SETTLEMENT AGREEMENT
The Department of Managed Health Care
and
Health Net of California, Inc.

PREAMBLE

As specifically described below, this Settlement Agreement recognizes Plan's voluntary decision to establish a process to give individuals whose IFP HMO coverage was rescinded the option of purchasing IFP HMO coverage going forward without medical underwriting and to reimburse past out-of-pocket medical expenses of specific individuals. This Settlement Agreement also provides individuals with a choice of dispute resolution processes designed to expedite the resolution of any potential claims, including claims for past out-of-pocket medical expenses. Except as otherwise expressly set forth herein, nothing in this Settlement Agreement limits an individual's right to pursue any available legal remedies.

I. FACTUAL BACKGROUND

Health Net of California, Inc. ("Plan") is a licensed health care service plan, license No. 933-0300. The California Department of Managed Health Care ("Department") enforces the laws that govern health care service plans in California.

Between January 2004 and present, approximately 9,546 people enrolled into Plan's health plan known as Health Net of California Individual and Family Plan HMO ("IFP HMO"). During this period of time the Plan rescinded the IFP HMO membership agreements of 85 enrollees, or 0.89% of the total number of individuals who were enrolled into IFP HMO.

Section 1389.3 of the Health and Safety Code prohibits a health care service plan from engaging in the practice of post claims underwriting, which means "the rescinding, canceling, or limiting of an enrollee's contract due to the plan's failure to complete medical underwriting and to resolve all reasonable questions prior to issuing the plan contract." (Health & Safety Code § 1389.3.)

Plan ceased rescinding enrollees in November 2007.

The Department and the Plan execute this Settlement Agreement, which shall be binding on both of them. This Settlement Agreement is the final settlement of the rescission issues discussed below.

II. UNDERSTANDINGS AND AGREEMENTS

The parties agree as follows:

A. **Additional Rescissions**. Plan will not rescind any IFP HMO membership agreement issued on or before May 15, 2008. Plan reserves its right to rescind IFP HMO membership agreements of enrollees who enroll after May 15, 2008, in accordance with California law.

B. **Notice**. . "FORMER ENROLLEES" means individuals whose IFP HMO membership agreements were rescinded between January 1, 2004, and May 15, 2008, and who have not already resolved their disputes about such rescission pursuant to a judicial judgment, arbitration award, prior reinstatement, prior Department Order or Letter of Agreement, settlement, or settlement agreement. Within 45 days following the effective date of this Settlement Agreement, Plan will commence reasonable efforts to contact FORMER ENROLLEES. If necessary, such reasonable efforts shall include use of an independent search service to assist Plan in confirming the whereabouts of such FORMER ENROLLEES, and the use of such service shall satisfy the Plan's obligation under this paragraph to make reasonable efforts. The notification to FORMER ENROLLEES shall be made by overnight mail or private delivery service with confirmation of delivery to the most recently available address identified pursuant to Plan's reasonable search efforts. The purpose of this notification is to inform these FORMER ENROLLEES of Plan's voluntary offer. The voluntary offer to the FORMER ENROLLEES to sell them IFP HMO coverage (that is most comparable to their rescinded IFP HMO policy) without medical underwriting shall be made in writing and shall be open for a period of 90 days from the date of delivery to the most recently available address identified pursuant to Plan's reasonable search efforts. Enrollment and continued membership will be conditioned on meeting nonmedical underwriting eligibility requirements set forth in the applicable IFP HMO membership agreement. These non-medical underwriting eligibility requirements include, by way of example, residence in a service area, age limits for members and

their dependents, signing an enrollment form, and paying all applicable premiums going forward. The effective date of IFP HMO coverage will be the first day of the month following Plan's receipt of the FORMER ENROLLEE'S first month premium. Plan's voluntary offer to sell IFP HMO coverage to these FORMER ENROLLEES without medical underwriting is not and shall not be construed as an admission of noncompliance or liability or as a waiver of rights or defenses. Once the Plan has made the reasonable efforts to contact the FORMER ENROLLEES to make the voluntary offers set forth in this Settlement Agreement, Plan's obligation to contact these FORMER ENROLLEES shall cease. However, Plan will accept independent or direct requests from FORMER ENROLLEES to accept Plan's voluntary offer to sell IFP HMO coverage without medical underwriting if received on or before December 31, 2008.

