Notice of Changes to Coverage Terms for New and Renewing Groups
Effective on and after August 1, 2012

The August 2012 Health Net of California, Inc. (Health Net) Group Hospital and Professional Service Agreement (GSA) and Evidences of Coverage (EOC), and Health Net Life Insurance Company (HNL) Group Insurance Policy (Policy) and Certificates of Insurance (COI) will include the changes that appear in this Notice for compliance with new laws, regulatory requirements and/or to address Health Net/HNL administrative changes. The following modifications apply to California Commercial Large Group and Small Business Group (SBG) plans, unless otherwise noted, and will appear (where applicable) in GSAs/EOCs and Policies/COIs with the effective date between August 1, 2012 and December 31, 2012.

Additional changes, not confirmed at the time of this mailing, may be required. Please ensure that subscribers in your groups are informed of the changes described in this Notice.

Legislative/Regulatory Changes

1. Termination for Nonpayment of Premiums – revised language per AB 2470 of 2010, which requires health plans and health insurers to provide a 30-day prior written notice regarding the plan’s right to terminate a group for nonpayment of the required premiums. (Applies to all products)

2. Misstatement of Age – In accordance with Insurance Code § 10369.3, a misstatement of age provision was added to the Policy for all health insurance products. (Applies to CDI-regulated products)

3. Medical Loss Ratio (MLR) Rebates – Health Net/HNL must collect information on employee contribution amounts from employer groups in order to calculate, report and pay any rebates due to members under the MLR provision of the Affordable Care Act (Title 45, CFR 158). The GSA and Policy have been revised to provide notice to employers that Health Net/HNL may request information from the employer of any contribution amounts paid by the employer's employees. If the employer group does not provide Health Net/HNL with the requested information, Health Net/HNL will use the maximum contribution amount an employee can pay according to Health Net/HNL Underwriting guidelines. (Applies to all products)

4. Preventive care * - New requirements from Section 2713 of the Affordable Care Act (ACA) expands preventive care coverage to include additional services and supplies for women's preventive health. The EOC/COI has been updated to include additional services and supplies that are covered under preventive care services to comply with the new requirements. Additionally, language has been

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revised for compliance with ACA to cover certain preventive medication at no cost to members who are on non-grandfathered plans. (Applies to all products.)

5. **Behavioral Health Treatment for Pervasive Developmental Disorder or Autism** - Per SB 946, coverage has been expanded to include behavioral health treatments for pervasive developmental disorder (“PDD”) or autism as specified in SB 946. This expanded coverage is subject to any Deductible, Copayment or Coinsurance that is applicable under the Severe Mental Illness outpatient consultation benefit listed for your Group Plan(s). (Applies to all products.)

6. **Domestic Partner Definition** - The definition of Domestic Partner has been clarified to confirm it includes the Subscriber’s same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the principal Covered Person’s registered Domestic Partner who meets all the requirements of Sections 297 or 299.2 of the California Family Code. (Applies to all products.)

7. **Summary of Benefits and Coverage (SBC) Distribution** – For plans issued or renewed on or after September 23, 2012, regulations under the federal Patient Protection and Affordable Care Act (PPACA) require that Health Net (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and uniform glossary to Subscribers and Dependents in a manner that is compliant with the requirements of PPACA. Health Net is committed to complying with the SBC requirements, providing Groups with notice of modification of the SBC, and instructions on how to access the uniform glossary. Health Net GSAs and HNL Policies will be updated to include the Groups’ responsibility for providing these documents to Subscribers and Dependents.

**Policy Changes**

1. **Diabetic Testing Supplies** – To comply with new regulations issued by the Centers for Medicare and Medicaid Services (CMS), diabetic testing supplies will no longer be covered under the Medicare Part D pharmacy benefit for employer groups that have Medicare Part D plans. Rather, these items will now be covered under the Medicare Part B medical benefit. Diabetic testing supplies include, blood glucose monitors, blood glucose testing strips, ketone urine testing strips, and lancets and lancet puncture devices. (Applies to all products).

2. **Fertility Preservation** – Health Net adopted a new policy that provides coverage for fertility preservation treatments when a cancer treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures that may be provided for cancer treatment. (Applies to all products.)

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3. **Certification Requirements** – The list of services requiring Certification has been modified. The following additional services or supplies will require prior Certification (treatment review before services or supplies are received) in order for full benefits to be payable.
   a. Custom orthotics
   b. Bone growth stimulator and neuro or spinal cord stimulator which are covered under the Durable Medical Equipment benefit:
   c. Home uterine monitoring and tocolytic services which are provided under Home Health Care Services
   d. Intensity modulated radiation therapy (IMRT)
   e. Hemophilia factors
   f. Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)

   (Applies to products that currently require Prior Certification, including Health Net PPO, SELECT, ELECT, Flex Net, Salud EPO and Salud PPO.)

4. **Maximum Allowable Amount** – The database of Physician charges that is used to determine the Maximum Allowable Amount for Physician services now comes from OptumInsight. In addition, for all services other than Physician or Hospital services, the Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (the Medicare allowable amount). The Maximum Allowable Amount of such services is 190% of the Medicare allowable amount. (Applies to all products that use the Maximum Allowable Amount as reimbursement for providers not contracting with Health Net or HNL, including Health Net PPO, EPO, SELECT, Flex Net, Salud EPO and Salud PPO.)

