication for at least 12 months.	Preferred
	As above, but use of non-narcotic prescription medication within past 12 months (subject to cost).	+20%
	As above, but 1 emergency room visit within 1–2 years.	+50%
	Above criteria not met or using Imitrex, Amerge, or other high cost prescription medication within past year.	Decline
Mononucleosis	Single episode with recovery time of no more than 8 weeks, no immune disorder symptoms, normal liver function studies, sign, symptom, treatment free for at least 12 months.	Preferred
	As above, but sign, symptom, treatment free for 6–12 months.	+20%
	Above criteria not met.	Decline
Osteoarthritis	No deformities requiring reconstructive surgery, taking infrequent non-steroid anti-inflammatory medications, no history of hospitalization.	Preferred
	As above, but requiring maintenance non-steroid anti-inflammatory medications.	+20%
	As above, but with single incidence of steroid treatment within past 12 months, treatment free for at least 6 months.	+50%
	Above criteria not met or on-going use of a medical appliance such as a brace.	Decline
Otitis Media	No more than 3 infections in 12 months, no hearing loss, not a candidate for tubes, sign, symptom, treatment free for at least 3 months.	Preferred
	As above, but more than 3 infections in 12 months, or tubes in place. Must be sign, symptom, treatment free for at least 3 months.	+20%
	Above criteria not met.	Decline
Ovarian Cyst	Cyst removed or resolved (as indicated by ultrasound), sign, symptom, treatment free for at least 24 months.	Preferred
	As above, but sign, symptom, treatment free for 1–2 years	+50%
	-or-	
	Ovary removed, sign, symptom, treatment free for at least 6 months.	Preferred
	Above criteria not met.	Decline
Pancreatitis	Single, acute episode, fully recovered, sign, symptom, treatment free for at least 5 years (must be non-alcohol related).	Preferred
	As above, but sign, symptom, treatment free for 3–5 years.	+50%
	Above criteria not met.	Decline

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Panic Attacks	Last treatment or medications more than 5 years ago.	Preferred
	Last treatment or medication within past 3–5 years.	+20%
	Treatment or medication within previous 3 years.	Decline
PAP Smear, abnormal	Two subsequent normal PAP smears & return to normal annual PAP schedule.	Preferred
	Above criteria not met.	Decline
Prostatitis	Single episode, not related to STDs, no in-patient hospitalization, no urinary retention problems, normal kidney function studies and PSA, sign, symptom, treatment free for at least 6 months.	Preferred
	As above, but with 2 acute episodes in two years.	+20%
	Above criteria not met.	Decline
Psoriasis	Stable for at least 2 years, using topical ointments only, no immune system disorder or other systemic condition, no oral medications within past 2 years.	Preferred
	As above but no more than 2 courses of oral medications within past 12–24 months.	+50%
	UV therapy or oral medication within past 12 months.	Decline
Pyelonephritis	Single episode, normal kidney function studies, sign, symptom, treatment free for at least 12 months.	Preferred
	2 episodes in 3 years, normal kidney function studies, sign, symptom, treatment free for at least 12 months.	+20%
	Above criteria not met.	Decline
Raynaud's Disease	Normal blood studies (ANA, RA, SLE, & thyroid), no smoking and sign, symptom, treatment free for at least 2 years.	Preferred
	As above, but smoking within 24 months.	+50%
Rhinitis (chronic)	No smoking and no prescription medication within past 12 months.	Preferred
	No smoking within 12 months, requires prescription medication.	+20%
	Has smoked within past 12 months, no prescription medication during past 12 months.	+50%
	Potential surgical candidate or requiring long term systemic steroid use, or desensitization injections within past 12 months, or has smoked and required prescription medication during past 12 months.	Decline
Strabismus	All surgical corrections or patching complete and cosmetically acceptable, sign, symptom, treatment free for at least 6 months.	Preferred
	As above, but sign, symptom, treatment free for 3–6 months.	+20%
	Above criteria not met.	Decline
Syphilis	No other STD within 10 years, no immune disorder symptoms, sign, symptom, treatment free for at least 12 months.	Preferred
	As above, but sign, symptom, treatment free for at least 6 months.	+20%
	Above criteria not met.	Decline
Tuberculosis (positive skin test and negative chest x-ray)	(Complete medical records required) Positive skin test, negative chest x-ray, INH therapy not required per physician -or- (Complete medical records required) Positive skin test, negative chest x-ray, prophylactic INH therapy required, sign, symptom, treatment free for at least 6 months following completion of INH treatment.	Preferred
	As above, but less than 6 months since completion of INH treatment.	+20%

CONDITIONS	EVALUATION CRITERIA	RATE ACTION
Tuberculosis (primary pulmonary)	Treated with prophylactic INH or oral antibiotics only, no hospitalization required, no immune system disorders or symptoms, negative chest x-ray within previous 12 months, sign, symptom, treatment free for at least 12 months.	Preferred
	As above, but required hospitalization, sign, symptom, treatment free for at least 2 years, no immune disorder symptoms.	+20%
	Above criteria not met.	Decline
Ulcer	(If due to H-Pylori infection) No bleeding for at least 5 years, no in-patient hospitalization within previous 5 years, treated with antibiotics, no smoking for previous 2 years, sign, symptom, treatment free for at least 3 months.	Preferred
	(If due to reason other than H-Pylori infection) No bleeding for at least 5 years, no in-patient hospitalization within previous 5 years, no smoking for previous 2 years, sign, symptom, treatment free for at least 2 years.	Preferred
	Above criteria not met.	Decline
Ulcerative Colitis	Post surgical proctocolectomy, no immune disorder symptoms, sign, symptom, treatment free for at least 10 years.	+20%
	As above, sign, symptom, treatment free for 5–10 years.	+50%
	Above criteria not met.	Decline
Uterine Fibroids	Surgically corrected by hysterectomy, myomectomy, or embolization, treatment free for at least 3 months.	Preferred
	Above criteria not met.	Decline