C. **Voluntary Offer**. Except as provided in paragraph II.F, below:

1. Plan will offer to permit FORMER ENROLLEES to purchase IFP HMO coverage going forward without medical underwriting ("voluntary offer").

2. Plan will not require FORMER ENROLLEES who are offered the right to purchase IFP HMO coverage without medical underwriting under this Settlement Agreement to execute a release of all claims against Plan as a condition of acceptance of this voluntary offer to sell future IFP HMO coverage. FORMER ENROLLEES who receive and/or accept the voluntary offer may pursue any legal remedies or claims available to them for causes of action they believe they have a right to assert against Plan. However, releases may be executed as part of the expedited dispute resolution options described in paragraph II.G. below.

D. **Unique Claims**. The parties recognize that FORMER ENROLLEES, including the SPECIFIED FORMER ENROLLEES described in paragraph II.F, below, may claim entitlement to damages in connection with Plan's rescission actions, which claims are entirely personal and unique for every person and different from every other of the FORMER ENROLLEES.

E. **Reservation of Rights**. Plan reserves the right to assert any and all defenses against any FORMER ENROLLEE, including, without limitation, defenses to any claim or action brought by such FORMER ENROLLEE, whether in court, in binding arbitration, in another forum, or under the expedited dispute resolution options described in paragraph II.G.

F. **Specified Former Enrollees**. In addition to Plan's voluntary offer of IFP HMO coverage on a going forward basis without medical underwriting to FORMER ENROLLEES, Plan will offer specifically identified FORMER ENROLLEES included in the confidential list attached to this Settlement Agreement as Confidential Attachment A ("SPECIFIED FORMER ENROLLEES"), the option to be reimbursed for out-of-pocket medical expenses (hereafter the term "Out-Of-Pocket Medical Expenses" shall have the meaning and be subject to the standards as set forth below in this paragraph II.F.) without any determination of the appropriateness of the prior rescission as described below.

1. Plan will offer to sell the SPECIFIED FORMER ENROLLEES IFP HMO coverage going forward without medical underwriting, as described in paragraph II.B, above.

2. Further, Plan will undertake reasonable efforts, as described above in paragraph II.B, to contact the SPECIFIED FORMER ENROLLEES to make a written offer to provide a financial settlement to each individual. The financial settlement offer shall be an amount equal to the SPECIFIED FORMER ENROLLEE'S Out-Of-Pocket Medical Expenses for medical services received during the Rescinded Coverage Period (which runs from the date of their original enrollment to the date upon which rescission was effective) and the Gap Period (which runs from the end of the enrollee's Rescinded Coverage Period through the date the offer letter is received at the address identified through the Plan's reasonable efforts pursuant to paragraph II.B. above). Such Out-Of-Pocket Medical Expenses shall be subject to reasonable documentation requirements. Out-Of-Pocket Medical Expenses shall not include any 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 the proceeds of any judgment or settlement.

3. Such Out-Of-Pocket Medical Expenses shall include only expenses for services that were medically necessary covered services within the parameters of the IFP HMO benefits structure contained in the rescinded IFP HMO membership agreement in effect at the start of the SPECIFIED FORMER ENROLLEE'S Rescinded Coverage Period.

4. This financial settlement offer will be contingent upon the SPECIFIED FORMER ENROLLEE'S agreement that acceptance of the financial settlement will result in a full and complete resolution of any and all disputes between the Plan and the SPECIFIED FORMER ENROLLEE arising out of Plan's rescission decision, including any and all claims for additional damages, (including pain and suffering, punitive damages, and other damages) or injunctive relief.

