2013 Outline of Coverage

Individual Medicare Supplement plan

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Health Net

M51102 (CA 7/12)

Health Net®
LIFE INSURANCE COMPANY

Health Net Life

Outline of Individual Medicare Supplement Plan Coverage
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

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 $4,800; paid at 100% after limit reached	Out-of-pocket limit $2,400; paid at 100% after limit reached		

*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 $2,110 deductible. Benefits from High Deductible Plan F+ will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this certificate. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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 Renewabilty.

Use this outline to compare benefits and premium among policies:

Rates effective July 1, 2012

Region 1 counties

Alameda, Contra Costa, San Diego, Shasta, Sonoma

Age range	*Plan A*	*Plan C*	*Plan F*	*Plan F+*	*Plan G*
65–66	$101	$144	$144	$60	$132
67–68	$111	$159	$159	$66	$146
69–70	$121	$173	$173	$73	$159
71–72	$131	$187	$187	$78	$172
73–74	$141	$201	$201	$84	$185
75–76	$151	$215	$215	$90	$198
77–78	$160	$229	$229	$96	$211
79–80	$169	$241	$241	$101	$222
81–84	$183	$261	$261	$110	$240
85+	$201	$288	$288	$120	$265
Disabled under 65	$201	$288	$288	$120	$265

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	$92	$132	$132	$55	$121
67–68	$102	$146	$146	$61	$134
69–70	$111	$159	$159	$66	$146
71–72	$120	$172	$172	$72	$158
73–74	$130	$185	$185	$78	$170
75–76	$138	$198	$198	$83	$182
77–78	$148	$211	$211	$89	$194
79–80	$155	$222	$222	$93	$204
81–84	$168	$240	$240	$100	$221
85+	$187	$268	$268	$112	$246
Disabled under 65	$187	$268	$268	$112	$246

Region 3 counties
Los Angeles, Orange

Age range	*Plan A*	*Plan C*	*Plan F*	*Plan F+*	*Plan G*
65–66	$115	$164	$164	$68	$151
67–68	$127	$181	$181	$76	$166
69–70	$138	$197	$197	$83	$181
71–72	$148	$212	$212	$89	$195
73–74	$160	$229	$229	$96	$211
75–76	$171	$244	$244	$102	$224
77–78	$182	$260	$260	$109	$239
79–80	$192	$274	$274	$115	$252
81–84	$207	$296	$296	$124	$272
85+	$232	$331	$331	$139	$305
Disabled under 65	$232	$331	$331	$139	$305

Region 4 counties
Kern, Napa, Riverside, San Bernardino, Ventura

Age range	*Plan A*	*Plan C*	*Plan F*	*Plan F+*	*Plan G*
65–66	$106	$152	$152	$64	$140
67–68	$118	$168	$168	$71	$155
69–70	$128	$183	$183	$77	$168
71–72	$138	$198	$198	$83	$182
73–74	$149	$213	$213	$89	$196
75–76	$159	$227	$227	$95	$209
77–78	$169	$242	$242	$102	$223
79–80	$179	$256	$256	$108	$236
81–84	$193	$276	$276	$116	$254
85+	$216	$308	$308	$129	$283
Disabled under 65	$216	$308	$308	$129	$283

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	$87	$125	$125	$53	$115
67–68	$97	$138	$138	$58	$127
69–70	$106	$151	$151	$63	$139
71–72	$113	$162	$162	$68	$149
73–74	$122	$175	$175	$74	$161
75–76	$131	$187	$187	$78	$172
77–78	$139	$199	$199	$83	$183
79–80	$147	$210	$210	$88	$193
81–84	$159	$227	$227	$95	$209
85+	$172	$246	$246	$102	$226
Disabled under 65	$172	$246	$246	$102	$226

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:

P.O. Box 10420
Van Nuys, CA 91499-6208
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.

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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 $147 has been met.