DECLINABLE CONDITIONS

Applicants with the following conditions will generally be considered uninsurable. This list is intended to serve as a guide only; decisions regarding an Applicant are subject to underwriting consideration of the facts related to a specific medical history. The absence of any impairment from this list does not imply insurability.

Any Applicant currently disabled, receiving disability payments or benefits, being treated for a work-related disorder, or receiving workers compensation benefits will be considered uninsurable. Any Applicant who is experiencing or who has experienced symptoms during the previous 12 months for which a physician has not been consulted or which has yet to be diagnosed will be considered uninsurable. Coverage will not be issued to **any Applicant who has had diagnostic tests recommended which have yet to be completed.**

- Abnormal cervical cancer screening (e.g., Pap smear)
  – Must have two normal subsequent cervical cancer screenings; annual follow-up to be considered
- Abnormal or unintended weight loss
- AIDS
- Airway obstruction – chronic
- Alcoholic cardiomyopathy
- Alcohol/substance abuse – within 5 years
- Arrhythmia – on medication
- Alzheimer's disease
- Angina pectoris
- Angioplasty – no time limit
- Ankylosing spondylosis/litis
- Asbestosis
- Asthma – treatment in emergency room or hospital within 2 years and/or smoking within 12 months or long-term steroid use
- Attention deficit disorder (ADD or ADHD) – if single juvenile applicant under 8 years of age
- Bi-polar disorder
- Black lung disease
- Brain disorder
- Breast cancer – 10 years
- Bronchitis – chronic
- Blood dyscrasias
- Bulimia
- Cancer – basal cell carcinoma, treatment within 3 months
- Cancer – internal; treatment within 10 years
- Cerebral vascular disease (stroke or TIA)
- Cardiomyopathy
- Connective tissue disease
- CREST syndrome
- Chronic obstructive pulmonary disease (COPD)
- Cystic fibrosis
- Diabetes – once diagnosed, all treatments
- Down's syndrome
- Eating disorders
- Emphysema
- Endometriosis – treatment or medication within two years
- Esophageal reflux
- Eye disorders – requiring ongoing treatment
- Fatigue disorders
- Fibromyalgia
- Fibromuscular hyperplasia
- Gastrointestinal bypass
- Heart disease or bypass surgery – no time limit
- Hepatitis B, C, E, F, G, non-A, non-B – no time limit
- Hip replacement
- Hydrocephalus

- Hyperhydrosis
- Hypertension/high blood pressure – any treatment when combined with history of diabetes, ratable height & weight, or treated with three or more medications or untreated or uncontrolled
- Immune disorders
- Infertility – any history in premenopausal women. The spouse will be uninsurable as well.
- Joint replacement
- Liver disease
- Lupus
- Lymphoma
- Manic depression
- Mitral valve prolapse – on medication
- Multiple sclerosis
- Myasthenia gravis
- Myocardial infarction (heart attack) – no time limit
- Obsessive-compulsive disorders (OCD)
- Organ transplant
- Osteoporosis
- Paralysis – will consider for cause and requirement for wheelchair
- Parkinson's disease
- Polycystic kidneys
- Polycystic ovary disease
- Pregnancy – current; includes male applicants expecting a child with someone
- Premature birth – within 6 months
- Psoriatic arthritis
- Psychiatric disorders – if hospitalized within 2 years
- Renal disease – chronic; includes dialysis
- Renal failure
- Rheumatoid arthritis
- Rhinitis – chronic, smoking within 12 months or long-term steroid use
- Reiter's syndrome
- Sickle cell anemia
- Seizure disorders – uncontrolled or seizure within 6 months
- Transposition of the great arteries
- Thalassemias
- Thromboangitis obliterans – Buerger's disease
- TMJ – (Temporomandibular joint pain/dysfunction)
- Weight loss – participation within the last 12 months in a program using prescription medication
- Wolf-Parkinson-White syndrome – WPW

CONDITIONS REQUIRING MEDICAL RECORDS[1]

The following is a list of some of the more common conditions that will require underwriting review of the Applicant's medical records. The underwriting decision will be based on the history of each Applicant and the underwriting outcome cannot be predicted. This is only a partial list; the need for review of medical records will be determined on an individual basis by Underwriting.

Ear infections:

- to age 6: 1 or 2 occurrences within the last 12 months
- ages 6–10: 1 or more within the last 6 months
- over age 10: no Attending Physician Statement

Anxiety or depression

Hypercholesteremia or hyperlipidemia

Hypertension

Kidney stones – within 5 years or multiple attacks

Migraine headaches within 3 years

[1]Kaiser Permanente patients experience greater success in obtaining a copy of their medical records on a timely basis and at a more reasonable fee than what is achievable by Health Net. When a copy of an applicant's medical records is required from Kaiser Permanente in order to assess insurability, Health Net will request that the applicant obtain that information directly. Health Net will reimburse the applicant up to $25 for fees related to obtaining these records.