5. If the SPECIFIED FORMER ENROLLEE disputes the Plan's determination of medical necessity, the scope of benefits coverage, or the amount of proposed reimbursement, the SPECIFIED FORMER ENROLLEE shall be immediately referred to the expedited dispute resolution processes described in Option 2 and Option 3 in paragraph II.G, except that the sole issue to be determined shall be the amount of reimbursement of Out-Of-Pocket Medical Expenses during the Rescinded Coverage Period and the Gap Period.

6. The election of this alternative dispute resolution remedy will be at the SPECIFIED FORMER ENROLLEE'S sole discretion. If a SPECIFIED FORMER ENROLLEE declines to accept this alternative dispute resolution remedy, he/she will be provided all the rights and remedies that this Settlement Agreement provides to all FORMER ENROLLEES and Plan will retain the right to assert any and all defenses.

G. **Expedited Dispute Resolution Options**. The parties recognize that certain FORMER ENROLLEES may claim entitlement to damages in connection with the prior rescissions. Such FORMER ENROLLEES may include SPECIFIED FORMER ENROLLEES who seek claims beyond reimbursement of the Out-Of-Pocket Medical Expenses described in paragraph II.F. As stated in paragraph II.C, this Settlement Agreement does not preclude such persons from pursuing legal recourse for causes of action they believe that they have a right to

assert against Plan. However, Plan has agreed to make available the following three options on an expedited basis in lieu of other legal remedies, to FORMER ENROLLEES to whose claims have not otherwise been settled or released, as follows:

Option 1. Former Enrollees who desire to negotiate their claims directly with Plan: FORMER ENROLLEES may submit a written claim for damages to the Plan, supported by any invoices, cancelled checks, and other supporting documentation that FORMER ENROLLEE may have available. The Plan may request authorization for the release of medical records and copies of such medical records to support the claim. Within 60 days of receipt of such claim, Plan will (a) provide a written offer of final settlement of all claims to the claimant, or (b) dispute the claim. The written offer of final settlement may be conditioned on the receipt of such additional supporting documentation as may be reasonably necessary to substantiate the claim and on the Plan's obtaining a release from the FORMER ENROLLEE in exchange for any settlement. In the event that a final settlement of all claims is not achieved, the claimant shall retain his or her rights to pursue legal recourse against the Plan or to opt for Option 2 or Option 3 below.

Option 2. Former Enrollees whose claims are limited to Out-Of-Pocket Medical Expenses for medical expenses received during the Rescinded Coverage Period and the **Gap Period that are less than or equal to $25,000:** Such persons may opt to resolve all of their claims through an expedited proceeding that shall be conducted by a JAMS arbitrator on the basis of a written record without appearance by any party. The record shall consist of evidence of the claimant's Out-Of-Pocket Medical Expenses during the Rescinded Coverage Period and the Gap Period, evidence that such expenses were for medically necessary covered services within the parameters of the benefits structure contained in the claimant's rescinded IFP HMO membership agreement and were not reimbursed by any third party, and the Plan's record of decision of the rescission, provided that both parties shall have the right to submit additional written statements and materials to the arbitrator. No discovery shall be permitted, except that Plan may obtain claimants' medical records and bills for purposes of verifying claims.

Plan will pay for the cost of the arbitrator. Any award shall be limited to documented Out-Of-Pocket Medical Expenses during the Rescinded Coverage Period and the Gap Period and shall resolve all claims.

Option 3. Former Enrollees whose claims for Out-Of-Pocket Medical Expenses are greater than $25,000 or include claims for damages other than Out-Of-Pocket Medical Expenses for medical services received during the Rescinded Coverage Period and the **Gap Period:** Such persons may opt to resolve all of their claims through arbitration held in Sacramento, San Francisco, Los Angeles, or San Diego (whichever is more convenient to the claimant) before one arbitrator. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures, subject to the modifications set forth in this Agreement. The Plan will pay for the cost of the arbitrator.

