

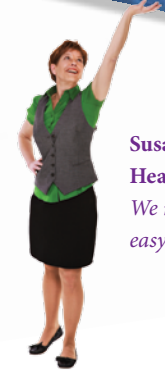
Health Net Health Plan of Oregon, Inc.

Quick Net Short-Term Coverage by the Day or Month

Effective October 1, 2012



Pam White,
Health Net
*We help members make
informed decisions.*



Susan Potthoff,
Health Net
*We make health care
easy to understand.*



Health Net®

It's a Fast-Moving World

Keep up with Quick Net from Health Net

Two kinds of health coverage for people on the go – daily and monthly. Choose **Quick Net Daily** if you want to choose your length of coverage down to the day, or **Quick Net Monthly** if you want coverage in monthly segments. Both options allow you the choice of how long you want coverage to last, up to six months.

Ideal short-term coverage for individuals who are:

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

Choose your doctor

Quick Net from Health Net is a PPO (preferred provider organization). Receive benefits when you seek care from health care providers who are on our PPO network list. Or, pay a little more to see licensed physicians who are not on our list. The choice is yours.



Christian Aparicio,
Health Net
*We make using health care
benefits simple.*



Quick Net short-term plans

<i>Benefit</i>	<i>Quick Net 1,000</i>		<i>Quick Net 2,500</i>	
	PPO network	Out-of-network	PPO network	Out-of-network
Individual deductible ^{1, 2, 3}	\$1,000	\$1,500	\$2,500	\$3,000
Benefit maximums				
Individual out-of-pocket maximum ^{1, 4}	\$2,000	\$4,000	\$3,000	\$6,000
Lifetime maximum	\$1,000,000 (PPO network and out-of-network combined)		\$1,000,000 (PPO network and out-of-network combined)	
Physician / professional / outpatient care				
Women's and men's health care – Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	25% contract rate	50% MAA	30% contract rate	50% MAA
Routine mammography	25% contract rate	50% MAA	30% contract rate	50% MAA
Physician services – office call	25% contract rate	50% MAA	30% contract rate	50% MAA
Physician services – urgent care center	30% contract rate	50% MAA	30% contract rate	50% MAA
Physician hospital visits	25% contract rate	50% MAA	30% contract rate	50% MAA
Diagnostic X-ray / EKG / ultrasound	30% contract rate	50% MAA	30% contract rate	50% MAA
Diagnostic laboratory tests	30% contract rate	50% MAA	30% contract rate	50% MAA
CT / MRI / PET / SPECT / EEG / Holter monitor / stress test	30% contract rate	50% MAA	30% contract rate	50% MAA
Therapeutic injections	25% contract rate	50% MAA	30% contract rate	50% MAA
Outpatient rehabilitation therapy – \$1,250 max	25% contract rate	50% MAA	30% contract rate	50% MAA
Outpatient or ambulatory surgery center	25% contract rate	50% MAA	30% contract rate	50% MAA
Hospital care				
Inpatient services ⁵	25% contract rate	50% MAA	30% contract rate	50% MAA
Inpatient rehabilitation therapy – 15 days max	25% contract rate	50% MAA	30% contract rate	50% MAA
Emergency services				
Outpatient emergency room services	30% contract rate	50% MAA	30% contract rate	50% MAA
Inpatient admission from emergency room	25% contract rate	25% MAA	30% contract rate	30% MAA
Emergency ambulance transport – \$1,500 max	20% (MAA applies to out-of-network providers)		20% (MAA applies to out-of-network providers)	
Other services				
Durable medical equipment – \$2,500 max	25% contract rate	50% MAA	30% contract rate	50% MAA
Prosthetic devices / orthotic devices	25% contract rate	50% MAA	30% contract rate	50% MAA

¹Family deductible and out-of-pocket maximum are met when three family members meet their individual amounts.

²You must meet the specified deductible each benefit period.

³Your payments do not apply to the annual out-of-pocket maximum.

⁴The out-of-pocket maximum does not include the deductible. After you reach the out-of-pocket maximum in a benefit period, we will pay your covered services during the rest of that benefit period at 100% of our contract rates for PPO services and at 100% of MAA for out-of-network (OON) services. You are still responsible for OON billed charges that exceed MAA.

⁵The above coinsurance for inpatient hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate coinsurance for inpatient hospital services will apply.

