



Health Net®

Health Net Health Plan of Oregon, Inc.

Washington PPO Plans

2010 Summary of Significant Group Contract Changes

BENEFIT OR PROVISION	CONTRACT REFERENCE	CHANGES MADE
Outpatient at Ambulatory Surgery Center	Copayment and Coinsurance Schedule	The Coinsurance for services received at an In-Network Ambulatory Surgery Center are now 5% less than your general In-Network Coinsurance amount.
Outpatient at Hospital Based Facilities	Copayment and Coinsurance Schedule	A new benefit line has been added to the Copayment and Coinsurance Schedule for services received at outpatient Hospital based facilities.
Outpatient Emergency Room Services	Copayment and Coinsurance Schedule	If you are on PPO Advantage plan with a \$100 Copayment plus Coinsurance cost share amount, your outpatient emergency room services Copayment has increased to \$150.
Inpatient Admission from Emergency Room	Copayment and Coinsurance Schedule	The inpatient admission from emergency room Out-of-Network cost share has changed to match the In-Network cost share amount, subject to MAA.
Behavioral Health Services	Copayment and Coinsurance Schedule	Legislative Update: Per the Federal Mental Health Parity interim final rules, the following change applies: If you are on a PPO Advantage plan, the In-Network Outpatient Mental Health and Outpatient Chemical Dependency cost share has changed to match the "Outpatient center" cost share, with deductible waived.
Out-of-Pocket Maximum (OOPM)	Copayment and Coinsurance	If you are on a PPO and/or PPO Advantage plan (DX or LX) that includes a separate Out-of-Network OOPM, the Out-of-Network OOPM has increased to three times the In-Network amount.
Lifetime Maximum for Authorized Organ Transplant Services	Copayment and Coinsurance	Washington Legislative Update: The lifetime maximum for authorized organ transplant services has been increased to \$350,000.
Deductible Carryover	Copayment and Coinsurance Schedule	The fourth quarter deductible carryover provision has been removed. Covered services that satisfy the deductible during the last three months of the Calendar Year will no longer apply to the following year's deductible.

BBS (Basic Benefit Schedule)

Other Services, Organ and Tissue Transplants	Article 7.8	<p>Washington Legislative Update: Article has been revised to read as follows:</p> <p><i>“Organ and Tissue Transplants.</i></p> <p><i>Exclusion Period. A 12-month Exclusion Period applies for services related to any organ or tissue transplant. Creditable Coverage applies to this Exclusion Period.</i></p> <p>a. <i>The following organ and tissue transplants are covered: kidney transplants; cornea transplants; heart transplants; liver transplants; lung transplants; heart-lung transplants; concurrent kidney-pancreas transplants for uremic insulin-dependent diabetics; artificial pump as a bridge to cardiac transplants; and autologous or allogeneic bone marrow transplants, stem cell rescue or hematopoietic support (all referred to herein as transplants) only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease or Wiskott-Aldrich Syndrome, neuroblastoma, Hodgkins and non-Hodgkins lymphoma and for breast cancer when necessary to support high dose chemotherapy. No other organ or tissue transplants are covered.</i></p> <p>b. <i>We will direct you to a designated Specialty Care Provider in accordance with Article 1.5. Services provided by other than the designated Specialty Care Provider will not be covered. Coverage is conditioned upon your acceptance into the transplant program. Coverage may also be subject to approval by a Transplant Evaluation Committee designated by us. The Committee shall have complete discretion in determining whether or not a transplant will be covered and will consider factors such as the treatment’s effectiveness in improving the length and quality of life; the mortality and morbidity associated with the treatment; alternative treatment methods; the current medical and scientific literature; the positions of governmental agencies regarding the treatment; community standards of care; and your physical and mental condition.</i></p> <p>c. <i>The lifetime maximum benefit is shown on the Copayment and Coinsurance Schedule and includes all amounts paid for transplant services listed below which occur during a 100-day period beginning on the day before the transplant. The lifetime maximum includes all covered services, supplies and pharmaceuticals required in connection with a covered transplant as follows: 1) evaluation of a transplant candidate; 2) tissue typing; 3) a covered transplant procedure and any complications resulting from such procedure; 4) scheduled follow-up care; 5) anti-rejection drugs; and 6) transportation and living expenses in connection with those services when we require you to receive care from a Specialty Care Provider outside the Service Area. When the recipient of a covered transplant is a Member, donor costs directly relating to surgical removal of the organ from the donor, as well as the costs of treating complications directly resulting from the surgery, will also be paid under the limits of this benefit. Donor-related services may apply to the lifetime limit for transplants at any time.</i></p> <p><i>The overall lifetime maximum limit for all covered services, if any, will apply before and after this 100-day period.</i></p> <p>d. <i>Prior Authorization is required for transplant evaluation, services, and procedures related to a transplant.</i></p> <p>e. <i>Exclusions and Limitations: All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered. Services for an organ donor or prospective organ donor when the transplant recipient is not a Member. Organ and bone marrow search, selection, transportation and storage costs. Non-human or artificial organs and the related implantation services. Permanent or temporary implantation of artificial or mechanical devices to replace or assist human organ function until the time of organ transplant, except for dialysis to maintain a kidney and artificial pump bridge to cardiac transplants. High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue. Transplants disapproved by our Transplant Evaluation Committee. Bone marrow transplantation, stem cell rescue or hematopoietic support for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, primary lysosomal storage disorders). All services in excess of the lifetime maximum benefit for organ and tissue transplants. Transplant services not Prior Authorized and/or not provided at the Specialty Care Provider designated by us.”</i></p>
--	-------------	--

