CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION
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California Department of Insurance

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

SAN FRANCISCO

In the Matter of the Certificate of Authority of: HEALTH NET LIFE INSURANCE COMPANY, Respondent.	File No. OSC-2008-00005 STIPULATION AND WAIVER

Respondent, HEALTH NET LIFE INSURANCE COMPANY ("HEALTH NET"), and the California Department of Insurance ("Department"), stipulate as set forth herein:

1. Respondent HEALTH NET holds a Certificate of Authority to transact the business of life and disability insurance in the State of California, pursuant to §700 et seq. of the California Insurance Code[1]; and,

[1] Unless otherwise stated, all references are to the California Insurance Code.

2. Respondent, HEALTH NET, is domiciled in California and is a subsidiary of Health Net of California, Inc., which is a wholly owned subsidiary of parent company Health Net, Inc., a Delaware corporation; and

3. On or about January 2005, the Department commenced a Market Conduct examination of HEALTH NET'S claims practices and procedures in California during the period of December 1, 2003 through November 30, 2004. The examination reviewed claims files and related records involving Group and Individual Preferred Provider Organization products and Group and Individual life insurance products, and examined guidelines, policies and procedures, training plans and forms adopted by HEALTH NET for use in California to determine whether HEALTH NET'S claims denials and claims handling practices conformed to contractual obligations and applicable law; and,

4. The Department's public report of the Market Conduct Examination as of November 30, 2004 identified, pursuant to California Insurance Code §735.5, the alleged manner and extent of noncompliance with California Insurance Code §790.03, other provisions of the Insurance Code, and the Fair Claims Settlement Regulations contained in Title 10, Chapter 5, Subchapter 7.5 of the California Code of Regulations, commencing with §2695.1; and,

5. The Department's Claims Services Bureau also investigated consumer complaints, pursuant to California Insurance Code §735.5, received by the Department from 2005 through 2007 regarding HEALTH NET'S claims handling and rescission practices. Based on its investigation, the Department identified a significant number of alleged violations of California Insurance Code §790.03 and/or the Fair Claims Settlement Regulations, and other provisions of the Insurance Code; and,

6. In April 2008, the Department's Field Claims Bureau commenced a targeted examination, pursuant to California Insurance Code §735.5, of HEALTH NET'S rescission

practices and related claims settlement practices during the period from 2004 through February 2008 involving Individual and Family Plan Preferred Provider Organization health insurance products written in California. The examination included a review of a sample of rescission files and related supporting records, personnel records, guidelines, policies and procedures, training manuals and forms adopted by HEALTH NET for use in California to determine HEALTH NET'S conformance with contractual obligations and applicable law; and

7. Based on a preliminary and limited review of a sample of rescission files and related records, the Department identified alleged violations of provisions of the California Insurance Code in the rescission practices and related claims settlement procedures of HEALTH NET; and,

8. On or about August 14, 2008, the Department caused to be served upon HEALTH NET an Order to Show Cause, Accusation, Notice of Noncompliance, and Demand ("Accusation") "In the Matter of the Certificate of Authority of HEALTH NET LIFE INSURANCE COMPANY, Respondent," File No. OSC-2008-00005, incorporated herein by reference. Said Accusation alleged, inter alia, that HEALTH NET engaged in violations of California Insurance Code §§790.03, 790.06, §700(c), 704(b), 796.02, 796.04, 10113, 10123.13, 10123.131, 10380, 10381.5, 10384, and the Fair Claims Settlement Regulations; and,

9. HEALTH NET and the Department, in order to avoid the expense, uncertainty and distractions of litigation, and without HEALTH NET admitting the allegations set forth herein and in the Accusation referenced herein, have undertaken discussions to resolve the issues in this proceeding and now wish to resolve those issues without the need for a hearing or further administrative action. Therefore, by this Stipulation and Waiver, HEALTH NET waives any and all rights to a hearing in this matter, and any and all other rights related to this proceeding which

may be accorded pursuant to Chapter 5, Part 1, Division 3, Title 2 (commencing with §11500) of the California Government Code, and by the California Insurance Code; and,