GUARANTEED ISSUE COVERAGE/ HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprehensive federal legislation providing, among other things, guaranteed issuance of individual coverage to certain eligible individuals. There are no plan changes allowed on HIPAA plans.

WHO IS ELIGIBLE FOR HIPAA?

Applicants who meet the following requirements are eligible to enroll in Health Net's Guaranteed Issue HMOs and PPOs, without underwriting. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance.

To be considered an eligible individual:

- The most recent coverage must have been under a group health plan. A group health plan includes COBRA and Cal-COBRA coverage, a federal government plan for federal employees, a governmental plan, or church plan as defined in the federal Employee Retirement Income Security Act (ERISA).
- The Applicant must have a total of 18 months of coverage (including COBRA or Cal-COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
- If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.
- The Applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- The individual's most recent coverage could not have been terminated due to fraud or non-payment of premiums.

THE CASHNET[SM] PLAN AVAILABLE WITH CFBF PLANS ONLY

The CashNet Plan is a supplemental medical expense product that can help "bridge" hospitalization costs. When combined with our CFBF HSA qualified PPO plan, our CashNet Plan is also HSA qualified.

CashNet Plan Includes Reimbursement for:

- Hospital Confinement
  $300 per Day for Hospital Covered Charges for All Illnesses and Accidental Injuries (Maximum of 30 days per calendar year. Lifetime maximum of 300 days.)
- Accidental Injury
  Up to a maximum of $500 per year. (This benefit does not apply to "Child(ren)-Only" policies.)
- Ambulance
  Ambulance Transportation Due to an Accident (This benefit does not apply to "Child(ren)-Only" policies.)
  - $300 for Land Transportation
  - $1,000 for Air Transportation
- Mammography
  Up to $100 (Maximum of 1 visit per calendar year.)

The CashNet Plan is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract or major medical expense insurance. It is available only with actively marketed Health Net PPO CFBF plans.

Payment is subject to all other terms of the policy. Please refer to the certificate for a list of exclusions and limitations.

SHORT-TERM PLANS – QUICK NET DAILY AND QUICK NET MONTHLY

Health Net short-term products, Quick Net Daily and Quick Net Monthly, offer coverage from 30 days to 185 days, or one to six months. These plans have been specially designed to accommodate your clients who are transitioning between jobs, entering the job market, or just need coverage for a short period of time. They can enroll in Health Net's Quick Net Daily or Quick Net Monthly plan and have the comfort and peace of mind that comes with knowing they're insured. Applying is easy! The Quick Net application features fewer medical questions than standard individual health applications, and the approval process is immediate.

If the application you submit does not have a "yes" answer to any medical question, and each applicant's height and weight are within Health Net's underwriting parameters, your client's application will be approved immediately. (Please be aware that, if the applicant has been enrolled in the past in any Health Net medical coverage, information included in claims history may be used to establish insurability. In addition, during the pre-enrollment underwriting process for each applicant, Health Net will submit an inquiry to the Medical Information Bureau (MIB) and to a commercial vendor of paid pharmacy claims data with whom Health Net contracts. Any information or data received from those sources will be used during the evaluation of each applicant's insurability.) The effective date will not precede the postmark date of the application. If the application is faxed, the effective date can be the day the application is received.

IMPORTANT THINGS TO REMEMBER

Quick Net Daily

Your clients must select their effective date and coverage period, from 30 days to 185 days. There are no changes or refunds once the policy is in force.[1]

The premium check must be for the full amount owed for the policy benefit period.[2]

[1]There are no changes allowed beyond the 10-day free look period. No exceptions will be made.

[2]The premium check will be held in trust while the application is reviewed by Health Net Life. Applications submitted without payment or 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.

Quick Net Monthly

Your clients must select their effective date.

They will be billed monthly for a maximum of six months the policy is in force.[1]

The first month's premium must accompany the application.[2]

IS THIS PLAN RENEWABLE?

Health Net's Quick Net Products are non-renewable. However, if there is a need to continue beyond the benefit period, your clients may re-apply under the following circumstances:

- There is no significant change in health
- The total days of coverage for all Quick Net plans does not exceed 365 days
- A re-application fee of $10 will be charged

IMPORTANT INFORMATION

To be eligible for a Guarantee 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.

SUPPLEMENTAL TERM LIFE INSURANCE OFFERED WITH INDIVIDUAL & FAMILY PLANS

Health Net Life Insurance company offers Supplemental Term Life Insurance for adults (up to age 64) in the following coverage amounts:

- $10,000
- $30,000
- $50,000
- $20,000
- $40,000

The maximum coverage amount for children ages 1–17 is $10,000.

To purchase Individual Term Life, an individual must apply for and enroll in an Individual & Family HMO or PPO Plan. However, the individual is not required to purchase Individual Term Life Insurance in order to enroll in an HMO or PPO plan. Any insured must be at least 19 years old in order to purchase Individual Term Life Insurance. Individual Term Life Insurance is underwritten by Health Net Life Insurance Company.

Simply complete the Supplemental Term Life portion of the health plan application. Premium is billed separately from Medical.

