



Steve Shorr Insurance
Steve@SteveShorr.com
310.519.1335

INDIVIDUAL MEDICARE SUPPLEMENT PLAN



OUTLINE OF COVERAGE





HEALTH NET LIFE

*Outline of Individual Medicare Supplement Plan Coverage – **Effective July 1, 2011** Benefit Plans A, C, F, F+ (high deductible) and G are offered by Health Net Life Insurance Company (HNL)*

Medicare supplement insurance can be sold in only standard plans. This chart shows the benefits included in each plan that can be sold on or after June 1, 2010. Every insurance company must offer Plan A. Some plans may not be available.

THE BASIC BENEFITS INCLUDED IN ALL PLANS ARE:

Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F/F+
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible
				Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

*Plan F also has an option called a High Deductible Plan F, designated by Health Net Life as Plan F+. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from Plan F+ will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

G	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit \$4,640; paid at 100% after limit reached	Out-of-pocket limit \$2,320; paid at 100% after limit reached		

PREMIUM INFORMATION

We, Health Net Life (HNL) can only raise your premium if we raise the premium for all policies like yours in California. Premiums in this Outline of Coverage will increase periodically due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the Medicare Supplement Plan Policy will be the renewal premium in effect for your attained age. You will receive written notification of any changes in payment fees at least 30 days prior to the effective date of the new rate.

Health Net Life provides an initial 6-month rate guarantee to members enrolling for the first time into a Health Net Life Medicare Supplement plan. During your 6-month rate guarantee period, your premium will not increase even if Health Net Life has a rate increase, you have a birthday which moves you into the next higher

age rate bracket or you move to a county in a different region that has a higher premium. If during your 6-month rate guarantee period you choose to enroll in a different Health Net Life Medicare Supplement plan, your 6-month rate guarantee period will end, and you will be charged the premium for the new plan selected.

HNL OFFERS VARIOUS PAYMENT OPTIONS: MONTHLY BILLING AND AUTOMATIC BANK DRAFT (ABD).

The term of your health plan is month-to-month, commencing on the date set forth in the Notice of Acceptance. Your coverage will remain in effect for each month for which premiums are received on or before the date it is due, or within the grace period.

This plan is subject to Guaranteed Renewability.

Use this outline to compare benefits and premium among policies:

Rates Effective July 1, 2011

Region 1, Counties: Alameda, Contra Costa, San Diego, Shasta, Sonoma					
Age Range	Plan A	Plan C	Plan F	Plan F+	Plan G
65-66	\$96	\$137	\$137	\$58	\$126
67-68	\$106	\$151	\$151	\$63	\$139
69-70	\$115	\$164	\$164	\$69	\$151
71-72	\$124	\$177	\$177	\$74	\$163
73-74	\$134	\$191	\$191	\$80	\$176
75-76	\$143	\$204	\$204	\$86	\$188
77-78	\$152	\$217	\$217	\$91	\$200
79-80	\$160	\$229	\$229	\$96	\$211
81-84	\$173	\$247	\$247	\$104	\$227
85+	\$190	\$272	\$272	\$114	\$250
Disabled Under 65	\$190	\$272	\$272	\$114	\$250
Region 2, Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yuba					
Age Range	Plan A	Plan C	Plan F	Plan F+	Plan G
65-66	\$88	\$126	\$126	\$53	\$116
67-68	\$97	\$139	\$139	\$58	\$128
69-70	\$106	\$151	\$151	\$63	\$139
71-72	\$114	\$163	\$163	\$68	\$150
73-74	\$123	\$176	\$176	\$74	\$162
75-76	\$131	\$187	\$187	\$79	\$172
77-78	\$140	\$200	\$200	\$84	\$184
79-80	\$147	\$210	\$210	\$88	\$193
81-84	\$159	\$227	\$227	\$95	\$209
85+	\$177	\$253	\$253	\$106	\$233
Disabled Under 65	\$177	\$253	\$253	\$106	\$233