10. This Stipulation and Waiver does not constitute an admission of liability, violation or wrongdoing by HEALTH NET and HEALTH NET expressly denies any liability, violation or wrongdoing; and,

11. HEALTH NET agrees to and shall cease and desist from engaging in any acts or practices in the business of life and disability insurance that constitute unfair methods of competition and unfair and deceptive acts or practices within the meaning of California Insurance Code §§790.03 and 790.06; and,

12. HEALTH NET agrees to and shall cease and desist from engaging in any acts or practices in the business of life and disability insurance in violation of California Insurance Code §§700(c), 704(b), 796.02, 796.04, 10113, 10123.13, 10123.131, 10380, 10381.5, and 10384; and,

13. HEALTH NET agrees to and shall pay, within twenty (20) business days after receiving an invoice from the California Department of Insurance, Division of Accounting, the amount of three million six hundred thousand dollars ($3,600,000) to the California Department of Insurance as a monetary penalty pursuant to California Insurance Code §§790.035 and 12976 upon written Order of the Insurance Commissioner to be made and filed herein and without further notice to HEALTH NET. In addition, HEALTH NET acknowledges that the Department will conduct a follow up examination to verify that HEALTH NET has timely and substantially implemented its corrective actions described in paragraph 24 hereunder. Upon completion of the follow up examination, if the Department determines that HEALTH NET failed to substantially and timely implement the corrective actions, the Department may impose an additional monetary penalty, proportional to the identified deficiencies, if any, of up to three million six hundred thousand dollars ($3,600,000); and,

14. HEALTH NET agrees to and shall pay, within twenty (20) business days after receiving an invoice from the California Department of Insurance, Division of Accounting, the amount of fifty thousand dollars ($50,000.00) to the California Department of Insurance for reimbursement of attorney's fees and costs, pursuant to California Insurance Code §12921, upon written Order of the Insurance Commissioner to be made and filed herein and without further notice to HEALTH NET; and,

15. HEALTH NET agrees to and shall offer, on a voluntary basis, to each FORMER INSURED, as defined below, an offer of health insurance coverage going forward on a guaranteed issue basis. Said coverage shall be subject to the following terms, conditions, and restrictions:

(a) "FORMER INSURED," for purposes of this Stipulation and Waiver, is defined as an individual who was formerly insured with HEALTH NET under an Individual and Family Plan Preferred Provider Organization ("PPO") health insurance policy written in California that was rescinded between January 1, 2004 and August 15, 2008; and,

(b) The offer to sell to FORMER INSUREDS Individual and Family Plan PPO coverage going forward will not require medical underwriting; and,

(c) The offer to sell to FORMER INSUREDS Individual and Family Plan PPO coverage going forward will waive exclusions for pre-existing conditions; and,

(d) The offer to sell to FORMER INSUREDS Individual and Family Plan PPO coverage going forward will be for coverage that is most comparable to the FORMER INSURED'S rescinded policy; and,

(e) The offer to sell to FORMER INSUREDS Individual and Family Plan PPO coverage will not include FORMER INSUREDS who were already reinstated or

have current coverage with HEALTH NET or an affiliate, or have entered into or are otherwise bound by a settlement with HEALTH NET regarding claims arising from rescission of the FORMER INSURED'S health insurance policy; and,

(f) The offer to sell to FORMER INSUREDS Individual and Family Plan PPO coverage going forward will be open for a ninety (90) day period from the confirmed date of delivery of the notice referred to in paragraph 19; and,

(g) Notwithstanding subsection (f) above, the offer to sell to FORMER INSUREDS Individual and Family Plan PPO coverage going forward, under the same terms, conditions, and restrictions identified in this paragraph 15, will be open to FORMER INSUREDS who were not contacted by HEALTH NET despite HEALTH NET'S commercially reasonable search efforts as set forth in paragraph 19 if acceptance of the offer by a FORMER INSURED is received by HEALTH NET on or before May 15, 2009; and,

