

## OVERVIEW OF MEDICARE SUPPLEMENT PLANS: PLANS A, F, F WITH HIGH DEDUCTIBLE, K AND M

*Rates effective as of January 1, 2012*

Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) offers five different specified Medicare supplemental plans to meet the needs of Medicare-eligible Oregon residents. This brochure outlines the five plans.

Medicare supplemental coverage can be sold only in specified plans. The chart below shows the benefits included in each plan. Every company that offers Medicare supplemental plans must make Plan A available. If the company chooses to offer a supplemental plan other than Plan A, they must also offer Plan C or Plan F. Some plans may not be available from any company in Oregon.

Health Net of Oregon offers Plan A, Plan F, Plan F with high deductible, Plan K, and Plan M. Plan A contains the basic or Core Benefits. Plan F, Plan F with high deductible, Plan K, and Plan M include the Core Benefits plus additional benefits as outlined in this brochure.

To apply for coverage or to obtain a complete packet, including an application form, please contact your insurance agent or Health Net of Oregon. To speak to a Health Net sales representative, please call 1-800-709-4193.

### **READ YOUR POLICY VERY CAREFULLY**

This is only a fact sheet describing the most important features of Health Net of Oregon's Medicare supplemental plans.

The Policy is your contract for health coverage.

You must read the Policy itself to understand all of the rights and duties that you and your health care service contractor have.

Your Policy describes the provisions of your plan.

If you ever have questions about your coverage, please call our Customer Contact Center at 1-888-802-7001 or email us at [service@healthnet.com](mailto:service@healthnet.com).

# Standard Medicare supplemental plans

Health Net of Oregon offers Plans A, F, F with high deductible, K and M. This chart identifies the benefits that are included in each of the ten standard Medicare Supplemental Plans.

<b>CORE BENEFITS</b>	<b>PLAN A</b>	<b>PLAN B</b>	<b>PLAN C</b>	<b>PLAN D</b>	<b>PLAN F<sup>1</sup></b>	<b>PLAN G</b>	<b>PLAN K<sup>2</sup></b>	<b>PLAN L<sup>3</sup></b>	<b>PLAN M</b>	<b>PLAN N</b>
Part A hospital (Days 61–90)	X	X	X	X	X	X	X	X	X	X
Lifetime reserve (Days 91–150)	X	X	X	X	X	X	X	X	X	X
365 lifetime hospital days (100%)	X	X	X	X	X	X	X	X	X	X
Parts A and B blood	X	X	X	X	X	X	50%	75%	X	X
Part B coinsurance	X	X	X	X	X	X	50%	75%	X	X <sup>4</sup>
Hospice care	X	X	X	X	X	X	50%	75%	X	X
<b>ADDITIONAL BENEFITS</b>	<b>PLAN A</b>	<b>PLAN B</b>	<b>PLAN C</b>	<b>PLAN D</b>	<b>PLAN F<sup>1</sup></b>	<b>PLAN G</b>	<b>PLAN K<sup>2</sup></b>	<b>PLAN L<sup>3</sup></b>	<b>PLAN M</b>	<b>PLAN N</b>
Skilled nursing facility coinsurance (Days 21–100)			X	X	X	X	50%	75%	X	X
Part A deductible		X	X	X	X	X	50%	75%	50%	X
Part B deductible			X		X					
Part B excess charges					100%	100%				
Foreign travel emergency			X	X	X	X			X	X
Annual out-of-pocket limitation							\$4,660	\$2,330		

- 1 Plan F also offers a high deductible option. You must pay for Medicare-covered costs up to the high deductible amount (\$2,070 in 2012) before your Medicare Supplement policy pays anything.
- 2 After you have reached the out-of-pocket limitation of \$4,660 on annual expenditures under Medicare Parts A and B, Plan K will provide coverage of one hundred percent (100%) of all cost-sharing for the balance of the calendar year.
- 3 After you have reached the out-of-pocket limitation of \$2,330 on annual expenditures under Medicare Parts A and B, Plan L will provide coverage of one hundred percent (100%) of all cost-sharing for the balance of the calendar year.
- 4 Provides coverage for 100% of the Part B coinsurance, except you pay the lesser of \$20 or the Part B coinsurance for each covered office visit and the lesser of \$50 or the Part B coinsurance for each covered emergency room visit. The emergency room visit copayment is waived if admitted.