Evidence of insurability is required for all Individual Term Life Insurance amounts. Coverage will not become effective until approved in writing by Health Net Life Insurance Company.

Life insurance is not available for Applicants applying for HIPAA guarantee issue coverage, those being offered modified issue plans or Quick Net plans.

SUPPLEMENTAL TERM LIFE OFFERED WITH THE CALIFORNIA FARM BUREAU MEMBERS' HEALTH INSURANCE PLAN

Health Net Life Insurance company offers Supplemental Term Life Insurance for adults (up to age 64) in the following coverage amounts:

- $10,000
- $30,000
- $50,000
- $20,000
- $40,000

The maximum coverage amount for children ages 1–17 is $10,000.

Clients who apply for a PPO health plan may also choose to apply for this Supplemental Term Life Insurance. If approved for health coverage, their term life coverage is also approved. Please note: this coverage is in addition to the Basic Term Life and AD&D insurance ($5,000 for member and $2,500 for spouse, if covered) automatically included at $3/month when approved for a PPO health plan. However, the individual is not required to purchase Supplemental Term Life Insurance in order to enroll in an PPO plan.

Simply complete the Supplemental Term Life portion of the health plan application. Premium is billed separately from Medical.

Supplemental Term Life Insurance is underwritten by Health Net Life Insurance Company.

Evidence of insurability is required for all Term Life Insurance amounts. Coverage will not become effective until approved in writing by Health Net Life Insurance Company.

Life insurance is not available for Applicants applying for HIPAA guarantee issue coverage or those being offered modified issue plans.

COMMON TERMS/ DEFINITIONS

ATTENDING PHYSICIAN STATEMENT (APS)

Attending physician statement is a document written by the Applicant's physician summarizing their health history or specific medical conditions. If an APS is requested, it must summarize the applicant's past history and current (within the past six months) prognosis. Certain conditions may require that the APS be as recent as within the last month. Health Net will reimburse a physician's office or an applicant (if the applicant received the medical records) up to $25 for a copy of medical records. The $25 reimbursement only applies to brokered applicants.

ACCIDENT DEDUCTIBLE WAIVER

For IFP PPO Value Plans and Quick Net Plans only, the Calendar Year/Benefit Period deductible will be waived for an accidental injury. Accidental Injury is physical harm or disability, which 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 (ER) or Urgent Care facility. The Calendar Year/Benefit Period deductible will be waived only for that day's treatment in the ER or Urgent Care, the ER or Urgent Care copay will still apply; follow up treatment will be subject to the Calendar Year/Benefit Period deductible. A completed Accident Waiver Form must be submitted within 60 days of the accident and is required in order for the claim to be reviewed. Once approved the Calendar Year/Benefit Period deductible will be waived. The Member will continue to pay any charges billed in excess of Covered Expenses.

CONFIDENTIALITY OF MEDICAL INFORMATION

In compliance with State and Federal regulations that protect the confidentiality of medical information, Health Net staff will not disclose or discuss an Applicant's medical history to anyone other than the Applicant without the Applicant's written authorization. Any such authorization must specify the medical information that may be discussed or disclosed and the specific person(s) with whom it may be discussed or disclosed.

COORDINATION OF BENEFITS (COB)

There are no Coordination of Benefit provisions for the IFP plans. The CFBF plans do have a coordination of benefit provision.

CREDITABLE COVERAGE

Any individual or group policy, contract or program, that is written or administered by a disability insurance company, healthcare service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

DATES

It is important to include all dates relating to the condition (such as date diagnosed, treated, treatment discontinued, etc.). Also be sure to include dates that medication was prescribed, as well as the date it was discontinued, if applicable (many prescriptions run beyond the date treatment ended). If a treatment or prescription has not ended, it is important to indicate that.

EFFECTIVE DATES

IFP	1st and 15th of the month (PPO only)
CFBF	Any day of the month

For IFP plans Health Net offers the 1st or 15th of the month effective dates. Insurance brokers have no authority to bind coverage or assign effective dates. Applications must be received by the published cut-off date (refer to Policy Dating, below) of the prior month in order to receive review for a 1st or 15th of the month effective date. Effective dates for applications will not be backdated. The 15th of the month is only available for Health Net's Individual & Family PPO plans.

Odd effective dates are only available for the Quick Net products.

For CFBF plans, any day of the month effective dates are available. Insurance brokers have no authority to bind coverage of assign effective dates. Applications must be received by the published cut-off date (refer to Policy Dating, below). Effective dates for applications will not be backdated.

MODIFIED ISSUE

Modified Issue helps certain applicants who might normally not be able to obtain coverage, attain it for a higher premium. It is available for PPO plans only. Modified Issue premiums are calculated by multiplying preferred premium[1] shown in the rate guide by the rate adjustment factor (RAF) of 1.20 or 1.50.

[1]Dental and Vision premium will also be adjusted to include the RAF if you are approved for an IFP PPO Plus plan.

POLICY DATING

For IFP plans, in order to receive a first of the month effective date, an application must be received by Health Net by the 25th of the preceding month and must be approved by Health Net's underwriting department by the 10th of the month. IFP HMO policies can only be dated the first of the month.

PPO polices can be dated the 15th of the month. In order to receive a 15th of the month effective date, an application must be received by Health Net by the 10th of the month and must be approved by Health Net's underwriting department by the 25th of the month.