Benefit	Quick Net 1,000		Quick Net 2,500	
	PPO network	Out-of-network	PPO network	Out-of-network
Medical supplies (including injected substances)	25% contract rate	50% MAA	30% contract rate	50% MAA
Diabetes management – one initial program	25% contract rate	50% MAA	30% contract rate	50% MAA
Blood, blood plasma, blood derivatives	25% contract rate	50% MAA	30% contract rate	50% MAA
Home infusion therapy	25% contract rate	50% MAA	30% contract rate	50% MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	25% contract rate	50% MAA	30% contract rate	50% MAA
Skilled nursing facility care – 30 days max	25% contract rate	50% MAA	30% contract rate	50% MAA
Hospice services	25% contract rate	50% MAA	30% contract rate	50% MAA
Home health visits – \$500 max	No charge	50% MAA	30% contract rate	50% MAA
Outpatient neurodevelopmental therapy, under age 7 – \$500 max	25% contract rate	50% MAA	30% contract rate	50% MAA
Prescription coverage	Prescription deductible: \$250 Prescription benefit maximum: \$1,000 Tier 1: \$15 Tier 2: \$30 Tier 3: You pay the full cost of the prescription at Health Net's discounted rate. Specialty pharmacy: You pay the full cost of the prescription at Health Net's discounted rate.		Prescription deductible: \$250 Prescription benefit maximum: \$1,000 Tier 1: \$15 Tier 2: \$30 Tier 3: You pay the full cost of the prescription at Health Net's discounted rate. Specialty pharmacy: You pay the full cost of the prescription at Health Net's discounted rate.	

Eligibility

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

- You are a U.S. citizen or permanent resident of the U.S. and have resided in the U.S. for at least six months.
- You reside and continue to reside in the service area.
- Members are older than 30 days or less than 65 years old on the policy effective date and are not totally disabled or eligible for Medicare.
- You do not have other medical or hospital coverage, including enrollment in an HMO or health care insurance plan.
- You or any family members are not pregnant at the time of application.

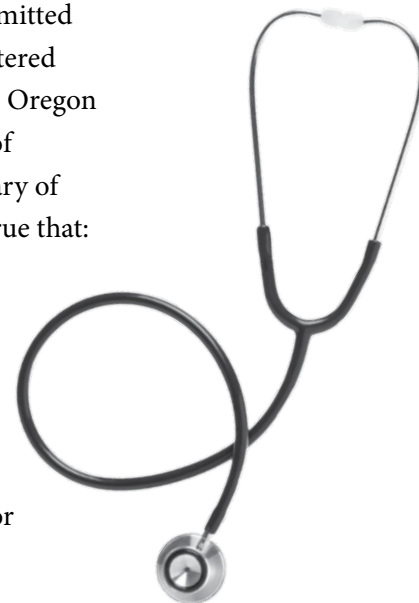
Dependent children are eligible to apply up to age 26 on a family plan.

Persons under 1 year of age or over 65 years of age on the policy effective date cannot be enrolled as a subscriber.

Registered Domestic Partner eligibility

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

- Both persons have a common residence.
- Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or adjudged a nullity.



- The two persons are not related by blood in a way that would prevent them from being married in Oregon.
- Both persons are at least 18 years old.
- Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance benefits under the Social Security Act.
- Both persons are capable of consenting to the domestic partnership.

Important information

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

This is a non-renewable plan

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

- You meet the application and underwriting requirements.
- There is no significant change in your health.
- The total days of coverage for Quick Net Daily plans does not exceed 360 days. The total days of coverage for Quick Net Monthly plans does not exceed 365 days.

When does coverage begin?

- If you are approved, your coverage will be in force as of the effective date determined by Health Net.
- Applications submitted without payment or with partial payment will be pended until payment is received. If payment is not received within two weeks of the application signature date, the application will be withdrawn.
- If you apply for a regular term Health Net medical insurance plan or enroll in a Health Net group medical insurance plan after your Quick Net plan is in effect, your Quick Net plan must expire before your regular term medical insurance plan becomes effective.

Summary of exclusions

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

Enrollment is as easy as 1-2-3!

1. Just select when you want coverage to start – and that’s any day, not just the first of the month or the first of the year – and how long you want coverage to last, up to six months.
2. Choose Quick Net Daily if you want to choose your length of coverage down to the day, or Quick Net Monthly⁶ if you want coverage in monthly segments.
3. Then compute your premium. Log on to www.healthnet.com/quote to complete your application and remit payment for the application fee and appropriate premium. Or complete the paper application enclosed in this brochure and send your check with the application fee and full amount owed for your premium.⁷

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

Length of coverage	Quick Net Daily	Quick Net Monthly
Minimum coverage time	30 days	1 month
Maximum coverage time	185 days	6 months

How to calculate your premium

Inside this brochure, you’ll find rates for your area.