## Plan A benefits (Core Benefits)

The benefits included in standardized Plan A are called Core Benefits.

For members of Plan A, Health Net of Oregon will pay benefits as follows for services that are covered by Medicare and while the member is covered under this plan:

- **Hospitalization** benefit provides coverage of Part A Medicare-eligible expenses for hospitalization, which are not covered by Medicare, from the 61st day through the 90th day in any Medicare benefit period.

Hospitalization benefit also provides coverage of Part A Medicare-eligible expenses incurred for hospitalization, which are not covered by Medicare, for Medicare lifetime inpatient reserve days.

When Medicare hospital inpatient coverage runs out, including the lifetime reserve days, the hospitalization benefit will provide coverage of the Part A Medicare-eligible expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days.

- **Blood** benefit provides coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells.
- **Part B coinsurance** provides coverage for the coinsurance amount of Medicare-eligible expenses under Part B, regardless of hospital confinement, subject to the Medicare Part B deductible.
- **Hospice care** benefit provides coverage of cost-sharing for the Part A Medicare-eligible expenses for hospice care and respite care.

## Plan F (including Plan F with high deductible) additional benefits

Plan F and Plan F with high deductible include the Core Benefits plus the following additional benefits:

- **Skilled nursing facility care** benefit, providing coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- **Medicare Part A deductible** benefit, providing coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.
- **Medically necessary emergency care** in a foreign country, providing coverage for benefits not covered by Medicare up to 80 percent of the billed charges for Medicare-eligible expenses.

Benefits are for medically necessary emergency hospital, physician and medical care received in a foreign country, when the care would have been covered by Medicare if provided in the United States and when the care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000.

For purposes of this benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset.

- **Medicare Part B deductible** benefit, providing coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

- **Part B Excess Charges** benefit, providing coverage for 100 percent of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

*NOTICE:* The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the standardized Medicare supplement Plan F, and shall be in addition to any other specific benefit deductibles. The annual deductible for 2012 is \$2,070.

## Plan K additional benefits

Plan K includes the Core benefits plus the following additional benefits:

- **Skilled nursing facility care** benefit, providing coverage for 50 percent of the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- **Medicare Part A deductible** benefit, providing coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.
- **Out-of-pocket limitation** After you have reached the out-of-pocket limitation of **\$4,660** on annual expenditures under Medicare Parts A and B, Plan K will provide coverage of one hundred percent (100%) of all cost-sharing for the balance of the calendar year.

## Plan M additional benefits

Plan M includes the Core Benefits plus the following additional benefits:

- **Skilled nursing facility care** benefit, providing coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- **Medicare Part A deductible** benefit, providing coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.
- **Medically necessary emergency** care in a foreign country, providing coverage for benefits not covered by Medicare up to 80 percent of the billed charges for Medicare-eligible expenses.

Benefits are for medically necessary emergency hospital, physician and medical care received in a foreign country, when the care would have been covered by Medicare if provided in the United States and when the care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000.

For purposes of this benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset.

### HEALTH NET HEALTH PLAN OF OREGON, INC. OFFERS THE FOLLOWING MEDICARE SUPPLEMENT POLICIES:

Plan A: HNOR Med Supp PlanR A 1/2012

Plan F: HNOR Med Supp PlanR F 1/2012

Plan F with high deductible: HNOR Med Supp PlanR FH 1/2012

Plan K: HNOR Med Supp PlanR K 1/2012

Plan M: HNOR Med Supp PlanR M 1/2012

## Services not covered

No payment will be made by Health Net of Oregon for loss arising from the following:

- Services or materials furnished, paid for or made available by any state or federal agency or under any law for which the member is not required to pay, including but not limited to Title XVIII of the Social Security Act of 1965, as amended-Medicare. (Except State of Oregon owned or operated hospitals and state-approved community mental health programs.)
- Vision aids (except when required following cataract surgery).
- Prescription medications.
- Conditions caused by or arising out of war or acts of war, declared or undeclared.
- Benefits that duplicate benefits paid by Medicare.
- Custodial care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Medicare does not cover care if it is mainly custodial.
- Any state or federal worker's Compensation, employer liability or occupational disease law or any motor vehicle no-fault law.
- Services and supplies not covered by Medicare except:
  - The Medicare Part A deductible and Medicare coinsurance covered under the Policy.
  - The 365 lifetime hospital days.
  - Any benefits endorsed to the Policy.