(h) The offer to sell such Individual and Family Plan PPO coverage to a FORMER INSURED and continuation of such coverage is conditioned on each FORMER INSURED meeting all non-medical underwriting eligibility requirements including, by way of example, residence in a geographic area of California where HEALTH NET has a substantial PPO network, age limits for insureds and dependents, and payment of the applicable premiums going forward; and,

(i) The effective date of health coverage under this voluntary offer will be the first day of the month following HEALTH NET'S receipt of a FORMER INSURED'S first month premium; and,

(j) HEALTH NET will not require FORMER INSUREDS who accept this voluntary offer of health coverage on a guaranteed issue basis without medical underwriting to execute a release of any and all claims against HEALTH NET as a condition of acceptance of this offer. Except as provided in paragraphs 16 and 17 herein, FORMER INSUREDS who receive and/or accept the voluntary offer of health insurance coverage on a guaranteed issue basis may pursue any legal remedies or claims available to them against HEALTH NET; and,

(k) Notwithstanding anything contained in this Stipulation and Waiver to the contrary, HEALTH NET may, at its sole option, and at no expense to the FORMER INSURED, reinstate the FORMER INSURED'S rescinded health insurance policy for all or a portion of the Rescinded Coverage Period and/or Gap Period. In the event that HEALTH NET elects to reinstate the FORMER INSURED'S rescinded health insurance policy, such reinstatement shall not affect the right of a FORMER INSURED to receive an offer of health insurance going forward on a guaranteed issue basis, without medical underwriting, or the offers as provided in paragraphs 16 and 17; and,

16. Subject to the conditions and limitations set forth in this paragraph 16 with respect to the medical expenses subject to reimbursement, HEALTH NET agrees to and shall offer, on a voluntary basis, to reimburse each FORMER INSURED for, or hold each FORMER INSURED harmless from, only those medical expenses described herein. Reimbursement of medical expenses shall be in an amount equal to all medical expenses for medically necessary medical services that would have been covered under the FORMER INSURED'S rescinded HEALTH NET Individual and Family Plan PPO health insurance policy as set forth in paragraphs 16 (a), (d) and 16(e) below that were received during the Rescinded Coverage Period (which runs from the

effective date of the original rescinded health insurance policy to the date upon which the rescission of that policy was effective) and the Gap Period (which runs from the end of the FORMER INSURED'S Rescinded Coverage Period through the confirmed date of delivery of the notice to the address identified through HEALTH NET'S commercially reasonable efforts pursuant to paragraph 19). HEALTH NET may fully satisfy its obligation to reimburse a FORMER INSURED for those unpaid medical expenses described herein by holding the FORMER INSURED harmless from such medical expenses, and references herein to reimbursement of medical expenses shall be interpreted to include the option by HEALTH NET to hold the FORMER INSURED harmless from such medical expenses. Such reimbursement of or holding harmless from medical expenses shall be subject to the following:

(a) Medical expenses of a FORMER INSURED shall include paid out-of-pocket medical expenses and medical expenses that were incurred and are owed but not yet paid by the FORMER INSURED for medically necessary medical services that (1) were provided to the FORMER INSURED during the Rescinded Coverage Period and the Gap Period, (2) would have been covered under the FORMER INSURED'S rescinded HEALTH NET Individual and Family Plan PPO health insurance policy, and (3) that are not covered or reimbursed by any third party payer, health care service plan, insurance company contract or as otherwise provided in paragraph 16(e) below; and,

(b) This offer of reimbursement of medical expenses is an option that is in addition to, and separate from, HEALTH NET'S offer to sell a FORMER INSURED Individual and Family Plan PPO coverage as described in paragraph 15. HEALTH NET will not require acceptance of the voluntary offer of such health insurance coverage going forward as a condition of acceptance of the offer

of reimbursement of medical expenses. Except as provided in paragraph 15(g), this offer of reimbursement of medical expenses shall remain open for ninety (90) days from the confirmed date of delivery of the notice referred to in paragraph 19; and,