Plan: A and C

	Physician accepts assignment	*Physician does not accept assignment*
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**

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.

Plan: F and G

	Physician accepts assignment	*Physician does not accept assignment*
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**

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 $1,184	$0	$1,184 (Part A deductible)
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	$0	Up to $148 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	$0	3 pints	$0
Additional amounts	100%	$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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services Tests for diagnostic services	100%	$0	$0

*Once you have been billed $147 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*
Home health care – Medicare-approved services			
Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	$0	$0
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

*Once you have been billed $147 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	All but $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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	$0	3 pints	$0
Additional amounts	100%	$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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services Tests for diagnostic services	100%	$0	$0

*Once you have been billed $147 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*
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	$0	$0
First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

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

*Once you have been billed $147 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 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 $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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	$0	3 pints	$0
Additional amounts	100%	$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 $147 of Medicare-approved amounts*	$0	$147 (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
Blood			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services Tests for diagnostic services	100%	$0	$0

*Once you have been billed $147 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*
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	$0	$0
First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

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

*Once you have been billed $147 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 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 $2,110 calendar-year deductible. Benefits from Plan F+ will not begin until out-of-pocket expenses exceed $2,110. 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 $2,110 deductible, plan pays*	*In addition to $2,110 deductible, you pay*
Hospitalization* Semiprivate room and board, general nursing and miscellaneous service and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $592 a day	$592 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 $2,110 deductible, plan pays*	*In addition to $2,110 deductible, you pay*
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 $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
Blood First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

*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 $2,110 calendar-year deductible. Benefits from Plan F+ will not begin until out-of-pocket expenses exceed $2,110. 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 $2,110 deductible, plan pays*	*In addition to $2,110 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 $147 of Medicare-approved amounts*	$0	$147 (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
Blood			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0

*Once you have been billed $147 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 $2,110 deductible, plan pays*	*In addition to $2,110 deductible, you pay*
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	$0	$0
First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

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

*Once you have been billed $147 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 $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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	$0	3 pints	$0
Additional amounts	100%	$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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services Tests for diagnostic services	100%	$0	$0

*Once you have been billed $147 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*
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	$0	$0
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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

*Once you have been billed $147 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.

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, and do not have end-stage renal disease (ESRD), 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

M51102 (CA 7/12)

Health Net®
LIFE INSURANCE COMPANY

Underwritten by Health Net Life Insurance Company

CA96981 (1/13)

M51102 (CA 7/12)

Health Net®
LIFE INSURANCE COMPANY

HEALTH NET LIFE INSURANCE COMPANY INDIVIDUAL MEDICARE SUPPLEMENT GUARANTEED ISSUE GUIDE

Dear Potential Member:

If you have recently become eligible for Medicare, or lost or ended your health care coverage with another plan, you may qualify for guaranteed acceptance in a Health Net Life Individual Medicare Supplement plan in certain situations.

Review the guaranteed issue guidelines outlined in the following chart and determine if you qualify for automatic acceptance under one or more criteria. If you qualify, write the corresponding situation number in the Guaranteed Acceptance section of your application. Include any supporting information and/or documents necessary to prove your eligibility under the noted criteria.

If the required proof of Guaranteed Issue is not provided to Health Net Life with the enrollment application, your application will not be processed and you, and if applicable, your broker, will be notified that the proof of Guaranteed Issue was not received and must be provided within 30 calendar days from the date of the Health Net Life notification letter. If the proof of Guaranteed Issue is not received within this time frame, your application will be denied.

Please note that if you are under age 65 and entitled to Medicare Part B and you have end-stage renal disease (ESRD), you are not eligible to enroll. If you are under 65, and do not have ESRD, you must attest that you do not have ESRD by answering "NO" to question #6 under the "Current Health Plan" section of the enrollment application.

Applicants who are applying for coverage during an open enrollment or guaranteed issue period are not required to complete the Statement of Health portion of the Medicare Supplement Application or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. Applicants who do not qualify for guaranteed acceptance must complete the Statement of Health.