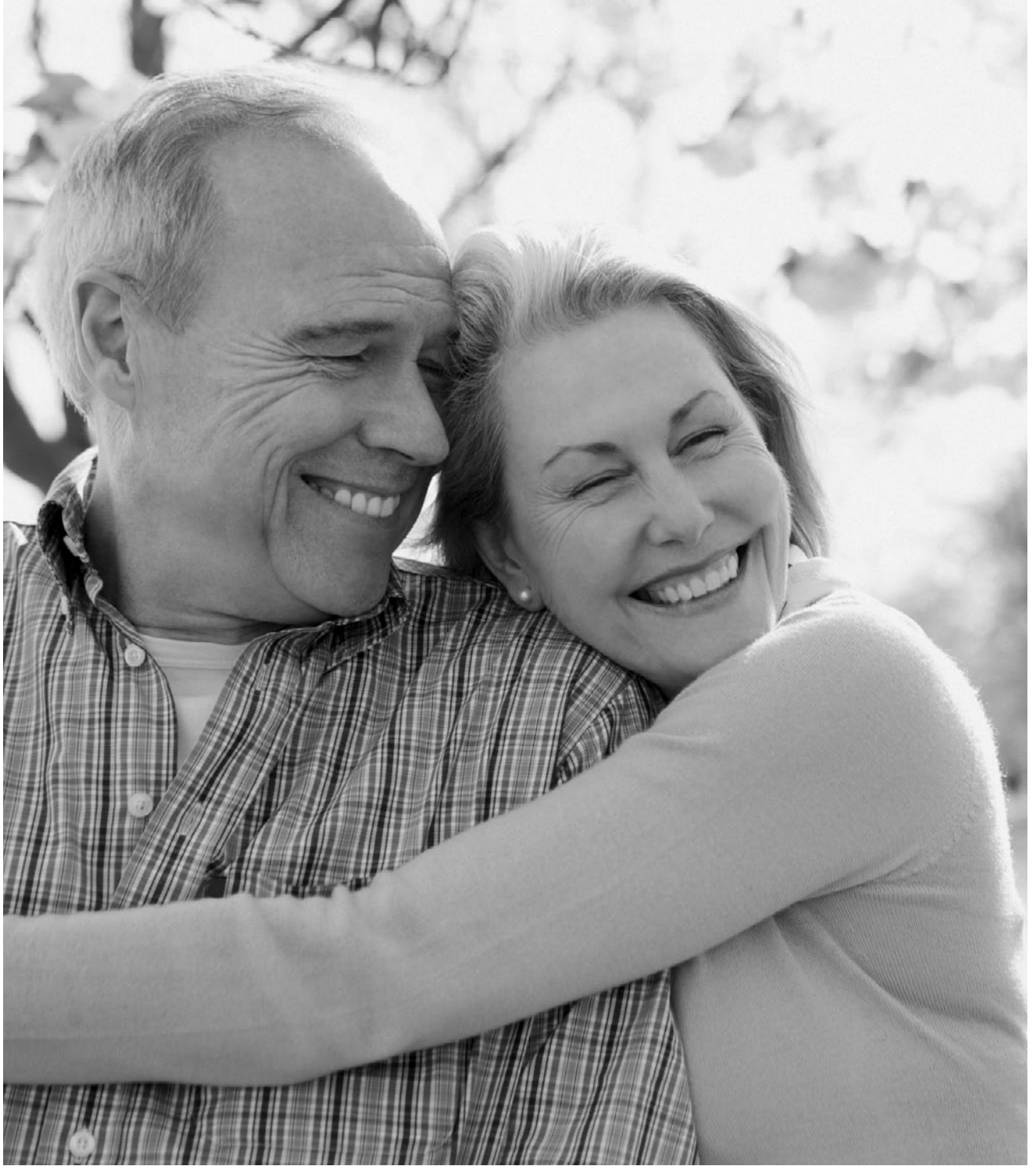
**No limitations or exclusions on coverage under this plan shall be more restrictive than those under Medicare.**

## Submitting claims

Medicare requires the provider of services to submit claims for covered services directly to Medicare for you. Many providers will also submit claims for balances not covered by Medicare directly to Health Net of Oregon for you.