To find your rate:

1. Select the Area rate page for the county where you live.
2. Select the type of coverage you want: Quick Net Daily or Quick Net Monthly.
3. Find the heading that fits the number of people in your family you want to cover.

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

⁶There are no changes allowed beyond the 10-day free look period. No exceptions will be made. The 10-day free look period only applies under the monthly policy.

⁷Your check will be held in trust while your application is reviewed by Health Net. Applications submitted without payment or with partial payment will be pended until payment is received. If payment is not received within two weeks of the application signature date, the application will be withdrawn. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you.

The oldest family member you wish to cover is the subscriber:

- Yourself (subscriber)
 - You and your spouse (subscriber and spouse)
 - You and your child[ren] (subscriber and children)
 - You, your spouse and child[ren] (family)
4. Choose your deductible.
 5. Find the age range band for yourself (subscriber).
 6. Find the dollar amount on the chart that corresponds to your coverage and deductible.
 7. **If you are choosing Quick Net Daily**, multiply the number on the chart by the number of days of coverage for which you are applying. Daily applicants need to send in a premium for their entire length of coverage.



Example of Quick Net Daily premium calculation

Brian, 32 and Kimberly, 28, live in Washington County (Area 1). They choose the **Quick Net Daily \$2,500 deductible** plan. They select 85 days of coverage.

Subscriber + Spouse rate, based on age of older spouse / domestic partner (age 32)
Per day rate = \$2.88
\$2.88 x 85 days = \$244.80 (Total premium due)

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

Please Note: Optional coverage for alcohol treatment is available for an additional charge. Please contact Health Net for details.

Quick Net Daily and Monthly Rates

Rates effective through September 30, 2013

Area 1 – For residents of the following counties: Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill.

Daily rates

Tier/Age	\$1,000 deductible	\$2,500 deductible	
Subscriber	1–19	\$1.93	\$1.31
	20–24	\$1.93	\$1.31
	25–29	\$1.93	\$1.31
	30–34	\$2.10	\$1.44
	35–39	\$2.63	\$1.74
	40–44	\$2.97	\$2.02
	45–49	\$3.85	\$2.46
	50–54	\$5.08	\$3.46
	55–59	\$6.66	\$4.48
	60–64	\$9.28	\$6.07
Subscriber and spouse	1–19	n/a	n/a
	20–24	\$3.86	\$2.61
	25–29	\$3.86	\$2.61
	30–34	\$4.20	\$2.88
	35–39	\$5.27	\$3.47
	40–44	\$5.95	\$4.04
	45–49	\$7.70	\$4.93
	50–54	\$10.17	\$6.92
	55–59	\$13.32	\$8.97
	60–64	\$18.57	\$12.14
Subscriber and child(ren)	1–19	n/a	n/a
	20–24	\$2.89	\$1.96
	25–29	\$2.89	\$1.96
	30–34	\$3.15	\$2.16
	35–39	\$3.95	\$2.60
	40–44	\$4.46	\$3.03
	45–49	\$5.77	\$3.69
	50–54	\$7.63	\$5.19
	55–59	\$9.99	\$6.72
	60–64	\$13.93	\$9.11
Family	1–19	n/a	n/a
	20–24	\$5.40	\$3.65
	25–29	\$5.79	\$3.92
	30–34	\$5.98	\$4.11
	35–39	\$7.50	\$4.95
	40–44	\$7.14	\$4.85
	45–49	\$9.23	\$5.91
	50–54	\$11.70	\$7.96
	55–59	\$14.66	\$9.86
	60–64	\$20.43	\$13.36

Monthly rates

Tier/Age	\$1,000 deductible	\$2,500 deductible	
Subscriber	1–19	\$75.25	\$50.90
	20–24	\$75.25	\$50.90
	25–29	\$75.25	\$50.90
	30–34	\$81.89	\$56.22
	35–39	\$102.69	\$67.73
	40–44	\$115.97	\$78.79
	45–49	\$150.06	\$96.06
	50–54	\$198.31	\$135.01
	55–59	\$259.84	\$174.85
	60–64	\$362.09	\$236.82
Subscriber and spouse	1–19	n/a	n/a
	20–24	\$150.50	\$101.81
	25–29	\$150.50	\$101.81
	30–34	\$163.78	\$112.43
	35–39	\$205.39	\$135.45
	40–44	\$231.95	\$157.58
	45–49	\$300.12	\$192.11
	50–54	\$396.61	\$270.02
	55–59	\$519.67	\$349.69
	60–64	\$724.18	\$473.64
Subscriber and child(ren)	1–19	n/a	n/a
	20–24	\$112.88	\$76.36
	25–29	\$112.88	\$76.36
	30–34	\$122.84	\$84.32
	35–39	\$154.04	\$101.59
	40–44	\$173.96	\$118.19
	45–49	\$225.09	\$144.08
	50–54	\$297.46	\$202.51
	55–59	\$389.75	\$262.27
	60–64	\$543.13	\$355.23
Family	1–19	n/a	n/a
	20–24	\$210.70	\$142.53
	25–29	\$225.75	\$152.71
	30–34	\$233.39	\$160.22
	35–39	\$292.68	\$193.02
	40–44	\$278.34	\$189.10
	45–49	\$360.14	\$230.53
	50–54	\$456.11	\$310.52
	55–59	\$571.64	\$384.66
	60–64	\$796.59	\$521.00

