CaliforniaChoice
Your Health. Your Choice.®

Salud con Health Net & Salud Mexico

Affordable HMO Coverage for Families in California and Mexico

Salud Means Health!

Salud con Health Net offers our popular Cal*Choice*® 25 plan coupled with a special Health Net sub-network of over 800 providers and a hospital network featuring East Los Angeles Doctor's, Memorial Hospital of Gardena, Pacifica Hospital of the Valley, Anaheim General Hospital and some of the leading Tenet hospitals in Los Angeles. All members can access over 140 doctors through the SIMNSA network.

Los Angeles County and North Orange County

Select a Primary Care Physician (PCP) a California*Choice* Directory or by using our online provider search at calchoice.com – or simply visit any of the IPA clinics listed below:

Health Net®
A Better Decision

Services	Cal*Choice*® 25 (Health Net Salud) HMO Network Benefit	Mexico SIMNSA Network Benefits
Annual Deductible	None	None
Out-of-Pocket Maximum	$2,500 (individual)/ $5,000 (family)	$1,500 (individual)/ $4,500 (family)
Doctor's Office Visit	$25	$5
Well baby care	$25	$0
Hospital & Maternity Services (Normal delivery or cesarean)	$500 a day $1,000 maximum	$0
Outpatient Surgery	Surgical Facility–$300 Physician Services–$0	$0
X-ray and lab procedures	Covered at 100%	$0
Emergency Room	$100	$10
Prescription Drugs		
Generic	$15	$5
Brand name	$25	$5
Drugs not on list	$35	Not covered

Médico Hispano IPA Medical Clinics:

Los Angeles
East Los Angeles
El Monte
Huntington Park
Van Nuys
Santa Ana

Angeles IPA:

Lakewood
Bellflower
Paramount
Downey

Other Participating Clinics:

Accountable IPA (33 cities from Inglewood to Long Beach*)
Alta Med (Los Angeles, Pico Rivera & El Monte)
Associated Hispanic Physicians (Los Angeles)
La Vida Multi Specialty Centers (Los Angeles)
Serra Community Clinic (Sun Valley)

*Refer to directory for specific locations

Your PCP can also refer you to one of these conveniently located community hospitals for covered hospital services:

- Queen of Angels-Hollywood Presbyterian Medical Center
- USC University Hospital
- Greater El Monte Community Hospital
- Encino-Tarzana Regional Medical Center Tarzana Campus
- Encino-Tarzana Regional Medical Center Encino Campus
- Community Hospital of Huntington Park
- Mission Hospital of Huntington Park
- Lakewood Regional Medical Center
- Garfield Medical Center
- Monterey Park Hospital
- Anaheim General Hospital

Salud Mexico

Salud Mexico is designed for employees residing in select zip codes of San Diego and Imperial counties. It provides across-border access to more than 140 doctors in all specialties of medicine.

This comprehensive and affordable health program is made possible through a unique partnership between Health Net and SIMNSA and is licensed by the California Department of Managed Health Care.

Services	Mexico SIMNSA Network Benefits
Annual Deductible	None
Out-of-Pocket Maximum	$1,500 (individual) $4,500 (family)
Doctor's Office Visit	$5
Well baby care	$0
Hospital & Maternity Services (Normal delivery or cesarean)	$0
Outpatient Surgery	$0
X-ray and lab procedures	$0
Emergency Room	$10
Prescription Drugs	
Generic	$5
Brand name	$5
Drugs not on list	Not covered

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(800) 558-8003

Frequently Asked Questions

Who is Eligible?

Any employee who resides in Los Angeles or North Orange County may participate in the Salud con Health Net HMO (SIMNSA network is available for dependents residing in Mexico).

Employees residing in select zip codes of San Diego and Imperial counties may participate in the Salud Mexico HMO.

Services are available in both English and Spanish.

What's covered in Salud con Health Net?

Medical services

Salud con Health Net HMO plans include doctor's office visits; well baby care; maternity and delivery services; outpatient/inpatient surgery; X-ray and lab procedures; services in the emergency room; and prescription drugs.

Specialist referrals

Employees residing in Los Angeles and North Orange County can receive referrals to contracted physician specialists through their designated Primary Care Physician (PCP). However in Mexico, eligible family members do not need to obtain referrals for specialty care, because they have direct access to any of the 140 SIMNSA providers.

Emergency

You are covered not only where you live, but anywhere in the world. Please read your Member Handbook carefully to understand what is covered as a true medical emergency.

Prescriptions

Only medications prescribed by your doctor (PCP) are covered by the Salud con Health Net plan. Employees can fill prescriptions for a small fee at any contracted pharmacy in the Health Net network in Los Angeles or North Orange County. Dependents in Mexico can obtain prescriptions through SIMNSA's network of participating pharmacies.

Salud con Health Net

CC 0194 10/2006

Salud con Health Net Application

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Use blue or black ink pen • Do not shrink this form

A. Personal Information

Name of Company	Employer Phone #	Employee Job Title	Full-time Employment Date

Sex ❑ M ❑ F **Marital Status** ❑ Married ❑ Single

Note: *• If you or any of your dependents are <u>not</u> enrolling, you must also complete and sign the waiver section on back.*
• Even if you have a domestic partner, you are still required to select one of these options

Employee Last Name

Employee Social Security Number

Employee First Name

Date of Birth MO / DAY / YEAR

Group Number

Residence Address	Apt #	City	State	Zip Code

Home Telephone ( )	Email Address	Mailing Address *(if different from above)*

B. Optional Benefits

Before completing this section, please ask your health plan administrator if any of the optional benefits below are offered by your employer

LIFE INSURANCE

Full Name of Beneficiary	Relationship of Beneficiary	Life Amount

DENTAL COVERAGE

❑ Dental 100 (no charge) ❑ Dental 1000 ❑ Dental 3000 ❑ Dental 5000
❑ Dental 3500 ❑ Dental 4000 ❑ Voluntary Dental 3000

Dependent children ages 19-24 must be full-time students to be considered for EPO/PPO dental coverage. "Full-time" is considered as college attendance with a minimum of 12 units or enrollment in trade school. A full-time student verification form (form #CC 0206) must be completed.