Important: Please note that this Guide is only a summary, and it is intended to help you identify the different situations which may qualify you for guaranteed acceptance. It may not contain all the details of each situation. It is important to remember that laws regulating guaranteed acceptance may change. Consequently, some requirements in the Guide may have changed since publication. Please ask your Sales Representative, Broker, or other advisor to confirm that you qualify for guaranteed acceptance.

For questions regarding the Health Net Life Insurance Individual Medicare Supplement Plan and/or the guaranteed issue guidelines, please call Health Net Medicare Sales Department at **1-800-944-7287** (or TTY/TDD **1-800-929-9955** for the hearing and speech impaired), Monday through Friday, 8:00 a.m. to 6:00 p.m., except holidays.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
1. You are age 65 or older, have Medicare Part A and are newly enrolled in Medicare Part B, or you already have Medicare because you are disabled and have just turned 65.	You are entitled to a six (6) month open enrollment period, during which you are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F, F+ or G.	Health Net Life must receive your application prior to or during the six-month period beginning with the first day of the month of your Part B effective date or your 65th birthday if you already have Medicare because you are disabled. **NOTE:** Your effective date cannot be prior to the first day of the month of your Part B effective date or your 65th birthday if you already have Medicare because you are disabled.	Proof of date of enrollment in Medicare (e.g., copy of Medicare card).
2. You currently have a Medicare Supplement plan with Health Net Life or another carrier and want to switch to a different Medicare Supplement plan and have requested an effective date with Health Net Life that is within 30 days after your last birthday.	You have an annual open enrollment period, during which you are eligible to enroll in a Health Net Life Medicare Supplement plan of equal or lesser benefits than your current Plan.	Health Net Life must receive your application up to **30 days prior to, or within 30 days after** your last birthday. **NOTE:** Your effective date cannot be prior to your birthday and can be no later than the first day of the month following the 30-day submission window after your last birthday.	Proof of current Medicare Supplement coverage with Health Net Life or another carrier.

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
3. You enrolled in a Medicare Advantage or PACE Provider Plan upon first becoming eligible for benefits under Medicare Part A at 65 years of age and then you disenrolled from the Medicare Advantage or PACE Provider Plan within 12 months of the effective date of enrollment. Your rights under these situations may last for an extra 12 months if the Plan you first joined leaves the Medicare program or stops giving care in your area before you have been in the Plan for one year, **and** you immediately join another similar Plan.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F, F+ or G.	Health Net Life must receive your application up to **60 days prior to, or within 63 days** of the date your disenrollment from the Medicare Advantage or PACE Provider Plan became effective.	Proof of enrollment and disenrollment effective dates from a Medicare Advantage or PACE Provider Plan. Proof of disenrollment must be received no later than 30 days after you receive your Health Net Life Medicare Supplement Plan policy certificate.

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
4. You disenrolled from a Medicare Supplement plan to enroll for the first time in a Medicare Select, Medicare Cost or similar organization operating under demonstration project authority before April 1, 1999, PACE Provider or a Medicare Advantage plan and then voluntarily disenrolled within 12 months of coverage. Your rights under these situations may last for an extra 12 months if the Plan you first joined leaves the Medicare program or stops giving care in your area before you have been in the Plan for one year, **and** you immediately join another similar Plan.	You are eligible to enroll in the **same** Medicare Supplement Plan you previously had, if it is offered for sale by Health Net Life, or Plan A, C, F or F+.	Health Net Life must receive your application up to **60 days prior to**, or **within 63 days** of the date your disenrollment from a Medicare Advantage, PACE Provider, Medicare Select or Medicare Cost Plan became effective.	Proof of termination from a Medicare Advantage, PACE Provider, Medicare Select or Medicare Cost Plan. Proof of termination must be received no later than 30 days after you receive your Health Net Life Medicare Supplement Plan policy certificate.