Optional Alcohol Rider

	Subscriber	Subscriber and Spouse
All ages	\$1.16	\$2.33
	Subscriber and Child(ren)	Family
All ages	\$1.75	\$3.49

Optional Alcohol Rider

	Subscriber	Subscriber and Spouse
All ages	\$45.40	\$90.80
	Subscriber and Child(ren)	Family
All ages	\$68.10	\$136.20

Quick Net Daily and Monthly Rates

Rates effective through September 30, 2013

Area 2 – For residents of the following counties: Baker, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lincoln, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco and Wheeler.

Daily rates

Tier/Age	\$1,000 deductible	\$2,500 deductible	
Subscriber	1-19	\$2.12	\$1.44
	20-24	\$2.12	\$1.44
	25-29	\$2.12	\$1.44
	30-34	\$2.32	\$1.59
	35-39	\$2.89	\$1.91
	40-44	\$3.27	\$2.22
	45-49	\$4.23	\$2.71
	50-54	\$5.60	\$3.81
	55-59	\$7.33	\$4.94
60-64	\$10.22	\$6.69	
Subscriber and spouse	1-19	n/a	n/a
	20-24	\$4.24	\$2.88
	25-29	\$4.24	\$2.88
	30-34	\$4.63	\$3.18
	35-39	\$5.79	\$3.81
	40-44	\$6.54	\$4.45
	45-49	\$8.47	\$5.43
	50-54	\$11.19	\$7.63
	55-59	\$14.66	\$9.87
60-64	\$20.43	\$13.37	
Subscriber and child(ren)	1-19	n/a	n/a
	20-24	\$3.18	\$2.16
	25-29	\$3.18	\$2.16
	30-34	\$3.47	\$2.38
	35-39	\$4.34	\$2.86
	40-44	\$4.90	\$3.34
	45-49	\$6.35	\$4.07
	50-54	\$8.39	\$5.72
	55-59	\$11.00	\$7.41
60-64	\$15.32	\$10.03	
Family	1-19	n/a	n/a
	20-24	\$5.94	\$4.04
	25-29	\$6.37	\$4.32
	30-34	\$6.60	\$4.53
	35-39	\$8.25	\$5.43
	40-44	\$7.85	\$5.34
	45-49	\$10.16	\$6.51
	50-54	\$12.87	\$8.77
	55-59	\$16.13	\$10.86
60-64	\$22.47	\$14.71	