Region 3, Counties: Los Angeles, Orange

Age Range	Plan A	Plan C	Plan F	Plan F+	Plan G
65-66	\$109	\$155	\$155	\$65	\$143
67-68	\$120	\$171	\$171	\$72	\$157
69-70	\$131	\$187	\$187	\$79	\$172
71-72	\$141	\$201	\$201	\$84	\$185
73-74	\$152	\$217	\$217	\$91	\$200
75-76	\$162	\$231	\$231	\$97	\$213
77-78	\$173	\$247	\$247	\$104	\$227
79-80	\$182	\$260	\$260	\$109	\$239
81-84	\$196	\$280	\$280	\$118	\$258
85+	\$220	\$314	\$314	\$132	\$289
Disabled Under 65	\$220	\$314	\$314	\$132	\$289

Region 4, Counties: Kern, Napa, Riverside, San Bernardino, Ventura

Age Range	Plan A	Plan C	Plan F	Plan F+	Plan G
65-66	\$102	\$145	\$145	\$61	\$133
67-68	\$112	\$160	\$160	\$67	\$147
69-70	\$122	\$174	\$174	\$73	\$160
71-72	\$131	\$187	\$187	\$79	\$172
73-74	\$141	\$202	\$202	\$85	\$186
75-76	\$151	\$216	\$216	\$91	\$199
77-78	\$161	\$230	\$230	\$97	\$212
79-80	\$169	\$242	\$242	\$102	\$223
81-84	\$183	\$261	\$261	\$110	\$240
85+	\$204	\$292	\$292	\$122	\$269
Disabled Under 65	\$204	\$292	\$292	\$122	\$269

Region 5, Counties: El Dorado, Fresno, Imperial, Placer, Sacramento, Santa Cruz, Solano, Tulare, Yolo					
Age Range	Plan A	Plan C	Plan F	Plan F+	Plan G
65-66	\$83	\$119	\$119	\$50	\$109
67-68	\$92	\$131	\$131	\$55	\$121
69-70	\$100	\$143	\$143	\$60	\$132
71-72	\$108	\$154	\$154	\$65	\$142
73-74	\$116	\$166	\$166	\$70	\$153
75-76	\$124	\$177	\$177	\$74	\$163
77-78	\$132	\$189	\$189	\$79	\$174
79-80	\$139	\$199	\$199	\$84	\$183
81-84	\$151	\$215	\$215	\$90	\$198
85+	\$163	\$233	\$233	\$97	\$214
Disabled Under 65	\$163	\$233	\$233	\$97	\$214

READ YOUR MEDICARE SUPPLEMENT PLAN POLICY VERY CAREFULLY

This is only an outline describing your Medicare Supplement Plan Policy's most important features. This Medicare Supplement Plan Policy is your contract. You must read the Medicare Supplement Plan Policy itself to understand all of the rights and duties of both you and HNL.

THIRTY-DAY RIGHT TO RETURN THE MEDICARE SUPPLEMENT PLAN POLICY

If you find you are not satisfied with your Medicare Supplement Plan Policy, you may return it to HNL Medicare Supplement Plan at: PO Box 10420, Van Nuys, CA 91409-0420, Attention: Membership Accounting. If you send the Medicare Supplement Plan Policy back to us within 30 days after you receive it, we will treat the Contract as if it had never been issued and return all of your payments.

MEDICARE SUPPLEMENT PLAN POLICY REPLACEMENT

If you are replacing another health insurance Policy, do NOT cancel it until you have actually received your new Medicare Supplement Plan Policy and are sure you want to keep it.

DISCLOSURES

This Policy may not fully cover all your medical costs. Neither HNL nor any of its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details. For additional information concerning Policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, **1-800-434-0222**, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

COMPLETE ANSWERS ARE VERY IMPORTANT

You do not need to answer questions about your medical and health history if you are applying for coverage during an open enrollment or guarantee issue period.

When you fill out the application for the HNL Medicare Supplement Plan, be sure to truthfully and completely answer all questions about your medical and health history. HNL may have the right to cancel your Medicare Supplement Plan Policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

An example showing a physician's charges

The following are examples of how the Plans pay benefits for Part B charges, assuming a physician bill of \$2,000 and the annual Medicare Part B deductible of \$162 has been met.