If the provider bills you directly for the balance, you are responsible for submitting the explanation of Medicare Benefits (EOMB) and an itemized statement to Health Net of Oregon.





To speak to a Health Net sales representative,  
please call 1-800-709-4193.

# Premium information

Health Net of Oregon can only raise your premium rate if we raise the premium for all policies like yours in the state of Oregon.

However, your premium will automatically change effective the first of the month following reaching a different premium classification.

HEALTH NET MEDICARE SUPPLEMENT PLAN A											
COUNTY		REGION									
		67 and under	68–69	70–71	72–73	74–75	76–77	78–79	80–81	82–84	85+
Baker	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Benton	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Clackamas	1	\$78	\$88	\$95	\$102	\$110	\$118	\$124	\$132	\$140	\$156
Clatsop	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Columbia	1	\$78	\$88	\$95	\$102	\$110	\$118	\$124	\$132	\$140	\$156
Coos	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Crook	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Curry	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Deschutes	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Douglas	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Gilliam	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Grant	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Harney	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Hood River	1	\$78	\$88	\$95	\$102	\$110	\$118	\$124	\$132	\$140	\$156
Jackson	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Jefferson	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Josephine	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Klamath	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166



## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN A (cont'd)											
COUNTY		REGION									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Lake	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Lane	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Lincoln	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Linn	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Malheur	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Marion	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Morrow	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Multnomah	1	\$78	\$88	\$95	\$102	\$110	\$118	\$124	\$132	\$140	\$156
Polk	2	\$82	\$92	\$100	\$108	\$116	\$124	\$131	\$138	\$148	\$164
Sherman	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Tillamook	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Umatilla	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Union	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Wallowa	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Wasco	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Washington	1	\$78	\$88	\$95	\$102	\$110	\$118	\$124	\$132	\$140	\$156
Wheeler	3	\$83	\$93	\$101	\$109	\$117	\$125	\$133	\$140	\$149	\$166
Yamhill	1	\$78	\$88	\$95	\$102	\$110	\$118	\$124	\$132	\$140	\$156

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN F											
COUNTY	REGION	AGE									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Baker	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Benton	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Clackamas	1	\$111	\$125	\$136	\$146	\$157	\$168	\$178	\$188	\$200	\$222
Clatsop	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Columbia	1	\$111	\$125	\$136	\$146	\$157	\$168	\$178	\$188	\$200	\$222
Coos	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Crook	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Curry	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Deschutes	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Douglas	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Gilliam	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Grant	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Harney	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Hood River	1	\$111	\$125	\$136	\$146	\$157	\$168	\$178	\$188	\$200	\$222
Jackson	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Jefferson	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Josephine	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Klamath	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN F (cont'd)											
COUNTY		REGION		AGE							
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Lake	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Lane	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Lincoln	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Linn	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Malheur	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Marion	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Morrow	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Multnomah	1	\$111	\$125	\$136	\$146	\$157	\$168	\$178	\$188	\$200	\$222
Polk	2	\$117	\$132	\$143	\$154	\$165	\$177	\$187	\$198	\$211	\$234
Sherman	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Tillamook	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Umatilla	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Union	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Wallowa	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Wasco	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Washington	1	\$111	\$125	\$136	\$146	\$157	\$168	\$178	\$188	\$200	\$222
Wheeler	3	\$119	\$133	\$145	\$156	\$167	\$179	\$189	\$200	\$213	\$237
Yamhill	1	\$111	\$125	\$136	\$146	\$157	\$168	\$178	\$188	\$200	\$222