Monthly rates

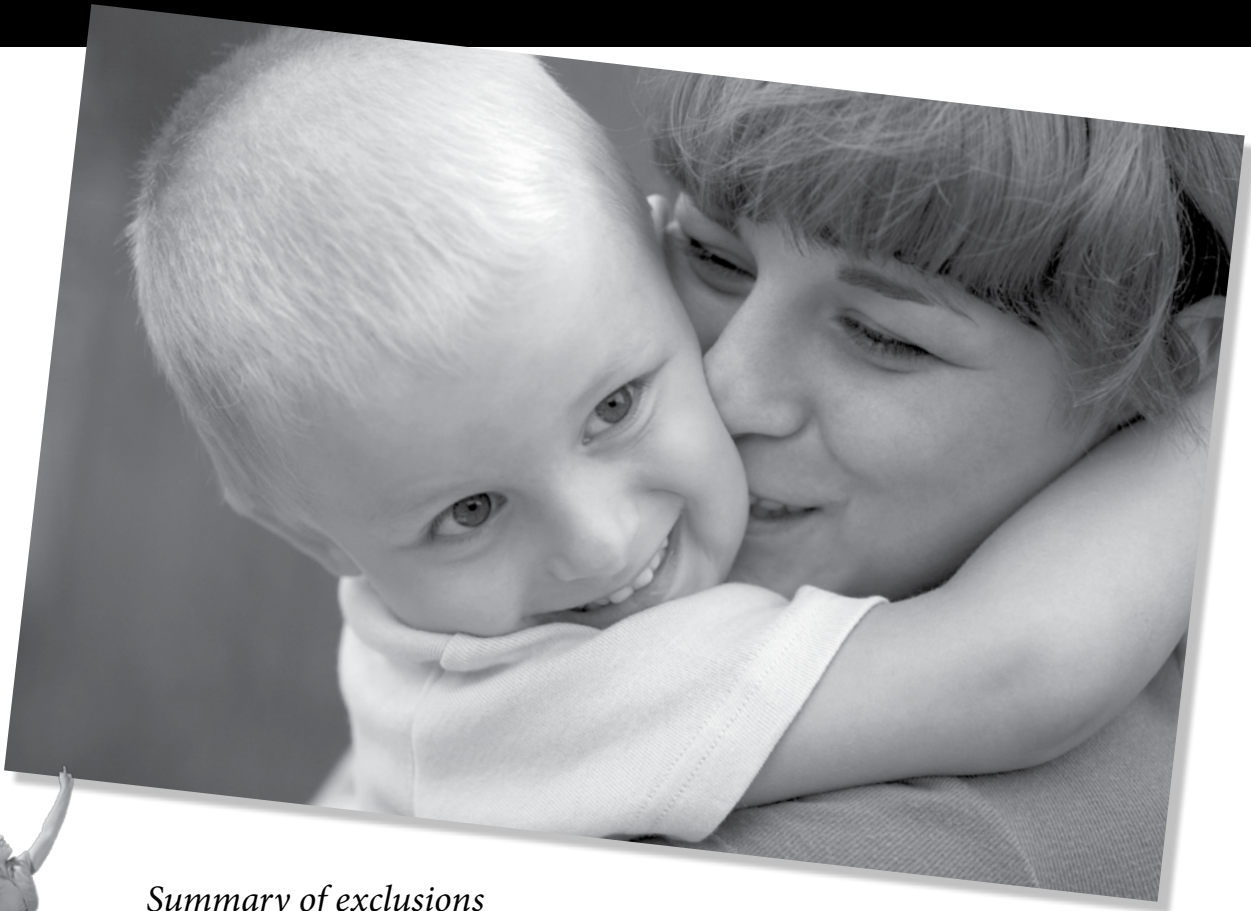
Tier/Age	\$1,000 deductible	\$2,500 deductible	
Subscriber	1-19	\$82.78	\$56.00
	20-24	\$82.78	\$56.00
	25-29	\$82.78	\$56.00
	30-34	\$90.08	\$61.83
	35-39	\$112.97	\$74.50
	40-44	\$127.57	\$86.67
	45-49	\$165.06	\$105.66
	50-54	\$218.14	\$148.51
	55-59	\$285.82	\$192.34
60-64	\$398.29	\$260.51	
Subscriber and spouse	1-19	n/a	n/a
	20-24	\$165.55	\$112.00
	25-29	\$165.55	\$112.00
	30-34	\$180.17	\$123.67
	35-39	\$225.93	\$149.00
	40-44	\$255.15	\$173.34
	45-49	\$330.13	\$211.31
	50-54	\$436.27	\$297.03
	55-59	\$571.63	\$384.67
60-64	\$796.59	\$521.01	
Subscriber and child(ren)	1-19	n/a	n/a
	20-24	\$124.16	\$84.00
	25-29	\$124.16	\$84.00
	30-34	\$135.13	\$92.75
	35-39	\$169.45	\$111.75
	40-44	\$191.36	\$130.00
	45-49	\$247.59	\$158.49
	50-54	\$327.20	\$222.77
	55-59	\$428.72	\$288.51
60-64	\$597.44	\$390.76	
Family	1-19	n/a	n/a
	20-24	\$231.77	\$156.80
	25-29	\$248.33	\$168.00
	30-34	\$256.74	\$176.23
	35-39	\$321.95	\$212.33
	40-44	\$306.18	\$208.00
	45-49	\$396.15	\$253.58
	50-54	\$501.71	\$341.58
	55-59	\$628.79	\$423.14
60-64	\$876.25	\$573.11	

Optional Alcohol Rider

	Subscriber	Subscriber and Spouse
All ages	\$1.28	\$2.56
	Subscriber and Child(ren)	Family
All ages	\$1.92	\$3.84

Optional Alcohol Rider

	Subscriber	Subscriber and Spouse
All ages	\$49.94	\$99.88
	Subscriber and Child(ren)	Family
All ages	\$74.91	\$149.82



**Herminia Escobedo,
Health Net**
*We get members what
they need.*

Summary of exclusions and limitations

To help you make an informed decision, we've listed some services that are either limited or excluded from coverage. This is not a complete list of all exclusions and limitations. Please refer to the policy documents for complete details. You'll have up to 10 days from the receipt of the Quick Net Monthly policy to decline the coverage contract.