The proceedings described in Option 2 and Option 3 immediately above shall be subject to the following rules:

a. The arbitrator shall be selected randomly by JAMS from a group of no more than six arbitrators who are mutually agreed upon by the Department and Plan. Such arbitrators shall follow applicable California law, including the Knox-Keene Act and the recent appellate court decision in Hailey v. California Physicians' Service, 158 Cal.App.4th 452 (2007) (as may be modified by subsequent decisions) and shall periodically consult with each other to assure consistency in decision-making.

b. Arbitration decisions shall be final, subject to judicial enforcement in accordance with California Code of Civil Procedure Sections 1285 et seq., and shall resolve all claims and disputes between FORMER ENROLLEES and the Plan relating to the Plan's rescission decision. The proceedings (including, without limitation, statements, deliberations, decisions, and documents made, created or issued therein by the arbitrator, any party or any other person) are a

compromise of claims and: (i) shall be inadmissible in any other legal or administrative proceeding and (ii) shall not be used for any purpose in any legal or administrative proceeding, including (without limitation) for purposes of collateral estoppel or res judicata. However, notwithstanding the foregoing, the proceeding may be used to establish that a FORMER ENROLLEE submitted claims, whether those claims were resolved, and whether the FORMER ENROLLEE released any claims. All documents (and copies thereof) exchanged shall be treated as confidential and returned to the producing parties promptly after conclusion of the arbitration. The form of decision will be a brief, non-narrative 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 a settlement or award agreed to or issued is, Under Option 3 above, based upon bills received by a FORMER ENROLLEE from a provider prior to May 15, 2008 that remain owed but were not paid by a FORMER ENROLLEE to a provider, Plan shall, at its sole discretion, have the right to directly resolve any such bills with the billing provider and deduct the amount paid to the billing provider from the amount of the settlement or award.

H. **Settlement**. By entering into this Settlement Agreement, the parties hereby settle all pending enforcement matters and all issues, accusations, and claims that the Department has or may have against the Plan, including, without limitation, any alleged violation of section 1389.3 of the Health and Safety Code or any other provision of the Knox-Keene Health Care Service Plan of 1975, relating to or arising from any rescission of IFP HMO membership agreements that may have occurred on or before May 15, 2008. The Department's Final Report of the Non-Routine Medical Survey on Post-Claims Underwriting (the "Final Report") regarding Plan's rescission practices will not be referred to the Division of Enforcement for any further administrative action or otherwise referred for enforcement. The Final Report may report the existence of this Settlement Agreement.

I. **Administrative Fine**. The Department contends an administrative fine is warranted, but recognizes Plan's good faith efforts to improve medical underwriting and rescission practices and to afford FORMER ENROLLEES a means of expedited dispute

resolution. Plan contends that its actions regarding rescission were in accordance with California law. Nevertheless, Plan agrees to an administrative fine of Three Hundred Thousand Dollars ($300,000) in order to resolve all matters with the Department as provided in this Settlement Agreement.

J. **Corrective Action**. On or before June 30, 2008, Plan will submit a corrective action proposal ("CAP") to address completion of medical underwriting, resolution of all reasonable questions arising from written information submitted on or with an application, and reasonable efforts to ensure the accuracy and completeness of the application before issuing IFP HMO coverage. At a minimum, Plan's corrective action plan will include the topics contained in Attachment B. The Department acknowledges that Plan has already commenced efforts on certain elements of the required CAP.

1. Within 120 calendar days of receipt of the Department's Final Report approving Plan's CAP, Plan will complete implementation of the CAP, provided that a reasonable additional time shall be permitted for implementation of essential systems (such as information technology) that typically require additional time. Plan and the Department may confer in good faith as necessary and agree to reasonable modifications of the CAP.