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN F WITH HIGH DEDUCTIBLE											
COUNTY		REGION		AGE							
		67 and under	68–69	70–71	72–73	74–75	76–77	78–79	80–81	82–84	85+
Baker	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Benton	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Clackamas	1	\$46	\$52	\$56	\$60	\$65	\$69	\$73	\$78	\$83	\$92
Clatsop	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Columbia	1	\$46	\$52	\$56	\$60	\$65	\$69	\$73	\$78	\$83	\$92
Coos	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Crook	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Curry	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Deschutes	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Douglas	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Gilliam	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Grant	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Harney	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Hood River	1	\$46	\$52	\$56	\$60	\$65	\$69	\$73	\$78	\$83	\$92
Jackson	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Jefferson	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Josephine	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Klamath	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN F WITH HIGH DEDUCTIBLE (cont'd)											
COUNTY	REGION	AGE									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Lake	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Lane	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Lincoln	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Linn	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Malheur	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Marion	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Morrow	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Multnomah	1	\$46	\$52	\$56	\$60	\$65	\$69	\$73	\$78	\$83	\$92
Polk	2	\$48	\$54	\$59	\$63	\$68	\$73	\$77	\$82	\$87	\$97
Sherman	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Tillamook	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Umatilla	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Union	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Wallowa	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Wasco	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Washington	1	\$46	\$52	\$56	\$60	\$65	\$69	\$73	\$78	\$83	\$92
Wheeler	3	\$49	\$55	\$60	\$64	\$69	\$74	\$78	\$83	\$88	\$98
Yamhill	1	\$46	\$52	\$56	\$60	\$65	\$69	\$73	\$78	\$83	\$92

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN K											
COUNTY	REGION	AGE									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Baker	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Benton	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Clackamas	1	\$59	\$66	\$72	\$77	\$83	\$89	\$94	\$100	\$106	\$118
Clatsop	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Columbia	1	\$59	\$66	\$72	\$77	\$83	\$89	\$94	\$100	\$106	\$118
Coos	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Crook	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Curry	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Deschutes	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Douglas	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Gilliam	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Grant	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Harney	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Hood River	1	\$59	\$66	\$72	\$77	\$83	\$89	\$94	\$100	\$106	\$118
Jackson	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Jefferson	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Josephine	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Klamath	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126



## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN K (cont'd)											
COUNTY	REGION	AGE									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Lake	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Lane	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Lincoln	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Linn	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Malheur	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Marion	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Morrow	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Multnomah	1	\$59	\$66	\$72	\$77	\$83	\$89	\$94	\$100	\$106	\$118
Polk	2	\$62	\$70	\$76	\$81	\$88	\$94	\$99	\$105	\$112	\$124
Sherman	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Tillamook	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Umatilla	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Union	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Wallowa	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Wasco	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Washington	1	\$59	\$66	\$72	\$77	\$83	\$89	\$94	\$100	\$106	\$118
Wheeler	3	\$63	\$71	\$77	\$82	\$89	\$95	\$100	\$106	\$113	\$126
Yamhill	1	\$59	\$66	\$72	\$77	\$83	\$89	\$94	\$100	\$106	\$118

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN M											
COUNTY	REGION	AGE									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Baker	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Benton	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Clackamas	1	\$94	\$105	\$114	\$123	\$132	\$141	\$149	\$158	\$168	\$187
Clatsop	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Columbia	1	\$94	\$105	\$114	\$123	\$132	\$141	\$149	\$158	\$168	\$187
Coos	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Crook	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Curry	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Deschutes	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Douglas	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Gilliam	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Grant	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Harney	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Hood River	1	\$94	\$105	\$114	\$123	\$132	\$141	\$149	\$158	\$168	\$187
Jackson	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Jefferson	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Josephine	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Klamath	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199

## Premium information (cont'd)

HEALTH NET MEDICARE SUPPLEMENT PLAN M (cont'd)											
COUNTY	REGION	AGE									
		67 and under	68-69	70-71	72-73	74-75	76-77	78-79	80-81	82-84	85+
Lake	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Lane	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Lincoln	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Linn	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Malheur	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Marion	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Morrow	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Multnomah	1	\$94	\$105	\$114	\$123	\$132	\$141	\$149	\$158	\$168	\$187
Polk	2	\$98	\$111	\$120	\$129	\$139	\$149	\$157	\$166	\$177	\$197
Sherman	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Tillamook	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Umatilla	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Union	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Wallowa	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Wasco	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Washington	1	\$94	\$105	\$114	\$123	\$132	\$141	\$149	\$158	\$168	\$187
Wheeler	3	\$100	\$112	\$122	\$131	\$141	\$150	\$159	\$168	\$179	\$199
Yamhill	1	\$94	\$105	\$114	\$123	\$132	\$141	\$149	\$158	\$168	\$187

## Policy replacement

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

## Notice

This policy may not fully cover all of your medical costs.