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
5. You enrolled in a Medicare Advantage or PACE Provider Plan, Medicare Cost, or similar organization operating under demonstration project authority before April 1, 1999, Health Care Prepayment Plan or a Medicare Select policy, but coverage was terminated because: • the certification of the organization or plan has been terminated, **OR** • the organization or plan discontinued providing the plan in the service area in which you reside, **OR** • you are no longer eligible to elect the plan because of a change in your place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment because the individual has not paid premiums on a timely basis or has engaged in disruptive behavior, or the plan is terminated for all individuals within a residence area.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F or F+.	Health Net Life must receive your application **within 63 days** of the date your Plan termination became effective. If you are enrolled in a Medicare Advantage plan, you are entitled to an **additional 60-day** open enrollment period.	Proof of termination (including reason and date of termination) from a plan as outlined under "Criteria."

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
6. You enrolled in an employer group health plan that provides health benefits that supplement the benefits under Medicare, but a) your employer group plan terminates or ceases to provide all of those supplemental health benefits to you; **OR** b) your employer no longer provides you with insurance that covers all of the payment for the Part B 20% coinsurance.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F or F+.	Health Net Life must receive your application **within 63 days** of the effective date that your employer group reduced or stopped providing health benefits that supplement the benefits under Medicare.	Proof of reduction or termination of benefits as outlined under "Criteria."
7. You are enrolled in Medicare Part B, and have lost your employer-sponsored health plan, employer-sponsored retiree health plan (including coverage under COBRA and Cal-COBRA), or are no longer eligible for employer-sponsored health plan coverage due to the divorce or death of a spouse.	You are entitled to a six (6) month open enrollment period, during which you are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F, F+ or G.	Health Net Life must receive your application **within six (6) months** of the date you lost your employer-sponsored health coverage.	Proof of voluntary or involuntary termination from an employer-sponsored health plan, or employer-sponsored retiree health plan as outlined under "Criteria".

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
8. You are enrolled in Medicare Part B and enrolled in a Medicare Supplement plan but you can no longer retain the coverage because you moved outside the Plan's service area.	You are entitled to a six (6) month open enrollment period, during which you are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F, F+ or G.	Health Net Life must receive your application **within six (6) months** of the date you lost your health coverage under a Medicare Supplement plan.	Proof of termination of coverage due to a change in residence outside the current insurer's coverage area.
9. You are a Medicare-eligible military retiree, retiree's Medicare-eligible spouse or dependent enrolled in Medicare Part B, and lost access to coverage due to: • a military base closure, **OR** • the base no longer offers health care services, **OR** • you have relocated.	You are entitled to a six (6) month open enrollment period, during which you are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F, F+ or G.	Health Net Life must receive your application **within six (6) months** of the termination of health services.	Proof of loss of coverage due to military base closure, base no longer offering health care services or proof of relocation.
10. You enrolled in a Medicare Supplement plan but coverage stopped because: • the company filed for bankruptcy or insolvency, **OR** • the company involuntarily terminated coverage, **OR** • the company violated a material provision of the Plan, **OR** • the company, or an agent acting on its behalf, materially misrepresented a provision of the Plan.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F or F+.	Health Net Life must receive your application **within 63 days** of the date your Medicare Supplement Plan termination became effective.	Proof of termination of coverage due to one of the reasons outlined under "Criteria."