2. Pursuant to section 1380 of the Knox-Keene Act, the Department will conduct a follow up survey to verify that Plan has timely and substantially implemented its CAP. Upon completion of the follow up survey, if the Department determines that the Plan failed to substantially and timely implement its CAP, the Department may impose an administrative fine, proportional to the identified deficiencies, if any, of up to three million dollars ($3,000,000).

K. **No Admission**. The Department agrees that Plan's voluntary offer, and this Settlement Agreement, are not made pursuant to any order, consent agreement, stipulated judgment, or any other mandate of the Department. The Department agrees that the Plan's offer and this Settlement Agreement are not, and shall not be construed as, any sort of admission by Plan of a violation of, or non-compliance with, Section 1389.3 of the California Health and

Safety Code, any other provision of the Knox-Keene Act., or any other federal or state statute, law or regulation, or under common law.

L. **Good Faith**. The parties understand and agree that this Settlement Agreement represents their good faith efforts to resolve difficult issues.

M. **Effective Date**. This Settlement Agreement shall be effective on May 15, 2008.

The parties have voluntarily executed this Settlement Agreement on the dates shown below:

On Behalf of
The Department of Managed Health Care

Amy Dobberteen
Assistant Deputy Director
Office of Enforcement

Date: May 15, 2008

On Behalf of
Health Net of California, Inc.

Douglas A. Schur
Chief Regulatory Counsel

Date: May 15, 2008

Confidential Attachment A
Specified Former Enrollees

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EXHIBIT B

UNDERWRITING/RESCISSION ISSUES TO BE ADDRESSED IN THE PLAN'S CORRECTIVE ACTION PROPOSAL

1) **The Plan's enrollment materials should promote the Plan's processes to complete medical underwriting.**

   At a minimum the Plan should consider whether its Health Care Questionnaire/Application form:
   - Is clear, unambiguous and understandable to the average consumer
   - Is designed to solicit accurate health history information
   - Includes reasonable time periods

2) **The Plan's pre-enrollment health history investigation processes should support the Plan's processes to complete medical underwriting.**

   At a minimum, the Plan should consider whether its operational processes ensure:

   - The review of available sources of health information reasonably necessary to develop a comprehensive understanding of the applicant's health history prior to issuing insurance coverage that takes into consideration the applicant's age, clarity of the responses and disclosed medical conditions.

   - That the applicant's responses on the application are accurate and complete taking into consideration language barriers.

   - Thresholds are established to indicate when follow-up inquiry is appropriate and when attestation from brokers, agents and the applicant is necessary.

3) **The Plan's rescission/post-claims investigation practices are initiated promptly and completed in a fair and timely manner that includes notice to the applicant of the investigation and an opportunity to respond.**

   At a minimum, the Plan should consider whether its operational processes ensure:

   - That the enrollee is provided timely notice of the Plan's investigation, the information/issue under review and why the Plan considers this information to be an omission or misstatement.

   - That prior to rescinding the individual policy, the rescission determination is reviewed by staff that is separate from those involved in the initial underwriting.

   - Physician consultations are available during the investigation and appeal process.

- The grievance and appeal process is impartial.

- That the Plan does not employ any compensation or bonus programs in connection with the Plan's rescission processes.

4) **The plan implements a self-audit program to ensure adherence to medical underwriting guidelines, policies and procedures, investigations and rescission procedures.**

   The Plan should consider whether its operational processes ensure:

   - That timely follow-up and re-training is instituted to correct problems identified from audits.

   - The provision of periodic training of all underwriting staff regarding changes to policies and procedures.

After consultation with the Department, Plan may modify the corrective action proposal and the corrective action plan ultimately approved by the Department as necessary to conform with any newly enacted legislation amending section 1389.3 of the Health and Safety Code, promulgation of regulations and/or guidance clarifying pre-enrollment and post-enrollment standards and processes, or judicial opinion affecting section 1389.3 and its interpretation.