If you choose plans 1000 or 3000, you must select a dentist:

Dentist:

ID#:

❑ Check if dentist chosen is current provider ❑ Check if you would like a dentist assigned

VISION COVERAGE

❑ Vision (discount plan) ❑ Voluntary Vision (additional charge)

PREMIUM ONLY PLAN (P.O.P.)

❑ I want my portion of eligible insurance premiums paid on a pre-tax basis

C. Enrollment / Family Information (Complete for MEDICAL, DENTAL AND/OR VISION)

Do NOT complete this section for yourself or dependents unless you are electing medical, dental, life or vision benefits

	Employee	Spouse	Child	Child	Child
Last Name	❑ Life coverage only				
First Name					
Relationship to Employee		❑ Spouse ❑ Domestic Partner			
Social Security Number					
Gender		❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth		/ /	/ /	/ /	/ /
Primary Care Physician*					
Physician ID# & City					
Current Patient of PCP?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Disabled?			❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Enrolling For?	❑ Med ❑ Dent ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision
Los Angeles, San Diego and North Orange County residents specify a PCP. Residents of Mexico use the SIMNSA Network	❑ PCP_____ ❑ Mexico: **Provider is SIMNSA**	❑ PCP_____ ❑ Mexico: **Provider is SIMNSA**	❑ PCP_____ ❑ Mexico: **Provider is SIMNSA**	❑ PCP_____ ❑ Mexico: **Provider is SIMNSA**	❑ PCP_____ ❑ Mexico: **Provider is SIMNSA**

❑ Check here if you would like your Health Care Service Plan to assign you a Primary Care Physician.
➡ For additional dependent enrollment, complete sections A & C on a separate application.

* *Please be sure to verify that your PCP is contracted with your selected carrier prior to enrolling. New Hire applications added to existing groups will automatically be assigned a PCP if one is not chosen or PCP is not contracted with the selected health plan.*

† *Dependents enrolled for dental must match dependents enrolled for medical (except voluntary dental or children under Age 3).*

D. Your LEGAL Acknowledgement (Read, Sign & Date Below)

By submitting this signed application, I agree and understand that the health plan I have chosen through the California*Choice* Program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the California*Choice* Program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review.

I authorize California*Choice* and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months for the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application:

- I am either actively, permanently working for the employer and considered eligible by my employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and **agree** to provide California*Choice* with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all California*Choice* benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through California*Choice* Program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued. If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

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

ARBITRATION: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and my health plan, whether arising out of tort or otherwise, must be submitted to binding arbitration and in lieu of a jury or court trial if not satisfactorily resolved through my health plan's grievance process. Additionally, specific requirements for health plans that require binding arbitration to resolve claims for professional negligence and medical malpractice are set out below.

HEALTH NET ENROLLEES: I understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net of CA and/or Health Net Life regarding the construction, interpretation, performance or breach of the Health Net Plan Contract, Insurance Policy or Certificate, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbit ration, all parties, including Health Net of CA and/or Health Net Life, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net of CA and/or Health Net Life involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration.

Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

A more detailed arbitration provision is included in my health plan contract or insurance policy. By signing and submitting this application, I hereby agree to the above terms and conditions, and confirm that the information contained in this application is true and correct.

Employee **SIGN HERE FOR MEDICAL, DENTAL OR LIFE COVERAGE:** ➡ Print Name: Date:

COBRA Applicants:
Please check COBRA type: ❑ **COBRA** ❑ **Cal-COBRA**

Indicate Qualifying Event:
❑ Termination of employment ❑ Child no longer eligible ❑ Medicare entitlement
❑ Reduction of hours ❑ Divorce/legal separation ❑ Death of employee

Date of Qualifying Event

California*Choice* Use Only ❑ New Group ❑ New Hire ❑ Open Enrollment Effective Date:

MEDICAL / DENTAL WAIVER

Complete **THIS SECTION and Section A** only if you do not want coverage for yourself and/or your eligible dependents. If offered, life coverage cannot be waived.

Employer Name: Employer Phone #:

Type of Waiver

I have been offered coverage by my employer, and wish to DECLINE coverage as follows:

1) **Medical for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

2) **Dental for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

Reason

3) **Reason waiving Medical:** ❑ Other group coverage Carrier Name: _____ Group # _____
❑ Medicare ❑ Medi-cal ❑ Individual Policy ❑ Other Reason: _____ (explanation required)

4) **Reason waiving Dental:** ❑ Other group coverage Carrier Name: _____ Group # _____
❑ Medicare ❑ Medi-cal ❑ Individual Policy ❑ Other Reason: _____ (explanation required)

✗ I understand that by failing to elect coverage now, California*Choice* Benefit Administrators can impose up to a 12 month period of exclusion should I request coverage at a later date.

✗ I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE:** ➡ Date