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**Language Clarifications**

1. **Recommended Drug List** – Added language in the “Schedule of Benefits” clarifying that in order to obtain information about the Health Net Recommended Drug List, Member’s should call the Member Services Department at the telephone number on the ID card. (Applies to DMHC-regulated products, HMO, EOA, SELECT and ELECT).

2. **Selecting a Participating Mental Health Professional** – Added a new section titled "Selecting a Participating Mental Health Professional" to more clearly distinguish the process for members to select a Primary Care Physician for medical care and a Participating Mental Health Professional for mental disorder and chemical dependency care. (Applies to DMHC-regulated products, HMO, EOA, SELECT and ELECT).

3. **Schedule of Benefits and Copayments** – Removed references to the term "Coinsurance" and revised the explanation of the term "Copayments" to include both fixed dollar and percentage amounts. (Applies to HMO and EOA only).

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Health Net
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4. **Termination of Coverage** – Revisions and clarifying language have been added to the section titled "When Coverage Ends." (Applies to DMHC-regulated products, HMO, EOA, SELECT and ELECT).
   a. "Termination for Nonpayment of Subscription Charges" – A new heading titled "Termination for Nonpayment of Subscription Charges" was added. Language was revised to more clearly state that Health Net will provide an employer group with a 30-day grace period to submit delinquent subscription charges before coverage is terminated.
   b. "Termination for Cause" – Language was revised to specify that members may be terminated for good cause with a 30-day written notice. The term "good cause" is described as any act or practice, which constitutes fraud or any intentional misrepresentation of material fact under the terms of the agreement.
   c. "How to Appeal Your Termination" – A new section titled "How to Appeal Your Termination" was added, which explains a member's right to file a complaint if his or her coverage is terminated or not renewed. In addition, this section also describes Health Net's duty to continue a member's coverage pending the outcome of the appeal and subject to certain qualifications.

5. **Prior Authorization for Mental Disorders and Chemical Dependency Benefits** – Revised language to state that certain services and supplies for Mental Disorders and Chemical Dependency would require prior authorization by the Behavioral Health Administrator, including outpatient procedures (that are not part of an office visit), inpatient, residential, partial hospitalization and intensive outpatient services. Prior authorization is not required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged. (Applies to DMHC-regulated products, HMO, EOA, SELECT and ELECT).

6. **Health Net Member Services Department** – All references to the "Member Services Department" were changed to state "Customer Contact Center." (Applies to all products).

7. **Refractive Eye Examinations** – For plans that cover refractive eye examinations, added language that such service would be covered under the "Vision or Hearing Examination (for diagnosis or treatment)" benefit. (Applies to all products).

8. **Newborn Hospitalization** – Added language clarifying that a separate inpatient hospital copayment would apply for a newborn who is admitted for inpatient services beyond routine newborn nursery care, regardless of the duration of the mother's inpatient hospital stay. (Applies to all products).

9. **Bariatric Surgery** – Added language to inform members that all clinical work-up, diagnostic testing and procedures to prepare for bariatric surgery must be acquired through Health Net/HNL Bariatric Surgery Performance Center. (Applies to all products). In addition, added language to inform members that the pre-surgical work-up is also covered with bariatric surgery coverage. (Applies to all products.)

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10. **Over Age Disabled Dependents** – Revised EOC/COI language to better assure the requirements are clear and easily understood. (Applies to all products).

11. **Corrective Footwear** – Clarified that the corrective footwear that is covered for diabetes also includes podiatric devices. (Applies to all products.)

12. **Methadone Maintenance Treatment** – Added text clarifying that Methadone treatment is not covered except when Medically Necessary and in an outpatient setting for the following services:
   - Short term use for detoxification purposes when the Member is experiencing acute withdrawal symptoms;
   - As a treatment for Pain; or
   - In an intensive outpatient program, partial Hospital/day treatment program or routine outpatient setting which provides treatment to Members with Chemical Dependency disorders other than methadone maintenance treatment.
   (Applies to all products.)

13. **Technology Assessment** – Added text clarifying that if coverage is denied, modified or delayed, the Member has the option to use the Independent Medical Review process. (Applies to all products.)

14. **Tailored networks** – The descriptions of tailored networks (Silver Network, SmartCare Network, PremierCare Network) has been modified to clarify that Members will continue to use the Contracted Behavioral Health providers for their Behavioral Health care. Applies to Tailored Network HMO and ELECT Open Access.

15. **Podiatrists** – The description of specialist care office visits has been clarified to include podiatrists. (Applies to DMHC-regulated products, HMO, EOA, SELECT and ELECT.)

16. **Specialty Drugs** – Coverage language has been modified at the request of the DMHC to better explain how specialty drugs can be obtained. (Applies to DMHC-regulated products, HMO, EOA, SELECT and ELECT.)

17. **Termination for Nonpayment of Subscription Charges** – Based on a DMHC request, the provision describing termination for nonpayment of subscription charges has been modified to clarify that a notice of possible termination will be sent on or prior to the due date of the charges.

18. **Colonoscopy*** - The description of colonoscopy has been modified to clarify that the removal of polyps, tumors or other lesions during a screening colonoscopy or sigmoidoscopy will be considered preventive care and not subject to the cost-sharing of a therapeutic (surgical) procedure.

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For more information regarding this Notice of Changes to Coverage Terms for 2012, please call Broker Services at 1-800-448-4411.

Lori Scott
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