(c) Any claim for medical expenses shall be subject to reasonable documentation requirements; and,

(d) Reimbursable medical expenses shall include only those expenses for medical services that were medically necessary covered services under the FORMER INSURED'S rescinded HEALTH NET policy and do not include any applicable co-payments, coinsurance, deductible amounts, or any other expense that would have been the responsibility of the FORMER INSURED under the FORMER INSURED'S rescinded HEALTH NET Individual and Family Plan PPO health insurance policy; and,

(e) Reimbursement of medical expenses shall not include any medical expenses covered or reimbursed by any third party payer, health care service plan, insurance company contract (including, but not limited to, any applicable disability, workers' compensation, group, individual, or employer self-insurance coverage) or charges covered or reimbursed by the proceeds of any judgment or settlement, and/or charges that a FORMER INSURED did not pay out-of-pocket and are waived, released, discharged, barred, settled or otherwise no longer collectible by the medical provider at issue (including the medical provider's agents and assigns); and,

(f) This offer to reimburse medical expenses is conditioned upon a settlement and full release by the FORMER INSURED of all disputes and claims arising

from the rescission of the FORMER INSURED'S original HEALTH NET health insurance policy; and,

(g) In the event a FORMER INSURED submits a request for reimbursement of medical expenses, HEALTH NET shall either make a written offer to reimburse all applicable medical expenses within sixty (60) days of receiving a written claim for all applicable medical expenses from a FORMER INSURED that includes reasonable documentation supporting the claim, such as invoices and cancelled checks, or dispute the claim on the basis of (1) medical necessity,(2) the scope of coverage, and/or (3) the amount of the claim. HEALTH NET shall not assert the validity of the rescission as a defense. HEALTH NET may request authorization from FORMER INSUREDS for the release of medical records and bills to verify the claims; and,

(h) If a FORMER INSURED disputes HEALTH NET'S determination of medical necessity, the FORMER INSURED may elect either of the following two options, in his or her sole discretion:

(1) A FORMER INSURED may decline to follow this process and may pursue any legal remedy for any and all claims, in which event HEALTH NET retains the right to assert any and all defenses to any claim, including but not limited to, the validity of the rescission, statute of limitations and whether the claim would have been covered under the rescinded HEALTH NET health insurance policy; or

(2) The determination of medical necessity shall be immediately referred to an Independent Medical Review Organization for review, pursuant to

California Insurance Code §§10169.2-10169.3. The cost of the independent medical review shall be paid by HEALTH NET.

(i) If a FORMER INSURED disputes HEALTH NET'S determination of the scope of coverage or the amount of the proposed reimbursement offer, the FORMER INSURED may elect either of the following two options, in his or her sole discretion:

(1) A FORMER INSURED may decline to follow this process and may pursue any legal remedy for any and all claims, in which event HEALTH NET retains the right to assert any and all defenses to any claim, including but not limited to, the validity of the rescission, statute of limitations and whether the claim would have been covered under the rescinded HEALTH NET health insurance policy, or

(2) A FORMER INSURED may resolve the dispute with respect to the scope of coverage or reimbursement of medical expenses through an expedited proceeding that shall be conducted by a JAMS arbitrator, subject to the rules described in paragraph 17, except that the only issues to be determined shall be the scope of coverage and the amount of reimbursement of medically necessary covered medical expenses during the Rescinded Coverage Period and the Gap Period as described in this paragraph 16. The proceeding shall be subject to the following rules:

i. HEALTH NET shall not assert the validity of the rescission as a defense; and,

ii The arbitration proceeding shall be on the basis of a written record without personal appearance of any party. The record shall consist of evidence of

paid out-of-pocket medical expenses and medical expenses owed but not yet paid by the FORMER INSURED for medically necessary covered medical services under the rescinded HEALTH NET health insurance policy that were provided during the Rescinded Coverage Period and the Gap Period, and that were not reimbursed or covered by any third party. Both parties shall have the right to submit additional written statements and materials. No discovery shall be permitted except that HEALTH NET may obtain FORMER INSURED'S medical records and bills for the purpose of verifying claims; and,

