



## GROUP PLANS

May 31, 2009

Dear Health Net Employer,

Thank you for enrolling your group with Health Net Health Plan of Oregon, Inc. We appreciate the opportunity to provide quality health care access to you.

Enclosed is an endorsement to your contract, which is effective July 1, 2009.

This endorsement contains language to help clarify our payment of out-of-network benefits. It is important to note that this endorsement does not have any effect on claims payment. Any changes which occur as part of your group's regular renewal will supercede the changes in this endorsement.

Please distribute a copy of this endorsement to each of your covered employees. If you have any questions about this mailing, please call the Customer Contact Center at 1-888-802-7001.

Thank you again for your business. We look forward to continuing to serve you.

Sincerely,

Health Net Health Plan of Oregon, Inc.



# Health Net Health Plan of Oregon, Inc. **Contract Update Addendum** To the 2008 Group Agreement – July 1, 2009

In this Addendum, the terms “we,” “our” and “us” refer to Health Net Health Plan of Oregon, Inc. and the terms “you” and “your” refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

## **Article 1 - Purpose and Function of this Schedule**

The purpose of this Addendum is to amend the Basic Benefit Schedule and/or the Group Medical and Hospital Service Agreement for specified contractual changes. This Addendum is an amending attachment to the Group Medical and Hospital Service Agreement, and the Basic Benefit Schedule. To the extent that the terms of this Schedule conflict with the terms of those documents, the terms of this Schedule will control. All other terms, conditions, exclusions and definitions in the Group Agreement and its attachments continue to apply.

Effective July 1, 2009, the Agreement is amended as follows:

## **Article 2 – Provisions, Basic Benefit Schedule**

### 2.1 Article 1.3 is amended to read as follows:

The fact that a Provider may provide, prescribe, order, recommend, approve, refer or direct a service or supply does not, in and of itself, make the service or supply a covered benefit. To qualify as covered Medical Services and supplies, all services and supplies must be expressly set forth as benefits in this Benefit Schedule.

Subject to the Specialty Care Provider requirements, you may choose to obtain covered Medical Services and supplies from a Nonparticipating Provider. You may incur higher out-of-pocket expenses if you receive services or supplies from a Nonparticipating Provider.

When services are performed by or received from a Nonparticipating Provider, your expenses include a Calendar Year deductible, fixed dollar amounts for certain services and a fixed percentage of Maximum Allowable Amount (MAA) for other services. The definition of MAA is set forth in Section 3.3 of this Addendum. The MAA for covered Medical Services and supplies may not be the same as what the Nonparticipating Provider bills.

Even though a Hospital or other Provider may be a Participating Provider, during your visit or stay you may receive services or supplies which are performed by or received from Nonparticipating Providers. We recommend that you contact your attending Provider or the Hospital or other facility where you are receiving services to discuss the ancillary Providers that may be used for your services, as these Nonparticipating Provider charges may not be covered or will be reimbursed at the Out-Of-Network level.

### 2.2 Article 3 - Hospital Inpatient Services is amended by the addition of the following provisions:

When multiple procedures are performed at the same time, we will use Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with our normal claims filing requirements. Per Medicare guidelines, no benefits are payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

We use Medicare guidelines to determine which procedures are eligible for separate professional and technical components.

We use Medicare guidelines to determine the circumstances under which claims for Assistant Surgeons, Co-Surgeons and Team Surgeons will be eligible for reimbursement, in accordance with our normal claims filing requirements.

We use Medicare guidelines to determine coverage during a post-operative global period for surgical procedures.

- 2.3 Article 4.3 Outpatient Services, Outpatient Surgery is amended by the addition of the following provisions:

When multiple procedures are performed at the same time, we will use Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with our normal claims filing requirements. Per Medicare guidelines, no benefits are payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

We use Medicare guidelines to determine which procedures are eligible for separate professional and technical components.

We use Medicare guidelines to determine the circumstances under which claims for Assistant Surgeons, Co-Surgeons and Team Surgeons will be eligible for reimbursement, in accordance with our normal claims filing requirements.

We use Medicare guidelines to determine coverage during a post-operative global period for surgical procedures.

- 2.4 Article 6 - Emergency Medical Care Article is amended by the addition of the following provision:

We use a prudent layperson standard to determine whether the criteria for Emergency Care has been met. Under this Agreement, the prudent layperson standard is outlined in the definition of "Emergency Medical Condition" in the Article 2.19. We also administer this Agreement in accordance with RCW 48.43.093, and the definitions of "Emergency Medical Care," "Emergency Medical Condition," and "Emergency Medical Screening Exam" in Article 2 - Definitions.

### **Article 3 – Provisions, Group Medical and Hospital Service Agreement**

- 3.1 Article 2.2, definition of Agreement , is amended to read as follows:

"Agreement" means this Medical and Hospital Service Agreement, all attached Benefit Schedules and Copayment and Coinsurance Schedules, the Signature Sheet, any exhibits, supplements, addenda, attachments, amendments, endorsements, applications, health statements or riders, and any information submitted as part of an application for this Agreement or for membership under this Agreement. A copy of the Agreement serves as both the description of coverage portion of the contract between us and the Subscriber Group, and when distributed to a Member, as the Member's Evidence of Coverage (EOC) document.

- 3.2 Article 2 - Definitions is amended by the addition of the following definition of Appeal:

"Appeal" means a written request submitted by or on behalf of a Member for reconsideration of a decision regarding a Grievance. When the Appeal involves an Expedited Appeal, the Appeal will not be required to be submitted in writing.