Exclusions and Limitations	Article 9.8	The exclusion has been revised to read as follows: <i>"Orthodontic services and dental implants, except for treatment covered under Article 7.20 Dental injury."</i>
Exclusions and Limitations	New: Article 9.43	The following exclusion has been added: <i>"Services provided outside the United States which are not Emergency Medical Care."</i>
GMHSA (Group Medical and Hospital Service Agreement)		
Definitions, Dependent	Article 2.14	The definition of Dependent has been revised to read as follows: <i>"Dependent" means any member of a Subscriber's immediate family who is one of the following:</i> <i>a. The spouse or State Registered Domestic Partner of the Subscriber.</i> <i>b. A child of the Subscriber from birth and extending up to the last day of the month in which that child becomes age 26, including a child who is the subject of a Qualified Medical Child Support Order (QMCSO) requiring the Subscriber to provide health coverage for the child. The QMCSO must be furnished to us to initiate Enrollment.</i> <i>"Child" means a natural child of the Subscriber, an adopted child of the Subscriber, or a stepchild of the Subscriber during the marriage of the Subscriber and the natural parent, or a child of the Subscriber's State Registered Domestic Partner during the State Registered Domestic Partnership, but does not include foster children, wards, or children who are under temporary custody of the Subscriber or spouse. "Child" also does not include children of Dependents unless the Subscriber is a court-appointed guardian. Provided, however, that a child who is placed with a Subscriber for the purposes of adoption shall be considered a Dependent of the Subscriber as required by the laws of the State of Washington. Placement for adoption means the assumption and retention by a Subscriber or spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Coverage of any Dependent child of a Subscriber shall not be terminated by the child's attaining the relevant limiting age if the child is and continues to be Disabled. Proof of disability must be furnished within 31 days of reaching a limiting age and not more frequently than annually after the first two years of continued coverage. We will not deny enrollment of a Child because the Child was: (a) born out of wedlock; (b) is not claimed on the parent's federal tax return; or (c) does not reside with the parent or within our Service Area."</i>
State Registered Domestic Partner	New: Article 2.55	Washington Legislative update: The following definition has been added: <i>"State Registered Domestic Partner" means a person who has entered into a civil contract with the Subscriber, both of whom meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary of state's office."</i>
Monthly Payments (Premiums)	Article 7.2	Article has been revised to read as follows: <i>"Premiums are due on the first day of each month. Each monthly premium shall be calculated on the basis of our records reflecting the number of Subscribers and Dependents in each premium classification, as set forth on the Signature Sheet, at the time of calculation and at the premium rate then in effect. Participating Employer shall submit to us, on behalf of each Subscriber and Enrolled Dependents, the entire amount due, on or before the first day of the month for which coverage is provided. If a payment is rejected by the financial institution on which it is drawn, premium is not considered paid until the payment, or an alternate payment, is honored by the issuing financial institution. We shall have the right to change the premium amount when any payment is returned as unfunded. Participating Employer assumes responsibility for collection of the contributory portion of the premium, if any, from each Subscriber."</i>