iii HEALTH NET shall pay the cost of the arbitrator. Any award shall be limited to reimbursable medical expenses specified in paragraph 16 and shall resolve all claims arising from the rescission of the FORMER INSURED'S original rescinded HEALTH NET health insurance policy; and,

iv The arbitration decision shall be final for both parties and shall be conditioned upon a full and complete release of HEALTH NET of all disputes and claims arising from the rescission of the FORMER INSURED'S original health insurance policy; and,

v. In the event that an award is based upon unpaid medically necessary covered medical expenses owed by a FORMER INSURED to a provider for medical services provided prior to August 15, 2008 that are not paid, covered, or reimbursed by any third party, the arbitration decision shall provide that HEALTH NET shall, in its sole discretion, have the right to resolve any such unpaid medical expenses directly with the billing provider in which event HEALTH NET shall hold the FORMER INSURED harmless from any such unpaid medical expenses and deduct the amount owed by the FORMER

INSURED from the award. In the event HEALTH NET resolves any unpaid medical expenses directly with the billing provider and holds the FORMER INSURED harmless from any such unpaid medical expenses, such action by HEALTH NET shall satisfy fully HEALTH NET'S obligation under this Stipulation and Waiver to reimburse the FORMER INSURED for such unpaid medically necessary covered medical expenses owed by the FORMER INSURED to such provider; and,

17. As an alternative to the option described in paragraph 16, HEALTH NET agrees to and shall offer, on a voluntary basis, an expedited dispute resolution process, conducted by a JAMS arbitrator, to resolve all claims of the FORMER INSURED for damages recoverable in an action at law or equity arising from the rescission of the FORMER INSURED'S original HEALTH NET health insurance policy, including medical expenses. This proceeding is subject to the following rules:

(a) This offer of expedited dispute resolution of all claims is an option that is not available to FORMER INSUREDS who elect to accept the offer of reimbursement of medical expenses as described in paragraph 16; and,

(b) The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures, subject to the modifications in this Stipulation and Waiver; and,

(c) HEALTH NET shall pay the cost of the arbitrator; and,

(d) The arbitrator shall be selected randomly by JAMS from a group of six arbitrators who are mutually agreed upon by HEALTH NET and the Department. Such arbitrators shall follow applicable California law, including the California Insurance Code and implementing regulations, and shall periodically consult with

each other to ensure consistency in decision-making. The arbitration proceedings shall be held in Sacramento, San Francisco, Los Angeles, or San Diego, whichever location is more convenient to the FORMER INSURED; and,

(e) Under this option to resolve all claims of the FORMER INSURED for damages arising from the rescission of the FORMER INSURED'S original HEALTH NET health insurance policy, HEALTH NET has the right to assert all defenses to any claim including, but not limited to, the validity of the rescission, statute of limitations and whether the claim would have been covered under the rescinded HEALTH NET health insurance policy; and,

(f) The form of the decision will be a brief statement of whether the rescission was lawful or unlawful, the type of damages (if any), and the amount of damages (if any). In the event that an award is based upon unpaid medically necessary covered medical expenses owed by a FORMER INSURED to a provider for medical services provided prior to August 15, 2008 that were not paid, covered or reimbursed by any third party, the arbitration decision shall provide that HEALTH NET shall, in its sole discretion, have the right to resolve any such unpaid medical expenses directly with the billing provider in which event HEALTH NET shall hold the FORMER INSURED harmless from any such unpaid medical expenses and deduct the amount owed by the FORMER INSURED from the award. In the event HEALTH NET resolves any unpaid medical expenses directly with the billing provider and holds the FORMER INSURED harmless from any such unpaid medical expenses, such action by HEALTH NET shall satisfy fully HEALTH NET'S obligation under this Stipulation and Waiver to reimburse the

