

# California Small Business Group Renewal Plan Election and Open Enrollment Change Form

Effective 1/1/2026

Your broker or Health Net account manager may have provided you with additional renewal proposals to help you choose the best coverage for your group. To help us serve you better, please provide the quote number of the renewal proposal you are accepting. The quote number can be found on the cover page and in the header of the renewal proposal pages.

Quote #: \_\_\_\_\_ Renewal effective date: \_\_\_\_\_

Do you have a grandfathered plan on your policy you wish to renew? ☐ Yes ☐ No

## 1. Employee information

New hire waiting period (Please check the waiting period for new hires. Federal law does not allow waiting periods beyond 90 days.)

First of the month following: ☐ Date of hire ☐ 30 days ☐ 1 month ☐ 60 days

On a typical business day, how many employees are eligible for health benefit plan coverage (count all employees throughout the U.S.)?

Total eligible employees: \_\_\_\_\_ California employees: \_\_\_\_\_ Out-of-state employees: \_\_\_\_\_

Is the group subject to ERISA? ☐ Yes ☐ No, government, public plan or church plan

☐ No (please specify reason) \_\_\_\_\_

### Medicare secondary payer (MSP)

Total worldwide employees: \_\_\_\_\_  
(Count all employees regardless of if they are eligible for coverage. Include full-time and part-time employees. Do not include 1099 and seasonal employees.)

### Medical loss ratio (MLR)

Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: \_\_\_\_\_  
An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.<sup>1</sup>  
To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.

## 2. Medical plan offerings (Complete the contribution and the plans you wish to offer.)

Employer monthly contribution – Employee: \_\_\_\_\_ % Dependent: \_\_\_\_\_ % or Employee: \$ \_\_\_\_\_ Dependent: \$ \_\_\_\_\_

### Health Net PPO

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Platinum PPO 0/5    | <input type="checkbox"/> Gold PPO 750/15        | <input type="checkbox"/> Silver PPO 2500/50       |
| <input type="checkbox"/> Platinum PPO 0/15   | <input type="checkbox"/> Gold PPO 1000/35       | <input type="checkbox"/> Silver PPO 2500/55       |
| <input type="checkbox"/> Platinum PPO 250/15 | <input type="checkbox"/> Gold PPO 1500/20       | <input type="checkbox"/> Silver HDHP PPO 1800/50% |
| <input type="checkbox"/> Gold PPO 0/35       | <input type="checkbox"/> Gold HDHP PPO 1800/20% | <input type="checkbox"/> Bronze PPO 5800/60       |
| <input type="checkbox"/> Gold PPO 350/25     | <input type="checkbox"/> Silver PPO 1700/50     | <input type="checkbox"/> Bronze HDHP PPO 7200/0%  |
| <input type="checkbox"/> Gold PPO 500/20     | <input type="checkbox"/> Silver PPO 2250/60     |   |

### Health Net HMO (First select your network, then select your plan.)

#### Network

- ☐ Full Network HMO  
☐ WholeCare HMO  
☐ SmartCare HMO  
☐ Salud HMO y Más

#### Plan

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Platinum \$0  | <input type="checkbox"/> Platinum \$35 | <input type="checkbox"/> Gold \$50   |
| <input type="checkbox"/> Platinum \$10 | <input type="checkbox"/> Gold \$30     | <input type="checkbox"/> Gold \$55   |
| <input type="checkbox"/> Platinum \$20 | <input type="checkbox"/> Gold \$35     | <input type="checkbox"/> Silver \$55 |
| <input type="checkbox"/> Platinum \$30 | <input type="checkbox"/> Gold \$40     |                                      |

### 3. Supplemental renewal offerings

(Select either voluntary or employer-paid and then select the plans you wish to offer.)

**Optional Rider (Optional coverage available on all HMO and PPO plans)** ☐ Chiropractic ☐ Infertility

**Note:** Dental and Vision can be either voluntary or employer-paid. If employer-paid, you must complete the employer contribution. If you select Dental and/or Vision with no contribution, indicate "0."

If you would like to add, change, or remove any of the below lines of coverage, please contact your Account Manager at 1-800-447-8812 Option 2.

#### Employer monthly contribution

**Dental** – Employee: \_\_\_\_\_% Dependent: \_\_\_\_\_% **Vision** – Employee: \_\_\_\_\_% Dependent: \_\_\_\_\_%

#### Vision

☐ Voluntary ☐ Employer-paid ☐ Preferred 1025-2 ☐ Preferred 1025-3 ☐ Preferred Value 10-3 ☐ Elite 1010-1  
☐ Supreme 010-2 ☐ Plus 20-1 ☐ Exam only

#### Dental

☐ Voluntary ☐ Employer-paid **Dental (DHMO)** ☐ HN Plus 150 ☐ HN Plus 225  
**Dental (DPPO)** ☐ Classic 4 1500 ☐ Essential 2 1000  
☐ Classic 5 1500 (w/ortho) ☐ Essential 5 1500 (w/ortho)  
☐ Classic 7 Unlimited ☐ Essential 6 1500  
☐ Classic 11 Unlimited (w/ortho) ☐ Essential 10 3000 (w/ortho & implants)  
☐ Essential 11 5000 (w/ortho & implants)