Monthly Payments (Premiums)	Article 7.3	Article has been revised to read as follows: <i>"Only Members for whom the premium is actually received shall be entitled to benefits, and then only for the period to which such premium is applicable. If the required premium for the Agreement is not received by the last business day of the coverage month, the Agreement shall terminate automatically. Thereafter, the Agreement will be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Agreement."</i>
Pre-existing Conditions Exclusion Period	Article 8.10.a	Article has been revised to read as follows: <i>"Pre-existing Conditions.</i> a. <i>"Pre-existing Condition" means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the three-month period preceding the enrollment date, which means the earlier of the first day of the Subscriber Group's probationary period or the Member's effective date of coverage. The enrollment date for a Late Enrollee is the effective date of coverage. Pregnancy is not 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. Pre-existing conditions do not apply to a newborn or newly adopted child."</i>
Termination	Article 9.3	Article has been revised to read as follows: <i>"Notwithstanding any provision of Article 9.1 to the contrary, we may rescind an Agreement for fraud or intentional misrepresentation of material fact by a Subscriber Group. We may rescind the coverage of a Participating Employer under the Agreement for fraud, material misrepresentation or concealment by the Participating Employer. The coverage of a Member may be rescinded for fraud or intentional material misrepresentation of material by the Member."</i>
Termination	Article 9.4	Article has been revised to read as follows: <i>"In the event of termination of this Agreement on one of the grounds specified in this Agreement, termination will be effective as to the Subscriber Group and all Subscribers and Enrolled Dependents irrespective of whether monthly premiums have been received for periods beyond the termination date. However, in no event will this Agreement continue beyond the last day of the month for which monthly premiums have been received. Premium will be charged and collected for any period between the date through which premiums are paid and the termination date. If the Agreement is to terminate due to the required premium not paid when due, we will provide a written notice to the Policyholder, specifying the last date the premiums may be paid (no less than 10 days from the date of the notice) in order to reinstate the Agreement. We shall have the right to change the premium amount to reinstate the Agreement after termination."</i>
Federal Continuation of Coverage	New: Article 11.3	The following provision has been added: <i>"Per federal regulations, a State Registered Domestic Partner and the State Registered Domestic Partner's covered children losing group coverage under this Agreement are not eligible for Federal Continuation of Coverage."</i>
Washington State Conversion Coverage	Article 12.5	The provision has been revised to read as follows: <i>"There are no conversion options available to any Member when the Member is covered under any other group plan, policy, contract, or agreement providing benefits for hospital or medical care. Such other coverage must not contain operable exclusions for Pre-existing Conditions or waiting periods greater than those remaining under the terminated plan."</i>

Subrogation	New: Article 15.7	The following provision has been added: <i>"We have the right to recover a mistaken payment from the person paid or anyone else who benefited from it, including a provider of services, if:</i> 1). <i>We make a payment to which a Member is not entitled under this Agreement; or</i> 2). <i>We pay a person who is not eligible for benefits at all."</i>
Miscellaneous	Article 17.16	Article has been amended by adding the following language: <i>"Claims filed by Medicaid must be received no later than three years from the date the services were rendered."</i>
Miscellaneous	Article 17.27	The fourth quarter deductible carryover provision has been removed. Covered services that satisfy the deductible during the last three months of the Calendar Year will no longer apply to the following year's deductible.
Optional Supplemental Benefit Schedules		
Non-Registered Domestic Partner Amendment	Definition of Dependent	The definition of Domestic Partner has been revised to read as follows: <i>"Non-Registered Domestic Partner" means a person who is in a "Domestic Partnership" with the Subscriber. A Non-Registered Domestic Partnership is defined as:</i> a. <i>A relationship of two people 18 years of age or older who are not related by blood closer than first cousins.</i> b. <i>A couple that has lived continuously in an exclusive and loving relationship that they intend to maintain for the rest of their lives.</i> c. <i>A partnership that includes joint financial accounts and joint financial responsibilities.</i> <i>The partnership must meet the eligibility requirements established by the Subscriber Group and agreed to by us and the Subscriber and Non-Registered Domestic Partner must complete an affidavit form approved by us declaring that the relationship meets the definition of Domestic Partnership. The Subscriber is required to provide notice of termination of the relationship."</i>