For CFBF plans, any day of the month effective is available. This effective date will be based on Underwriting's completion.

PRE-EXISTING CONDITION

An illness, injury or condition which existed during the six-month period 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.

PROBABLE ACTION

The action that the underwriter will take based upon the information provided. Multiple conditions can be a key factor in the final decision, and the final decision may deviate from the printed guideline when that is the case. In addition, the guidelines are not inclusive of all possibilities and conditions, and therefore underwriter discretion will always be used.

RATE GUARANTEE

Health Net IFP's rates are guaranteed for six months from the time of the member's original effective date. If a member's age changes during the six-month period, the original premium will be guaranteed for the remainder of the guaranteed period. If the member changes plans during the rate guarantee period, the rate guarantee is broken.

If a member is approved for a permanent plan after their Quick Net policy expires and there is no lapse in coverage, the rate guarantee period begins on the original effective date of the Quick Net policy. For example, if the Quick Net plan's effective date is 4/1/07 and there is no lapse in coverage and the permanent plan is effective 6/1/07, the rate expiration of the permanent plan is effective 10/1/07.

For CFBF plans, rates are guaranteed from twelve months from the time of the member's original effective date. If a member's age changes during the 12-month period, the original premium will be guaranteed from the remainder of the guaranteed period. If the member changes plans during the rate guarantee period, the rate guarantee is broken.

RESCISSION

Under certain circumstances as described below, Health Net may rescind coverage after issuing a Plan Contract or Policy/Certificate.

Rescission of Membership for Members of Health Net of California Inc.'s Individual HMO Plans
Health Net of California, Inc. may not rescind an Individual and Family HMO Plan Contract unless it has made reasonable efforts to complete medical underwriting and resolve all reasonable questions arising from written information submitted by the applicant on or with the enrollment application before issuing a Plan Contract, except that any willful nondisclosure or misrepresentation in the enrollment application of a material fact is also cause for disenrollment and rescission of the Plan Contract. If the Plan Contract is rescinded, Health Net may revoke the applicant's coverage as if it never existed and the applicant will lose health benefits including coverage for treatment already received. This means that Health Net of California, Inc. may recover from the applicant any amounts paid under the Plan Contract from the original date of coverage. If the Plan Contract is rescinded, Health Net of California, Inc. shall have no liability for the provision of coverage under the Plan Contract. If the Plan Contract is rescinded, Health Net of California, Inc. will refund all premium amounts paid by the applicant, less any medical expenses paid by Health Net of California, Inc. on behalf of the applicant.

Rescission of Membership for Health Net Life Insurance Company Individual PPO Plans, including the CFBF Plans
Health Net Life Insurance Company ("HNL") underwrites Individual PPO and CFBF health insurance plans. HNL will undertake reasonable steps to complete medical underwriting and resolve all reasonable questions

arising from the written information submitted on or with the applicant's enrollment application before issuing an Insurance Policy/Certificate. However, intentional or unintentional nondisclosure or misstatement of material facts in written information submitted by an applicant on or with the applicant's application materials may be cause for disenrollment and rescission of the Insurance Policy/Certificate and HNL may recoup from the applicant any amounts paid under the Insurance Policy/Certificate obtained as a result of such nondisclosure or misstatement of material facts. In addition, if an applicant makes an intentional or unintentional nondisclosure, misstatement or omission of material facts in written information submitted on or with the enrollment application as to the Subscriber's or Family Member's health status or history, HNL shall have no liability for the provision of cover-age under the Insurance Policy/Certificate. Should the contract be rescinded, HNL will provide a written notice that will explain the basis of the decision and the applicant's appeals rights. HNL will refund all amounts paid by the applicant, less any medical expenses that HNL paid.

Broker commission is adversely affected by any retroactive cancellations. Any commissions paid on a policy that is rescinded will be charged back and collected from the broker.

TREATMENT

For the purposes of these guidelines, doctor or medical provider visits and examinations, tests and lab work, bloodwork, surgical procedures, medications, radiological exams, therapy, physician follow-up, and consultations are considered treatment.

UNDERWRITING DISCRETION

While the underwriting practices will adhere to the printed guidelines as closely as possible, there may be occasions when the Underwriter will have to deviate from the guidelines.

THIRD PARTY INFORMATION

During the pre-enrollment underwriting process for each applicant, Health Net will submit an inquiry to the Medical Information Bureau (MIB) and to a commercial vendor of paid pharmacy claims data with whom Health Net contracts. Any information or data received from those sources will be used during the evaluation of each applicant's insurability.

LEGAL REQUIREMENTS

APPLICANT/CLIENT RESPONSIBILITY

Health Net requires all Applicants age 18 and over to read, complete and assume accountability for the "Conditions of Enrollment" section by signing and dating the application. The Applicant and the Applicant's spouse must complete the application, and it must be signed with blue or black ink.

Applicants under the age of 18 years old, the parent or legal guardian is legally responsible for the accuracy of information in the 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 the Application.

BROKER/AGENT RESPONSIBILITY

It is important that during the enrollment process you protect yourself. You want to be sure you are not at fault for any errors or omissions in information on behalf of your clients. You need to advise your client that they must provide complete and accurate information even if the information does not seem important to you or your client. ALL APPLICATIONS, ONLINE AND PAPER, MUST BE COMPLETED BY THE APPLICANT.