FORMER INSURED for such unpaid medically necessary covered medical expenses owed by the FORMER INSURED to such provider; and,

(g) The arbitration decision shall be final and binding on both parties, subject to judicial enforcement in accordance with California Code of Civil Procedure §§1285 et seq.; and shall be conditioned upon a full and complete release of HEALTH NET of all disputes and claims arising from the rescission of the FORMER INSURED'S original HEALTH NET health insurance policy; and,

18. HEALTH NET shall report to the Department, on a monthly basis, beginning ninety (90) days after the date of the Order adopting this Stipulation, the following information: the name, last known address, last known telephone number (if available), and policy number of each FORMER INSURED as described herein. Each monthly report shall also contain a summary of the number of FORMER INSUREDS who accepted the offer of health insurance coverage going forward on a guaranteed issue basis and the number of FORMER INSUREDS who did not accept the offer of health insurance coverage on a guaranteed issue basis; and the number of FORMER INSUREDS who accepted the offer of reimbursement of medical expenses and the total dollar amount of reimbursed medical expenses subject to this Stipulation and Waiver and the date of the expected payment of such medical expenses; and the number of FORMER INSUREDS who accepted the offer of expedited dispute resolution of all claims and the total dollar amount of arbitration awards as an outcome of such proceedings; and,

19. HEALTH NET shall use its commercially reasonable efforts to contact eligible FORMER INSUREDS to make the voluntary offers set forth herein, commencing no later than ninety (90) days from the date of the Order adopting this Stipulation and Waiver. HEALTH NET shall provide a report to the Department identifying the date and method of each attempt to contact eligible FORMER INSUREDS. Commercially reasonable efforts to contact eligible

FORMER INSUREDS shall consist of notification of the voluntary offers by overnight or certified mail or private delivery service with confirmation of delivery to the last known address, use of an independent search service to locate the current address of FORMER INSUREDS, and notice and publication of information regarding the settlement on HEALTH NET'S website; and,

20. HEALTH NET shall exercise its commercially reasonable efforts to issue and send payment for reimbursement of medical expenses to FORMER INSUREDS who accept the voluntary offer described in paragraph 16 within thirty (30) days of the date of the final resolution of the FORMER INSURED'S claim for reimbursement of medical expenses, and shall complete the offer to reimburse medical expenses, the expedited dispute resolution process and the reimbursement of medical expenses as soon as is reasonably possible, and in no event later than one year from the date of the Order adopting this Stipulation and Waiver; and,

21. HEALTH NET agrees not to rescind any Individual and Family Plan PPO health insurance policies issued on or before August 15, 2008. After August 15, 2008, HEALTH NET may rescind Individual and Family Plan PPO health insurance policies in accordance with applicable California law upon establishment of an independent third party review process satisfactory to the Department, as described in paragraph 22; and,

22. HEALTH NET agrees to and shall establish an independent third party review process to determine any future rescissions of Individual and Family Plan PPO health insurance policies. HEALTH NET agrees to and shall work with the Department to establish criteria for the effective implementation of such process, provided that the Department shall not require HEALTH NET to adopt criteria for the implementation of such process that are contrary to applicable law; and,

23. HEALTH NET agrees to and shall institute policies and procedures, as soon as is reasonably possible, to ensure that medical underwriting for Individual and Family Plan PPO

health insurance policies is complete and all reasonable questions arising from the application are resolved prior to the issuance of a policy, including requiring review of at least one source of information other than the application (e.g., reviewing HEALTH NET claim records, pharmacy claim records, other insurer claim records, contact with the applicant); and,

24. HEALTH NET agrees to and shall submit a corrective action proposal to the Department within thirty (30) days of the date of the Order adopting this Stipulation to modify the application form and health history questionnaire to ensure the accuracy and completeness of the application, improvements in the underwriting process, improvements in the training and integration of agent/broker involvement in the application and underwriting process, improvements in the notification to policyholders and providers of a rescission investigation and decision, improvements in the rescission claims handling and decision-making process, and improvements in the rescission appeals process. At a minimum, HEALTH NET'S corrective action proposal shall include those actions contained in paragraph 23 and this paragraph 24 and in Attachment A. HEALTH NET agrees to and shall work with the Department to establish appropriate criteria for such corrective actions. HEALTH NET agrees to and shall complete implementation of the corrective action proposal within one hundred twenty (120) days of the date the Department approves in writing the criteria for such corrective action.