Pre-existing conditions⁸ and related services; non-medically necessary care; benefits available to you under other insurance; experimental or investigational services; non-emergency services for which prior authorization is required; complications related to excluded coverage; non-medically necessary private room or private/special nurses; cosmetic services; temporomandibular (jaw) joint disorders or uncovered dental services; custodial care; respite care;

routine eye/vision exams and services; hearing exams; corrective appliances and artificial aids; reduction or augmentation mammoplasty; medical or psychological report preparation for third parties; military service-connected disabilities; diagnosis and treatment of infertility; reversal of voluntary sterilization; services/supplies related to sex transformation, transsexualism or paraphilias (sexual deviations); diagnosis and treatment for obesity and eating disorders; all organ and tissue transplants or autologous stem cell rescue or any complications resulting from such procedure; organ donor services; personal comfort items; learning disorders, except as provided in the contract; speech generating devices; rehabilitation therapy, except as provided in the contract; treatment of impotency; genetic engineering; non-medical self-help training or therapy; bone

⁸Pre-existing condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period preceding the effective date of coverage. Pregnancy is a pre-existing condition. Genetic information does not constitute a pre-existing condition in the absence of a diagnosis of the condition related to such information.

bank and eye bank charges; non-covered prescription drugs; specific biofeedback and pain management treatments or programs; hair analysis; autologous extraction and storage of blood; routine foot care, including treatment for corns, calluses and cutting of nails unless prescribed for the treatment of diabetes; growth hormone therapy; family planning; preventive and routine examinations, services, testing and supplies except as provided in the contract; non-medically necessary circumcisions; drug and chemical dependency detoxification; non-covered congenital defects or diseases; chiropractic, acupuncture, naturopathy, massage therapy and hypnotherapy services; health education services other than diabetes self-management education; mental health benefits; services of a nutritionist, except as outlined for diabetes management and inborn errors of metabolism; services and supplies

for which the member is not required to pay or that the member would receive at no cost in the absence of health coverage; services and supplies for which the member is not billed by a provider or for which we are billed a zero dollar charge; all services provided in wilderness residential treatment programs; services and supplies rendered by an immediate family member (spouse, domestic partner, parent, child, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by an immediate family member of the member; member self-treatment, including but not limited to self-prescribed medications and medical self-ordered services and laboratory tests; orthodontic services and dental implants, except for treatment covered for dental injury as specifically indicated in the contract; services provided outside the United States which are not emergency medical care.



Quick Net PPO Non-Renewable Short-Term Health Insurance Application

Health Net Health Plan of Oregon, Inc.

Applicant must be the oldest person in the family unit, at least one year of age, less than 65 years of age, a U.S. citizen or permanent resident and not eligible for Medicare on the policy's effective date in order to qualify as an eligible applicant.

Applicant information

Applicant's last name:		First name:		MI:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant's birth date (mm/dd/yyyy): __ / __ / ____	
Home address:				City:		State:	ZIP:
County:	Home phone number: ()	Work phone number: ()	Email address:			Applicant's SSN: __-__ / __-__ / ____-__	

Dependents must be legal dependents of the applicant, at least 31 days of age, less than 65 years of age, a U.S. citizen or permanent resident and not eligible for Medicare on the policy's effective date in order to qualify as an eligible dependent.

Last name	First name	MI	Relationship to applicant	Social Security number	Gender	Date of birth
Spouse/Registered Domestic Partner:					<input type="checkbox"/> Male <input type="checkbox"/> Female	__ / __ / ____
Child 1:					<input type="checkbox"/> Male <input type="checkbox"/> Female	__ / __ / ____
Child 2:					<input type="checkbox"/> Male <input type="checkbox"/> Female	__ / __ / ____

For additional dependents, please attach another sheet with the requested information.

Plan choice

Please designate your plan choice: <input type="checkbox"/> \$1,000 deductible per person / \$3,000 deductible per family <input type="checkbox"/> \$2,500 deductible per person / \$7,500 deductible per family <input type="checkbox"/> Optional alcohol treatment benefits	Please request your effective date: <i>(cannot precede the postmark date of this application)</i> Requested effective date: ____/____/____ Please designate your plan type: <input type="checkbox"/> Daily plan <input type="checkbox"/> Monthly plan
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Daily policy (complete only if choosing daily plan)

Benefit coverage period: Please choose the number of days for your benefit period. Once enrolled, there are no changes permitted and the policy cannot be renewed.