	Physician Accepts Assignment	Physician Does not Accept Assignment
Plan: A and C		
Charges Approved for Payment by Medicare	\$1,850	\$1,850
Medicare pays 80% of Approved Charges	\$1,480	\$1,480
This policy pays	\$370	\$370
You Pay Coinsurance	\$0	\$150

	Physician Accepts Assignment	Physician Does not Accept Assignment
Plan: F and G		
Charges Approved for Payment by Medicare	\$1,850	\$1,850
Medicare pays 80% of Approved Charges	\$1,480	\$1,480
This policy pays	\$370	\$520
You Pay Coinsurance	\$0	\$0

If your physician accepts assignment of Medicare benefits, the difference between your physician's charge, (\$2,000) and the Part B Charges Approved for Payment by Medicare (\$1,850) is absorbed by your physician and you pay no coinsurance. If your physician does not accept assignment of Medicare benefits, you pay the Part B Excess Charges.

Unlike Plans A and C, Plans F and G pay Part B Excess Charges. Part B Excess Charges are the difference between physician charges and the Charges Approved for Payment by Medicare. If you enroll in Plans F or G, you pay no Part B coinsurance.



PLAN A

MEDICARE (PART A)

HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous service and supplies			
First 60 days	All but \$1,132	\$0	\$1,132 (Part A deductible)
61st through 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$141.50 a day	\$0	Up to \$141.50 a day
101st day and after	\$0	\$0	All costs

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

PLAN A

MEDICARE (PART B)

MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN C

MEDICARE (PART A)

HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies First 60 days 61st through 90th day 91st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond the additional 365 days 	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN C

MEDICARE (PART B)

MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B Excess Charges (above Medicare-approved amounts)	\$0 Generally 80% \$0	\$162 (Part B deductible) Generally 20% \$0	\$0 \$0 All costs
BLOOD First 3 pints Next \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$162 (Part B deductible) 20%	\$0 \$0 \$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F

MEDICARE (PART A)

HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous service and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st through 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN F

MEDICARE (PART B)

MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B Excess Charges (above Medicare-approved amounts)	\$0 Generally 80% \$0	\$162 (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$162 (Part B deductible) 20%	\$0 \$0 \$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F+

MEDICARE (PART A)

HOSPITAL SERVICES – PER BENEFIT PERIOD

This high deductible plan pays the same benefits as Plan F after one has paid a \$2,000 calendar-year deductible. Benefits from Plan F+ will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st through 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: • While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: • Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE, YOU PAY
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.</p> <p>First 20 days 21st through 100th day 101st day and after</p>	<p>All approved amounts All but \$141.50 a day \$0</p>	<p>\$0 Up to \$141.50 a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PLAN F+

MEDICARE (PART B)

MEDICAL SERVICES – PER CALENDAR YEAR

This high deductible plan pays the same benefits as Plan F after one has paid a \$2,000 calendar-year deductible. Benefits from Plan F+ will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE, YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE, YOU PAY
BLOOD First 3 pints Next \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$162 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$162 (Part B deductible) 20%	\$0 \$0 \$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN G

MEDICARE (PART A)

HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous service and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st through 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN G

MEDICARE (PART B)

MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

ELIGIBILITY PROVISIONS

You are eligible for enrollment in one of HNL's Medicare Supplement plans if you are 65 or older or under 65 and entitled to Medicare on the basis of Social Security disability benefits, enrolled in Medicare Parts A and B, and you reside within the State of California. Your continued eligibility to participate in this health plan depends on your continued Medicare enrollment. You may be eligible for guaranteed issuance of a Medicare Supplement Plan Policy under Health Net Life. Please call Health Net Medicare Inside Sales for more details at **1-800-944-7287**.

CLAIMS REIMBURSEMENT

The Health Net Life Medicare Supplement plan features electronic claims processing, a claims payment process between Health Net Life and Medicare. Medicare-certified and Medicare-accepting providers bill Medicare for services provided and, upon processing, Medicare then sends claims electronically to Health Net Life for secondary payment. Electronic claims processing is provided with your membership in the Health Net Medicare Supplement Plan. There is no registration necessary.