In order to become a Health Net contracted broker, you or your brokerage firm must: (a) have an active California Life Agent license; (b) sign and complete the Health Net Agent/Broker Agreement; (c) sell a group with Health Net or sell an Individual & Family or CFBF Plan; and (d) have E&O insurance. You or your brokerage firm must become a contracted Health Net broker in order to receive commissions.

LIMITED/NON-ENGLISH PROFICIENT APPLICANTS

An individual who is limited English proficient is a person who does not speak English as their primary language and who has a limited ability speak, read, write or understand English.

In 2003, the California legislature passed Senate Bill 853 mandating that all California health plans and insurers provide language assistance services to their enrollees with limited English proficiency in order to alleviate language and cultural barriers. The legislation stipulates that all vital documents must be translated into threshold languages and interpretation services made available to enrollees at all points of contact.

Health Net requires that only the Applicant can complete and sign the Enrollment Application. A limited English proficient applicant would need to use the services of a Qualified Interpreter to complete the Application. Interpreter services are available through Health Net at no charge by calling 800-909-3447, option 2.

For a person other than someone from Health Net's contracted interpreter service to be considered qualified they should meet the following qualifications of a Qualified Interpreter.

A qualified bilingual speaker would:

- Have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language.
- Be able to demonstrate cultural sensitivity in their communication taking into consideration every language encompasses a wide range of variation.
- Have native speaker language skills (Native speaker language skills are developed by growing up or functioning in a language community).
- Have corresponding reading and writing skills in the non-English language (The reading and writing skills would be demonstrated by advanced education in the native language).

MEMBER INFORMATION

CHANGING BENEFITS / CHANGING PLAN DESIGNS

If a member enrolled in a Health Net IFP or CFBF Plan wishes to change plans a completed new application and underwriting approval will be required with the following exceptions:

1. The member is enrolled in an Individual HMO plan that is actively being marketed and wishes to enroll in an Individual HMO plan[1] with a lower benefit level.
2. The member is enrolled in an IFP PPO plan that is actively being marketed and wishes to enroll in an IFP PPO plan[1] with a lower benefit level.
3. The member is enrolled in a CFBF PPO plan that is actively being marketed and wishes to enroll in a CFBF PPO plan[1] with a lower benefit level.

Those individuals who are enrolled in any of Health Net's HIPAA plans are ineligible to change their benefits or plan designs.

When submitting an application for a plan change, the member MUST keep premiums paid to current. The effective date of the plan change will only be the first of the month following underwriting approval. If medical records are requested, the member will be responsible for any fees related to obtaining those records.

Should an individual transfer from one PPO plan to another PPO plan the deductible paid prior to the transfer will rollover to the deductible in the new plan as long as there is no lapse in coverage and it is within the calendar year.

Members enrolled in an IFP plan and who wish to enroll in a CFBF plan or vice versa, will need to submit a completed new application and underwriting approval will be required.

ADDING DENTAL AND VISION OPTION

For IFP, there is no waiting period to add the dental and vision option to the client's HMO or PPO plan, however, if they remove the dental and vision option

[1]Certain plans are not available.

from their plan there is a 12 month waiting period to add the dental and vision option to the client's existing plan.

For CFBF plans, either dental, vision or both can be added with no waiting period, however, if coverage is cancelled, there is a 12 month waiting period to add coverage.

REINSTATEMENT OF COVERAGE

- Reinstatement request must be received at Health Net within 30 days of the cancellation notice.
- The reinstatement request must be accompanied by a check that includes all past due premiums plus current month and prepaid premium (if billing has been generated). For example, Member terminated November 1st, requests reinstatement on December 12th, they must remit November, December and January premiums to be reinstated.
- All payments must be received within 65 days from the effective date of termination.
- To ensure payment is received, credit card (Visa/MasterCard) will be accepted.
- A reinstatement fee of $15 will be charged.

There will be no more than two reinstatements in a given 12-month period and upon the second reinstatement the member must pay by automatic bank draft.

NONSUFFICIENT FUND FEE

A nonsufficient fund (NSF) fee of $25 will be charged to a member's account if there is a check/credit card returned for NSF.

RE-APPLICATION

Members / Insureds who have terminated individual health coverage due to non-payment of premium with Health Net can reapply after three months. A member who has terminated coverage voluntarily can re-apply at any time.

DISCRIMINATION

Health Net strives to provide coverage to all Applicants who either meet Health Net's underwriting guidelines or qualify for HIPAA guaranteed coverage. Health Net does not discriminate among Applicants by race, religion, gender, color, national origin, ancestry, marital status or sexual orientation or other conditions or criteria that are unrelated to the Applicant's health status.

AUTOMATIC BANK DRAFT (ABD)

If there are two non-sufficient fund transactions related to ABD they will be set up on the standard billing options for one year.

FREQUENTLY ASKED BILLING QUESTIONS

When does Health Net send out billing statements?
Bills are mailed out on approximately the 9th for HMO plans, the 10th for PPO plans, and the 13th if your payment option is quarterly.

When are payments due?
Payments are due on the first of every month.

Where would a billing payment be mailed?
Health Net
P.O. Box 894702
Los Angeles, CA 90189-4702

If a member is late paying their bill, how long do they have to pay before their plan is cancelled?
There is a 30-day grace period from the day the bill is due.

Are late notices sent out?
Late notices are sent approximately the 15th of the month.