_____ days (30–185 days)

Calculate your total premium due:

\$ _____ daily rate¹ (please see rates) x _____ # of coverage days + \$20 non-refundable application fee
= \$ _____ total amount due

¹Daily rate is based on the number of days selected.

Please remit a check payable to “Health Net” for the full amount owed for the policy benefit period and one-time application fee.

Termination date:

_____/_____/_____

Please calculate your termination date from the number of days from your requested effective date.

Monthly policy (complete only if choosing monthly plan)

Calculate your first month’s premium due:

\$ _____ monthly rate (please see rates) + \$20 non-refundable application fee = \$ _____ total amount due

Please remit a check payable to “Health Net” for the first month’s premium and one-time application fee.

Medical questions

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

During the previous 62 days, have you or any person applying for coverage been covered by other health insurance? Yes No
If “Yes,” please complete the prior coverage information below for all periods in the last 12 months. For additional dependents, please attach additional sheets.

Insured’s name:	Current carrier:	Effective date:	Expected termination date:
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1) Do you, or any person to be insured, now have hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If “Yes,” this policy cannot be issued.
2) Are you, or any person to be insured, including male applicants and dependent males or females, now pregnant or responsible for a current pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If “Yes,” this policy cannot be issued.
3) Within the last 12 months, have you or any person to be insured, been advised to have or contemplated having an operation or medical procedure not yet performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If “Yes,” this policy cannot be issued.
4) Within the last 5 years, has anyone listed on this application had any diagnosis, treatment or advice relating to any of the following: heart, chest pain or angina, stroke, paralysis, diabetes, sugar in urine, cancer, alcohol, chemical or drug abuse or habit, liver, hepatitis or kidney disorder; or AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-related complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If “Yes,” this policy cannot be issued.

5) Please provide the following information for each female on this application: N/A

Family member name:				
a. Initial menstrual cycle begun?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Date of last menstrual period:				
c. If (b) is more than 35 days ago, please explain:				

Medical questions (continued)

d. Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If (d) is "Yes," please explain:				
f. Date of last DEPO Provera shot?				
g. Abnormal Pap smears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Prior cesarean section or miscarriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

How did you hear about Health Net Health Plan of Oregon, Inc.? Please check the box that best describes how you heard about us.

Radio Mail Billboard Newspaper Yellow Pages Broker Internet Other: _____

Important information

I understand that:

- The minimum coverage time under the Health Net Health Plan of Oregon, Inc., Quick Net **daily policy is 30 days**, and for the **monthly policy it is one calendar month**. The maximum length of coverage time is **185 days for the daily policy** and **6 months for the monthly policy**.
- Under no circumstances will I, or my dependents, be allowed to make changes except as outlined in the policy once it goes into force. There is a ten-day free look period under the monthly policy. **There is no ten-day free look period, and no refunds whatsoever under the daily policy**. No exceptions will be made.
- No benefits are payable for any expenses incurred as a result of a pre-existing condition. Pre-existing condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period preceding the effective date of coverage. Genetic information does not constitute a pre-existing condition in the absence of a diagnosis of the condition related to such information. The pre-existing condition exclusion does not apply to a newborn or newly adopted child.
- The pre-existing condition exclusion does not apply to physical or mental injuries sustained as a result of domestic or sexual violence or treatment received for such injuries.
- If I am approved under a Health Net renewable plan, I must exhaust my coverage under this Quick Net non-renewable plan before the new plan becomes effective.
- My check will be held in trust while my application is reviewed by Health Net. Applications submitted **without payment** or with **partial payment** will be **pending** until payment is received. If my payment is not received within 2 weeks of the application signature date, my application will be withdrawn.

Additional information for **monthly policies only**:

- If my monthly policy is terminated due to lack of payment, my policy will not be reinstated.
- I may terminate my policy at any time, and refunds are limited as outlined in the policy. Initials: _____

Certification and authorization

Certification of completion and correctness: I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Health Net Health Plan of Oregon, Inc. to enroll in the insurance coverage. I understand that if this application contains any intentional misstatements or omissions of material fact, Health Net may deny coverage; modify, rescind or cancel the contract; and/or take any other legal action available to it by law. I will promptly inform Health Net in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Health Net. If approved, coverage will be in force as of the effective date determined by Health Net. Health Net may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Conditional authorization to use and disclose protected health information: To any physician; health care provider, including Oregon Health and Science University (OHSU); hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), pharmacy benefit manager or other insurance information exchange: Each of us authorizes you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical information (including alcohol, chemical dependency, mental treatment or HIV treatment) you have about my family members or me. Such information may be used for processing applications for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