#### Life and AD&D options (If Health Net Life is selected, all full-time employees are eligible.)

☐ \$15,000 (2–100 employees) ☐ \$25,000 (15–100 employees) ☐ \$50,000 (25–100 employees)

**I/We have reviewed and understand my/our medical plan renewal notification along with the following informational pieces provided by Health Net of California, Inc. and/or Health Net Life Insurance Company. After reviewing the renewal information, by my/our signature below, I/we confirm that I/we intend to renew my/our health benefit plan(s).**

**I/We understand that Health Net is relying on my/our answers to the above questions to assess whether my/our group meets the State of California's definition of a small employer group. I/We affirm these answers are true to the best of my/our knowledge and belief.**

Policyholder name:	Policyholder/Case ID: (located on the coverage page and header of renewal proposal pages)
Company authorized representative (please print):	Title:
Signature:	Date:
Email address:	Phone:

**This form must be completed and returned to your Health Net account manager in order to perform renewal election changes. If the completed form is not received by Health Net by the 1st of the month prior to the effective date of your renewal, your health benefit plan(s) will be auto-renewed to the closest matching plan(s). Please fax completed forms to the Health Net Account Management Department at 1-800-303-3110.**

<sup>1</sup>This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.

# Open Enrollment Medical Plan Change Request Form

Effective 1/1/2026



Use this form to indicate plan changes for your employees and their dependents during your renewal. Please refer to the Group Policy and Procedures Guide for acceptable plan changes and guidelines. You may also call your authorized Health Net of California, Inc. (Health Net) broker or Health Net account manager for more information.

Employer group information			
Group number:		Company name:	
Group contact:		Contact phone:	Contact fax:
		Contact email address:	
Optional rider information			
Do you want to add the Infertility Rider Benefit to your medical plan offerings? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you want to add the Chiropractic Rider Benefit to your medical plan offerings? <input type="checkbox"/> Yes <input type="checkbox"/> No	

List all **currently enrolled** members making plan changes during Open Enrollment on this form. New enrollees will need to submit separate enrollment applications. You may photocopy this form if more space is required. **Using blue or black ink, please indicate the plan each member wishes to move into with a checkmark.** Fax completed forms to the Health Net Account Management Department at 1-800-303-3110.

Member's name	Member's SSN or reference ID #	Group #	Primary care physician's enrollment ID #	HMO															
				1. Pick your network				2. Pick your plan											
				Full Network	WholeCare	SmartCare	salud	Platinum \$0	Platinum \$10	Platinum \$20	Platinum \$30	Platinum \$35	Gold \$30	Gold \$35	Gold \$40	Gold \$50	Gold \$55	Silver \$55	

(continued)

Member's name	Member's SSN or reference ID #	Group #	PPO															
			Platinum PPO 0/5	Platinum PPO 0/15	Platinum PPO 250/15	Gold PPO 0/35	Gold PPO 350/25	Gold PPO 500/20	Gold PPO 750/15	Gold PPO 1000/35	Gold PPO 1500/20	Gold HDHP PPO 1800/20%	Silver PPO 1700/50	Silver PPO 2250/60	Silver PPO 2500/50	Silver PPO 2500/55	Silver HDHP PPO 1800/50%	Bronze PPO 5800/60

**Note: You must provide the *Summary of Benefits and Coverage (SBC)* to each individual listed on this form before the individual makes the plan choice and PRIOR TO SUBMITTING THIS FORM TO HEALTH NET. To download and print an SBC, go to [www.healthnet.com/sbc](http://www.healthnet.com/sbc). Or please contact your Health Net account manager to obtain a copy.**

As an owner or officer of stated company, I hereby authorize the above changes to our Health Net Group medical coverage. I have informed the employees listed above that the enrollment terms of the Health Net form they completed previously at enrollment are still in force and a copy is available upon request.

Printed name	Signature	Date

## English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call **1-800-522-0088** (TTY: 711).

## Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) **1-800-522-0088**

## Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք **1-800-522-0088** (TTY: 711).

## Chinese

免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 **1-800-522-0088** (TTY: 711)。

## Hindi

बनिा लागत की भाषा सेवाएँ। आप एक दुभाषयिा प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या **1-800-522-0088** (TTY: 711)।

## Hmong

Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu **1-800-522-0088** (TTY: 711).

## Japanese

無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、**1-800-522-0088**、(TTY: 711)。

## Khmer

សេវាកម្មភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន **1-800-522-0088** (TTY: 711)។

## Korean

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하십시오 **1-800-522-0088** (TTY: 711).

## Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'éhjí naaltsoos hach'í' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzínígíí bikáa'gi béesh bee hane'í bikáa' áají' hodíílnih éí doodaii' **1-800-522-0088** (TTY: 711).

## Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی **1-800-522-0088** (TTY: 711).

### Panjabi (Punjabi)

ਬਨਿ ਕਸਿ ਲਾਗਤ ਤੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711)।

### Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711)।

### Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711)।

### Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalisting numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711)।

### Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711)।

### Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711)।