What is the draft date if the billing option selected is by credit card or Automatic Bank Draft (ABD)?
Premiums are deducted on the 20th of every month, unless that day falls on a Sunday, then it will be on the following Monday.

How long does it take to set up the credit card monthly billing option?
It takes approximately 10 days to set up the credit card monthly option and approximately 30 days to be deducted from a bank account.

How much notice needs to be provided to Health Net if the member needs to stop their credit card from being charged or having premiums taken out of their bank account?
It takes approximately 30 days to stop a credit card from being charged or premiums to be deducted from a bank account.

If I send in a check, how long will it take for my check to post?
It takes approximately four to seven business days for a check to post.

CERTIFICATION REQUIREMENTS FOR PPO PLANS

1. **Inpatient admissions**
   Any type of facility, including but not limited to:
   - Hospital
   - Skilled Nursing Facility
   - Mental health facility
   - Chemical dependency facility
   - Acute rehabilitation facility
   - Hospice
2. **Surgical procedures including:**
   - Abdominal, ventral, umbilical, incisional hernia repair
   - Bariatric procedures
   - Blepharoplasty
   - Breast reductions and augmentations
   - Rhinoplasty
   - Sclerotherapy
   - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
3. **Organ, tissue and bone marrow transplant services, including pre-evaluation and pre-treatment services and the transplant procedure**
4. **Home Health Care Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy and home uterine monitoring**
5. **Hospice Care**
6. **Outpatient Diagnostic Imaging:**
   - CT (Computerized Tomography)
   - MRA (Magnetic Resonance Angiography)
   - MRI (Magnetic Resonance Imaging)
   - PET (Positron Emission Tomography)
   - SPECT (Single Photon Emission Computed Tomography)
7. **Durable Medical Equipment including power wheelchairs, scooters, hospital beds and custom-made items**
8. **Prosthesis and orthotics over $2,500**
9. **Air ambulance**
10. **Tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor)**
11. **Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function) including TMJ treatment**
12. **Self-injectable drugs**
13. **Clinical trials**
14. **Bariatric-related services:**
    - Non-surgical bariatric-related consultations and services
    - All bariatric-related surgical services

EXCEPTIONS

HNL does not require certification for dialysis services or maternity care. However, please notify HNL upon initiation of dialysis services or at the time of the first prenatal visit. Certification is not needed for the first 48 hours of inpatient Hospital Services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, HNL should be notified within 24 hours following birth. Certification must be obtained for a scheduled cesarean section or if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth. Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy.

CALIFORNIA FARM BUREAU FEDERATION

The California Farm Bureau Federation (CFBF) was formed in 1919 and today is the largest farm organization in the state, representing over 89,000 member families in 53 counties. The Federation was formed to provide a variety of related services to the agricultural community and to its members in particular.

Farm Bureau is organized on a local, state and national basis – in that order. The local county Farm Bureau is the nucleus of the organization. It is here that the members join by payment of nominal annual dues, which entitles them to a wide range of services and benefits of membership. The 53 county Farm Bureaus in California are members of the California Farm Bureau Federation, which in turn is a member of the American Farm Bureau Federation, along with 50 other state Farm Bureaus, and Puerto Rico. There are over 2,700 county Farm Bureaus in the U.S. with over 4 million members.

Applicants applying for a Health Net CFBF PPO plan must join the California Farm Bureau association, if not already a member.

AGRICULTURE'S #1 FARM ORGANIZATION

Farm Bureau is the country's largest county, state and national farm organization working on behalf of agriculture. Farm Bureau is a voluntary, non-governmental, nonpartisan organization seeking solutions to the problems that affect the lives of its members, both socially and economically.

Legislative representatives are constantly working to secure needed agricultural legislation, to amend bills to make them more acceptable, or to work for the defeat of legislation adversely affecting farmers and ranchers. They work on legislation and regulations affecting food quality and safety, taxes, education, water, land use, energy, labor, biological controls, transportation and commodities.

These issues directly impact all employers and employees in California; all Californians benefit directly and indirectly from Farm Bureau's success.

In 1949 the California Farm Bureau Federation established an insurance service-to-member program. The California Farm Bureau Member's Health Insurance Program has provided affordable, high-quality health insurance protection for Californians since 1947. It is the first and oldest association health program in California with over five decades of continuous service.

Health Net's health plans provide Farm Bureau members:

- Quality insurance products.
- Fast, fair and efficient claims service.
- A network of professional agents to service the Farm Bureau members.

We encourage you to become familiar with the Farm Bureau, become a Farm Bureau member and visit your county Farm Bureau. Get to know your county Farm Bureau leaders. They are leaders in your community and are valuable centers of influence. Discuss with your county Farm Bureau how to work together to market Farm Bureau memberships and Health Net health plans.

TYPES OF MEMBERSHIP

When a person joins the California Farm Bureau Federation, he or she joins the local county Farm Bureau in which they work or reside. Membership takes effect when your insurance becomes effective. Membership renewals are sent directly from the Farm Bureau Federation to the member.

There are two types of membership:

Voting Member
Any member who reasonably expects to receive during the current membership year any income from farming operations, either as an owner, lessor, lessee, or officer, substantial shareholder or full time employee of such owner, lessor, or lessee, shall be a voting member. The right to vote is limited to these types of members.

Sustaining Member
Any member who is not a voting member.