25. This Stipulation and Waiver resolves fully the matters alleged or arising out of the Market Conduct Examination, dated as of November 30, 2004, the matters alleged or arising out of the consumer complaints against HEALTH NET from 2005 through 2007 regarding claims handling and rescission practices, and the allegations in the Accusation (File No. OSC-2008-00005) or arising out of the targeted rescission examination of HEALTH NET specified in paragraph 6 hereof and any report of examination issued by the Department as a result of such targeted rescission examination.

26. HEALTH NET and the Department agree that this Stipulation and Waiver is intended to be a complete and final resolution of the issues and allegations referenced in paragraph 25 and the Accusation and no further action will be brought against HEALTH NET based upon the matters referenced in paragraph 25 and the allegations contained in the Accusation, provided, however, that neither this Stipulation and Waiver nor the Order approving this Stipulation and Waiver are in any way intended to limit or waive the Commissioner's authority to bring further disciplinary action against HEALTH NET for alleged violations of California law arising from acts or failures to act not referred to in either paragraph 25 or the Accusation; and,

27. Nothing contained in this Stipulation and Waiver or the Order approving this Stipulation and Waiver shall prevent the Department from taking action at any time to enforce this Stipulation and Waiver or the Order approving this Stipulation and Waiver if HEALTH NET is not in compliance with the terms and conditions of the Stipulation and Waiver and/or the Order approving this Stipulation and Waiver; and,

28. The Insurance Commissioner retains jurisdiction to ensure that HEALTH NET complies with the provisions and terms of this Stipulation and Waiver and/or Order approving this Stipulation and Waiver; and,

29. HEALTH NET represents and warrants that the persons executing this Stipulation and Waiver on behalf of HEALTH NET are authorized to enter into and execute this Stipulation and Waiver; and,

30. HEALTH NET acknowledges that California Insurance Code §12921 requires the Insurance Commissioner to approve the final settlement of this matter. Both the settlement terms and conditions contained herein and the acceptance of those terms and conditions are contingent

upon the Commissioner's approval, which shall be evidenced and memorialized by the issuance of the Order provided for herein.

31. This Stipulation and Waiver is a compromise within the meaning of California Evidence Code §§1152 and 1154.

Dated: August 15, 2008

HEALTH NET LIFE INSURANCE COMPANY

Signed: James E. Woys

Name: James E. Woys

Title: President

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Dated: August 15, 2008

CALIFORNIA DEPARTMENT OF INSURANCE

By: Mary Ann Shulman

Mary Ann Shulman
Senior Staff Counsel

ATTACHMENT A

ATTACHMENT A

UNDERWRITING AND RESCISSION PROCESS IMPROVEMENTS

Underwriting and other Front-End Improvements:

- Application form has been and is being improved to highlight importance of complete and accurate completion of the medical questionnaire, and the potential risk to the applicant (rescission risk) if there is a failure to do so
- Application has been enhanced with more time limitations on medical questions, e.g. "During the past 12 months, have you had . . .."
- We have instituted the use of separate medical questionnaires for each person for whom coverage is sought in the application, to avoid confusion and increase completeness. All such medical questionnaires, once completed, are to be attached to the application to which it relates.
- We have instituted the policy of requiring review of the applicant's prior claims history with Health Net if the applicant had previously been a Health Net member
- We have materially increased the number of written policies and procedures to document the role of the underwriter, the means of reviewing the medical questionnaire, the circumstances under which supplemental questionnaires will be sent to the applicant, the circumstances under which external information, such as from providers, will be required.
- Application form is being evaluated for improved clarity, and to ensure an appropriate balance between ease of understanding for the applicant and our need for detailed information in order to fulfill our underwriting responsibility
- Evaluate requiring greater disclosure of recent providers who have treated the applicant, in order to increase the Plan's ability to secure medical information from the provider
- Evaluate the circumstances under which the plan should request additional information from applicant and/or providers and/or third parties (such as databases that contain medical and pharmacy information, i.e. policy of greater intensity of review based on such factors as revealed medical history, age, gender, etc.)
- Greater participation of medical directors or others with clinical experience in the evaluation of the medical questionnaire and revisions thereto, and of applicant's responses if ambiguous.
- We are evaluating how to increase the communication to the applicant of Health Net's language assistance services, so that more applicants access that service to overcome weakness in English language skills and to address the applicant's concerns about medical and other questions.
- Develop an application checklist as an aid to the applicant in filling out the application. This document would also offer an opportunity to communicate the availability of language assistance services and remind the applicant of his/her responsibilities to complete the application accurately and the possible consequences of not doing so.

- For broker-involved applications and those received on-line, we are considering sending the application to the applicant directly for attestation of the accuracy of the application, to better identify inappropriate broker involvement in completing the application.
- Develop a broker checklist to reiterate the limits of the broker's assistance in the process of completing the application, alert the broker that Health Net has a language assistance service to avoid the broker's language assistance which may not be as accurate.
- Improve the application by requiring the broker to complete a more detailed portion of the application, which would include an attestation that the broker has not assisted in the completion of the application in a manner inconsistent with the Plan's policies, and a more detailed description of the manner in which the broker has assisted the applicant, if at all.
- We are considering developing a number of training tools. For example, we have a broker newsletter which is e-mailed on a monthly basis. We have decided to place "compliance" articles in the newsletter on a periodic basis, which will educate brokers on such things as Health Net's restrictions on broker involvement, our language assistance services, legal and regulatory requirements and restrictions as to broker activity, recent case law and regulatory actions on rescission-related issues. Further, we are considering how to provide periodic training to both our internal underwriting staff and outside brokers.
- At the time of delivery of the EOC document with application attached, we are considering including a letter asking the applicant/enrollee to review once again the completeness and accuracy of his/her application, and the potential consequences of a material inaccuracy.
- We are evaluating how to implement a process for internal evaluation of underwriting, rescissions and related decisions so as to better assure consistency, detect problems and failures to follow policies and procedures, and identify improvements that can be made prospectively.

Rescission Process Improvements:

- We have developed more comprehensive written policies and procedures as to identification of pre-existing conditions, inquiries and investigations of potential rescissions
- We have speeded up the process of investigation so that a rescission decision is reached more quickly, reducing the period of uncertainty for enrollees, providers and the Plan
- We have instituted an early letter process under which the enrollee is notified upon commencement of an inquiry, thus affording the enrollee the opportunity to provide the Plan with information helpful to the enrollee.
- We have established a rescission review committee, which includes a medical director and a member of the customer service department, which must meet and decide unanimously that a rescission is appropriate. The membership of this committee does not include the investigating underwriter(s).

Post-Rescission Process Improvements:

- We have better integrated our rescission appeals process and the standard Grievance and Appeal process.
- We have established a rescission appeal committee, which includes a medical director and a member of the customer service department, which must meet and decide unanimously that a rescission decision will be upheld. Otherwise, the rescinded member will be reinstated. This committee has completely different membership than the rescission review committee.
- We are evaluating how to improve communicating to a rescinded member the availability of both the grievance process in the Plan and the complaint process of the DMHC's Help Center.

Third Party Review:

- Since the recent decision in Bates v. Health Net, the Plan has announced that it is suspending rescissions pending several improvements, including the identification of a third party review organization. We are in the process of making that identification.
- Health Net has generally supported the development of a third party review process to improve the credibility of rescission decisions, and allow the rescinded member to benefit from an independent organization's objective evaluation.