- 3.3 The use of a "Usual, Customary and Reasonable" methodology as the basis for determining payment for covered Medical Services or supplies provided by Nonparticipating Providers is replaced with the "Maximum Allowable Amount" methodology, as defined below.

Therefore, the term and definition of Usual, Customary and Reasonable (UCR) are replaced by the term Maximum Allowable Amount (MAA), as defined below, wherever used in the Agreement other than the Coordination of Benefits provision, and any attachments.

**Maximum Allowable Amount (MAA)** is the amount that we use to calculate what we pay for covered Medical Services and supplies provided by a Nonparticipating Provider. MAA is determined by applying a designated percentile from the database of charges from the Ingenix Prevailing Healthcare Charges System (PHCS) or a similar type of database of charges.

Ingenix collects provider data as follows:

- Ingenix collects information on billable charges for various types of claims.
- Ingenix ranks the billable charge data for each type of claim from lowest to highest.

If the billed charges for a claim are less than MAA, we will pay the billed charges.

MAA is subject to other limitations on covered Medical Services. See your Copayment and/or Coinsurance Schedule, Basic Benefit Schedule, and any Supplemental Benefit Schedules and Amending Attachments for specific deductibles, benefit limitations, maximums, requirements and surgery payment policies that limit the amount that we pay for covered Medical Services and supplies. The following example shows how MAA applies to claims payment:

**For illustration purposes only, Out-of-Network Provider: 70% Plan Payment / 30% Member Coinsurance**

Nonparticipating Provider's billed charge for extended office visit	\$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount)	\$102.40
<b>Your Coinsurance is 30% of MAA:</b> 30% x \$102.40 (assumes deductible has already been satisfied)	\$30.72
<b>You are also responsible for</b> the difference between the billed charge (\$128.00) and the MAA amount (\$102.40)	\$25.60
<b>TOTAL AMOUNT OF \$128.00 CHARGE THAT IS YOUR RESPONSIBILITY</b>	<b>\$56.32</b>

From time to time, we may contract with networks that have contracted fee arrangements with providers ("third party networks"). In the event we contract with a third party network that has a contract with the Nonparticipating Provider, we may, at our option, use the rate agreed to by the third party network as the MAA, in which case you will not be responsible for the difference between the MAA and the billed charges. You will be responsible for any applicable deductible, Copayment and/or coinsurance.

In addition, we may, at our option, refer a claim for Nonparticipating Provider services to a fee negotiation service to negotiate the MAA for the service or supply provided directly with the Nonparticipating Provider. In that situation, if the Nonparticipating Provider agrees to a negotiated MAA, You will not be responsible for the difference between the MAA and the billed charges. You will be responsible for any applicable deductible, Copayment and/or coinsurance **at the Out-of-Network level.**

You may contact us and request assistance from our fee negotiation service on a pre-service or supply single case basis when the cost of your Out-of-Network services is projected to be \$15,000 or more. We will provide information on our website about how to obtain this assistance, or you may also call the Customer Contact Center. Your use of our fee negotiation service does not obligate us to agree to any particular amount requested by an Out-of-Network Provider, or to negotiate with an Out-of-Network Provider who is contracted with a network with which we have an arrangement to pay the provider in accordance with that network's fee schedule.

In the event that the billed charges for covered Medical Services and supplies received from a Nonparticipating Provider are more than the MAA, You are responsible for any amounts charged in excess of the MAA, in addition to applicable deductibles, Copayments or coinsurance, except where the Nonparticipating Provider's fee is determined by reference to a third party network agreement or the Nonparticipating Provider agrees to a negotiated MAA.

The MAA for covered Medical Services and supplies may be revised periodically by us.

For more information on the determination of Maximum Allowable Amount, call the Customer Contact Center at the number on your Member identification card.

3.4 Article 8.9 of the Group Medical and Hospital Service Agreement which reads as follows:

Any complaint or grievance brought to recover on this Agreement shall be limited to the complaint and grievance procedure under Article 10 – Rights of Members. No complaint or grievance, including but not limited to complaints regarding denial of claims for payments or for services, may be brought more than one year after the event which precipitates the action, unless the complainant is legally incapacitated throughout that year in which case the complaint must be brought as soon as reasonably possible.

is amended to read as follows:

Any Appeal or Grievance brought to recover on this Agreement shall be limited to the Grievances and Appeals procedure under Article 10 – Rights of Members. No Appeal or Grievance, including but not limited to inquiries regarding denial of claims for payments or for services, may be brought more than one year after the event which precipitates the action, unless the complainant is legally incapacitated throughout that year in which case the Appeal or Grievance must be brought as soon as reasonably possible.

3.5 Article 17 - Miscellaneous of the Group Medical and Hospital Service Agreement is amended by the addition of the following provisions:

If You Are Enrolled In An Employer Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some employer plans:

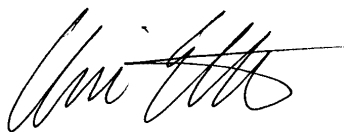
IN ADDITION TO THE RIGHTS SET FORTH IN THIS EVIDENCE OF COVERAGE (EOC), YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS EVIDENCE OF COVERAGE (EOC), YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact your Subscriber Group to determine if you are enrolled in a Plan that is subject to ERISA.

**Health Net Health Plan of Oregon, Inc.**



Chris Ellertson, President