Changes in the type of membership must be approved by the county Farm Bureau board of directors. Each county Farm Bureau is a separate corporation with its own set of bylaws. We encourage you to work closely with your local county Farm Bureau Manager regarding classification of their members.

Individual/family membership qualifications:

- A single person
- A married person, spouse and unmarried children under 21[1] years of age, who live at home
- A widowed person and unmarried children under 21[1] who live at home

[1]Up to 25 years if they are full-time students.

- A divorced person and unmarried children under 21[1] who live at home

MEMBERSHIP DUES

Annual Farm Bureau dues can be found in the rate guide. The dues for voting and sustaining members are determined by the county board of directors and vary by county throughout the state. Many counties have special dues categories such as “Business,” “Gold,” “Senior Citizen,” etc. Agents should be familiar with the dues in the county or counties where they do business. Agents are not required to sell the special dues amounts.

MEMBERSHIP BENEFITS

The California Farm Bureau Federation provides information to members through publications of AgAlert® (voting) and California Country® (sustaining). In addition, Farm Bureau members receive benefits statewide and at the local county level.

The following statewide benefits[2] are available to all Farm Bureau Members:

- Health Insurance
- Dental Insurance
- Vision Insurance
- Farm Bureau Bank
- Farm Bureau Connection

  Members can call (800) 698-FARM for more information.

- *The International Travel Club-50*
  Members can call (800) 698-FARM for more information.
- *Lenscrafters 20% Discount*
  The Plan number for this program is #9111907, listed as “California Farm Bureau Federation.” For the LensCrafters store nearest you call (800) 522-LENS or check online at www.lenscrafters.com.
- *NAPA Auto Parts Discount*
  For the location of your nearest NAPA store, call (800) LET -NAPA or go to ww.napaonline.com.
- *Dodge Rebate*
  Contact your Dodge dealer for details. To locate your nearest dealer, call toll-free (877) 668-4356.
- *Car Rental Savings through Hertz and Budget*
  Use the appropriate program ID to receive your discount.

  Hertz: (800) 654-2200 ID # 42283.
  Budget: (800) 527-0700 ID # T553900.
- *Madison Travel*
  Contact (800) 933-3450 for more information.
- *Bioscripp Prescription Savings Card*
  Call 1-800-228-3353 for more information.
- *Accidental Death and Dismemberment Insurance Plan*
  This benefit is provided by the Farm Bureau at no additional charge and applies to each eligible member and spouse.
- *Labor Service Discount Offered by Farm Bureau Employers Labor Service (FELS)*
  For more information call your County Farm Bureau office or FELS at (800) 753-9073.
- *Weather Forecast Discount through Accu-Weather*
  For more information, a detailed brochure, or to sign up call Accu-Weather at (800) 483-6329.
- *Entertainment and Attractions Discounts*
  Contact your local County Farm Bureau to obtain your FB discount club cards.
- *County Farm Bureau Benefits*
  The previous statewide benefits are available to all Farm Bureau members. In addition to these benefits, County Farm Bureaus offer their own benefits to their members. Contact your local county Farm Bureau for a list of their benefits.

[1]Up to 25 years if they are full-time students.

[2]Benefits are subject to change.

IMPORTANT BROKER INFORMATION

APPLICATION MAILING ADDRESS

Individual & Family Enrollment

Health Net
Post Office Box 1150
Rancho Cordova, CA 95741-1150
Fax Number: 800-977-4161

FORMS & BROCHURES

All materials to enroll your client are available on our Broker site. You have the ability to order, email or download the forms you need.

Log on to www.healthnet.com, click the *Broker* tab, select *Get Things Done* and choose *IFP Forms and Brochures.*

Forms and Brochures available:

- Benefit Brochures
- Rate Guides
- Overview Brochures
- Quick Net Brochure
- Quick Net Application
- Applications
- Underwriting/Application Guidelines
- Accident Waiver Request Form

SUPPLEMENTAL MEDICAL QUESTIONNAIRES

- Acne
- Arthritis
- Asthma
- Breast Augmentation
- Broken Bones
- Cataract
- Chiropractic Care
- Ear Infection
- Female
- Fibroid
- Generic Supplemental
- Headache
- Height and Weight
- Herpes
- Kidney Stone
- Mental Health
- Ovarian Cyst
- Psoriasis
- Seizure Disorder
- Sinus Disorder
- Skin Cancer
- Thyroid Disorder
- TMJ
- Ulcer

HMO & PPO Provider directories are also available. However, you can also create your own personalized directory. Go to www.healthnet.com and click on the *Quote the Right Plan* tab and click on *Doctor Search.*

For more information please contact:

Health Net
Post Office Box 1150
Rancho Cordova, California 95741-1150

Fax: 1-800-977-4161

Individual & Family Plans
1-800-909-3447

Telecommunications device for the hearing and speech impaired
1-800-995-0852

www.healthnet.com

Other options:

Coverage for family members over 65 years of age:
1-800-944-7287

Coverage for children in a low-income household:
1-800-327-0502

Coverage for businesses with 50 and fewer employees:
1-800-447-8812

Coverage for businesses with 50+ employees:
1-800-448-4411, option 4

CA55863 (12/08)
Health Net of California, Inc. is a subsidiary of Health Net, Inc. Health Net® is a registered service mark of Health Net, Inc. All rights reserved.