For claims for services covered by your Health Net Life Medicare Supplement Plan, but not by Medicare, such as Foreign Travel Emergency care, you or your medical provider should submit the claims directly to Health Net at:

Health Net Claims
PO Box 14702
Lexington, KY 40512

You may request a Health Net claim form by contacting the Member Services number provided on your identification card.

HOW TO APPLY

You may apply by completing the application and returning it in the enclosed envelope. You may enroll in your choice of plans A, C, F, F+ and G. You may be eligible for guaranteed issuance of a Medicare Supplement Plan Policy under Health Net Life. Please call Health Net Medicare Inside Sales for more details at **1-800-944-7287**.

TERMINATION PROVISIONS

You can terminate your enrollment in this health plan by giving written notice to HNL that you wish to disenroll at least 30 days prior to the month in which you wish to end your enrollment.

HNL can terminate your coverage:

- If your premium is not paid within the allowed grace period. Your coverage will be canceled on the last day of the month for which premium was last received and accepted by HNL.
- If you make a false statement as to your health status or obtain or attempt to obtain Covered Services by means of false, misleading, or fraudulent information, acts or omissions, HNL may terminate your coverage upon 30 days notice, except that no such termination shall be allowed after the expiration of two years from your initial effective date of coverage under this Policy.

If your coverage is terminated by HNL and you have reason to believe that the termination was based upon your health status or requirements for health care services, you may request a review of the termination by the Commissioner of the California Department of Insurance. Information relative to this procedure is available by contacting the Member Services Department.

In the event of cancellation by either HNL (except in the case of fraud or deception in the use of services of this health plan or knowingly permitting such fraud or deception by another) or yourself, HNL shall within 30 days return to you the prorated portion of the money paid to HNL which corresponds to any unexpired period for which payment had been received. The amounts shall be adjusted to reflect amounts due on claims, if any.

GRACE PERIOD

A grace period of 45 days is allowed after each premium due date. When payment is not received within the first two weeks of the month for which it is due, a final bill showing the amount owed will be sent to you. If payment is not received within 30 calendar days after the final bill is sent, your coverage will be terminated on the last day of the month for which premiums were last received and accepted by HNL.

HEALTH NET MEDICARE INSIDE SALES

Once you have had a chance to review the information presented here, please feel free to call Health Net Medicare Inside Sales at **1-800-944-7287**. We'll be glad to talk to you about this plan and all the benefits it offers you.

GRIEVANCE AND ARBITRATION

If you have a grievance against HNL, or are ever dissatisfied with our services and our HNL Medicare Supplement Plan Member Services department is not able to solve the problem, there is a procedure for appealing the issue. You may write a letter explaining the problem to:

HNL Medicare Supplement Plan
Appeals and Grievances Department
PO Box 10344
Van Nuys, CA 91410-0344

HNL uses neutral, binding arbitration to settle disputes, which arise out of or relate to coverage under the Policy. When you enroll in HNL Medicare Supplement Plan, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

This binding arbitration provision does not apply to claims, disputes, or controversies relating to alleged professional negligence (medical malpractice) and applies only to matters arising under this Policy.

Medicare has specific appeals procedures for the portion of the bill they pay. If you feel a decision made on a claim is incorrect, any Social Security office can help you request a review.

DEPARTMENT OF INSURANCE

If the Covered Person is unable to resolve a dispute with HNL, the Covered Person may wish to contact:

State of California
Department of Insurance
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP



For more information, please contact us at:

Health Net Life
Medicare Supplement Plan
Post Office Box 10198
Van Nuys, California 91410-0198

Health Net Medicare Inside Sales:

1-800-944-7287

Health Net Member Services:

1-800-926-4178

Para los que hablan español:

1-800-926-4178

Telecommunications Device for the Deaf:

1-800-929-9955

Steve Shorr
Steve@SteveShorr.com
310.519.1335

CA79145 (7/11)

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