Certification and authorization (continued)

This authorization takes effect on the date signed, and it remains in effect as follows:

- For information used to process this application – 24 months.
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected by federal privacy rules governing the privacy of health information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Health Net or its business associates in reliance on this authorization. I may send a written and dated revocation to Health Net at:

Health Net, Inc., PO Box 1150, Rancho Cordova, CA 95741-1150

I affirm that I received a disclosure statement and outline of coverage from Health Net Health Plan of Oregon, Inc. or its authorized agent. I understand that a PPO policy will not pay benefits for any loss incurred during the first six months after the effective date on account of a disease or physical conditions, which I now have or have had in the past. I understand that if my application for coverage is accepted, and I am on a monthly plan, I will have ten days after receiving notice of acceptance during which I may either make a replacement election or cancel the policy for a full refund. I affirm that my employer is not paying the premium for this coverage.

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

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

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signatures (required in ink)	
Family contact name, if different than the primary applicant name:	Date signed:
Applicant signature:	Date signed:
Spouse signature:	Date signed:
Signature of applicant dependent (age 18 or older):	Date signed:

No alteration of any written application for any health insurance policy shall be made by any person other than the applicant without the written consent of the applicant, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Mail your completed application to: Health Net, Inc., PO Box 1150, Rancho Cordova, CA 95741-1150

For producer's use only		Health Net producer ID: _____
Name (print):	Phone number:	Fax number:
Address:	Email address:	
Agreement signature/number:		Date signed (required):

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

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Health Net's Simple Pay Option

Payment options for Individual & Family Plans

- Send a bill by mail.** Monthly premiums will be paid by check.
- Simple Payment Option (Automatic Bank Draft).** Monthly premium charge can be withdrawn directly from your personal checking account. The premium will be deducted on approximately the fifth day of each month. Your premium payments will be clearly identified on your monthly bank statement.

Mail to: Health Net Health Plan of Oregon, Inc., PO Box 2066, Rancho Cordova, CA 95741 or **fax to:** (916) 935-4522
or **email to:** orifp_rc-membership.accounting@healthnet.com

Voided check must be attached to this form

Account holder's Social Security number:		Transit routing number:		Account number:		
Bank name:	Bank address:	City:		State:	ZIP:	
Name of Health Net member:						

I understand that by requesting the automatic payment option, I am authorizing Health Net Health Plan of Oregon, Inc. (Health Net), and my financial institution named above, to debit my checking account for my monthly premium payment(s).

I understand that the premium withdrawn from my account will be for the billing period, plus any past due balances. I understand that my premium payments will automatically adjust if my monthly premium changes.

This authority is to remain in effect until revoked by me in writing and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such debit. (**Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with my bank.**)

I understand that ABD transmissions are withdrawn from my bank on approximately the 5th of every month.

I understand that if there are insufficient funds at the time my account is debited, a service fee of \$15.00 (in addition to any fees my bank may charge me) will be assessed by Health Net for all dishonored payments. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the loss of health coverage.

Signature of account holder: _____ **Date:** _____

Credit card for first month's payment

First month's premium can be charged directly to your credit card account. All future premiums due may be paid by Automatic Bank Draft (please complete form above) or by mailing a monthly check.

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

As a convenience, I request and authorize Health Net Health Plan of Oregon, Inc. ("Health Net") to charge my credit card account identified above for the payment of my initial premium. I understand that my first month's withdraw/charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a \$15.00 service charge.

¹The ZIP code must match the cardholder's address; otherwise, the credit card cannot be processed.

Signature of credit card account holder (required to process): _____ **Date:** _____

For more information please contact

Health Net Health Plan of Oregon, Inc.

13221 SW 68th Pkwy., Ste. 200

Tigard, OR 97223

1-888-802-7001

Customer Contact Center

Monday–Friday, 7:30 a.m. to 5:00 p.m.

1-888-802-7001

Assistance for the hearing and speech impaired

Monday–Friday, 8:00 a.m. to 5:00 p.m.

TTY/TDD 1-888-802-7122

www.healthnet.com

When services are performed by a provider who is not in our PPO network, your expenses include a calendar-year deductible, fixed-dollar amounts for certain services and a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay out-of-network providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a provider bills for a service. Out-of-network providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. Your responsibility for any amounts that exceed our MAA payment is shown on this schedule as MAA.

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