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
11. You are under age 65 and entitled to Medicare Part B, because of disability, **but you do not have end-stage renal disease (ESRD)**.	You are entitled to a six (6) month open enrollment period, during which you are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, or F.	Health Net Life must receive your application **prior to or during the six-month period** beginning with the first day of the month of your Part B effective date. **NOTE:** Your effective date cannot be prior to the first day of the month of your Part B effective date.	Proof of enrollment in Medicare Part B, and attestation that you do not have end-stage renal disease (ESRD) by answering **"NO"** to question #6 under the "Current Health Plan" section of the enrollment application.
12. You are enrolled in a Health Net Medicare Advantage plan and Health Net **either**: • reduced its benefits, **OR** • increased the amount of cost-sharing, or premium, **OR** • discontinued, for other than good cause relating to the quality of care under the Plan, a provider who is currently furnishing services to the individual.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F or F+.	Health Net Life must receive your application **60 days before** the effective date of the disenrollment, but **no later than 63 days** after the effective date of the disenrollment.	Health Net will review its records for applicability.

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
13. You are enrolled in a Medicare Advantage Plan with a carrier that does not offer a Medicare Supplement product and the plan **either**: • increased the premium by 15 percent or more, **OR** • increased physician, hospital, or drug copayments by 15 percent or more, **OR** • reduced any benefits under the plan.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F or F+.	Health Net Life must receive your application during the Medicare Annual Election Period (AEP) beginning with the 2012 AEP October 15th – December 7th.	A copy of the Medicare Advantage Annual Notice of Change (ANOC) that shows that the Medicare Advantage Plan is reducing its benefits and/or increasing the amount of cost sharing or premium effective January 1st of the following year as outlined under "Criteria" **AND** proof of termination from the Medicare Advantage Plan. Proof of termination must be received no later than 30 days after you receive your Health Net Life Medicare Supplement Plan policy certificate.
14. Effective January 1, 2012, you are enrolled in a Medicare Advantage Plan with a carrier that does not offer a Medicare Supplement product and the plan discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F or F+.	Health Net Life must receive your application **60 days before** the effective date of the disenrollment, but no later than **63 days after** the effective date of the disenrollment.	A copy of the provider termination member notification letter **AND** proof of termination from the Medicare Advantage Plan. Proof of termination from the Medicare Advantage Plan must be received no later than 30 days after you receive your Health Net Life Medicare Supplement Plan policy certificate.

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
15. If you currently have a Health Net Life Medicare Supplement plan with prescription drug benefits and have enrolled in a Medicare Part D (Prescription Drug Plan), and want to change your coverage to a different Health Net Life Medicare Supplement plan without prescription drug coverage, you may contact Health Net Life at **1-800-944-7287** (TTY/TDD **1-800-929-9955** for the hearing and speech impaired), Monday–Friday, 8:00 a.m.–6:00 p.m., except holidays, and change your Medicare Supplement Plan to A, C, F or F+ without submitting a new application.	You are eligible to enroll in Health Net Life Medicare Supplement Plan A, C , F or F+ without submitting a new Medicare Supplement application.	Health Net Life must receive your **written request** to change your enrollment to another Health Net Life Medicare Supplement plan **within 63 days after your coverage in a Medicare Part D Plan begins.**	Health Net Life will review its records for applicability.

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

CRITERIA	YOUR CHOICES[1]	TIME FRAME	SUPPORTING DOCUMENTS
16. You are enrolled in Medicare Part B and have been notified that because of an increase in your income or assets you meet one of the following requirements: 1. You are no longer eligible for Medi-Cal benefits, **OR** 2. You are only eligible for Medi-Cal benefits with a share of cost and certify at the time of application that you do not meet the share of cost by answering "**NO**" to question #2 under the "Current Health Plan" Section of the enrollment application.	You are entitled to a six (6) month open enrollment period, during which you are eligible to enroll in Health Net Life Medicare Supplement Plan A, C, F, F+ or G.	Health Net Life must receive your application **within six (6) months** of the date you received notification that you are no longer eligible for benefits under the Medi-Cal program because of an increase in your income or assets.	A copy of Medi-Cal's notice of termination due to a change in income/assets as outlined under "Criteria".

[1]Health Net Life offers Plans A, C, F, F+ and G for Medicare beneficiaries eligible based on disability, and as required by applicable California law.

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