This overview of coverage does not give all the details of Medicare coverage. For more details, contact your local Social Security Office or consult the Medicare handbook called *Medicare & You*.

Health Net of Oregon is not connected with Medicare. Health Net of Oregon agents are not connected with Medicare.

## Complete answers are important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and Health Net coverage history. The company may cancel your 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.

## Right to return policy

If you are not satisfied with your Medicare Supplemental plan, you may return the policy to Health Net Health Plan of Oregon, Inc., 13221 SW 68th Parkway, Suite 200, Tigard, Oregon 97223. If you return it within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

### CONTACT US

Health Net Health Plan of Oregon, Inc.  
13221 SW 68th Pkwy., Ste. 200  
Tigard, OR 97223  
1-888-802-7001

[www.healthnet.com](http://www.healthnet.com)

To speak to a Health Net sales representative, please call 1-800-709-4193.

If you ever have questions about your coverage, please call our Customer Contact Center at 1-888-802-7001 or email us at [service@healthnet.com](mailto:service@healthnet.com).



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HEALTH NET HEALTH PLAN OF OREGON, INC.
MEDICARE SUPPLEMENT COVERAGE APPLICATION

Please follow these application instructions:

Complete your application, provide any supporting information requested, then sign and date it where indicated.
If your spouse or Registered Domestic Partner is applying to be insured, please complete a separate application.
If your application is approved, the contract will become effective on the first of the month following the date that Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) receives your completed application and premium payment.

Upon acceptance by Health Net of Oregon, this application becomes part of your contract.

I. Check the Health Net Medicare Supplement Plan for which you are applying:

- Plan A, Plan F, Plan F with high deductible, Plan K, Plan M

II. Your Personal Information:

Form with fields for Last name, First name, Initial, Birth date, Sex, Residence address street, City, State, ZIP, Home phone, PO Box, Work phone, Social Security Number, Requested start date, Email address.

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



SAMPLE ONLY

Name:
Medicare Claim Number Sex
Is Entitled To Effective Date
HOSPITAL (Part A)
MEDICAL (Part B)

Applicant, please go to the next page

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### III. Existing insurance information

#### Note that you do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.

If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

### IV. Current health plan information

Under certain circumstances, we cannot deny you enrollment under this policy. In general, this applies when you have recently terminated coverage under a prior policy. To qualify for a Health Net of Oregon Medicare supplement policy, your prior coverage and manner of termination must meet certain requirements. You must also enroll under the Health Net of Oregon plan (and provide proof of termination of the previous plan) within 63 days of that termination.

#### To determine if you qualify, please answer the following questions to the best of your knowledge:

Did you turn age 65 in the last six months?  Yes  No

Did you enroll in Medicare Part B in the last six months?  Yes  No

If "Yes," what was the effective date? \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(MM / DD / YYYY)

Are you covered for medical assistance through the state Medicaid program?  Yes  No

**Note to applicant:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question. If "Yes,"

(a) Will Medicaid pay your premiums for this Medicare supplement policy?  Yes  No

(b) Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?  Yes  No

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**IV. Current health plan information (continued)**

If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" section blank.

Start \_\_\_\_/\_\_\_\_/\_\_\_\_ End \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM / DD / YYYY) (MM / DD / YYYY)

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?  Yes  No

Was this your first time in this type of Medicare plan?  Yes  No

Did you drop a Medicare supplement policy to enroll in the Medicare plan?  Yes  No

Do you have another Medicare supplement policy in force?  Yes  No

If so, with what company, and what plan do you have? \_\_\_\_\_

If so, do you intend to replace your current Medicare supplement policy with this policy?  Yes  No

Have you had coverage under any other health insurance within the past 63 days?  Yes  No  
(For example, an employer, union, or individual plan.)

If so, with what company and what kind of policy? \_\_\_\_\_

What are your dates of coverage under the other policy?

Start \_\_\_\_/\_\_\_\_/\_\_\_\_ End \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM / DD / YYYY) (MM / DD / YYYY)

If you are still covered under the other policy, leave "End" section blank.

Are you covered for medical assistance through the state Medicare program as (1) a Specified Low Income Medicare Beneficiary (SLMB), (2) a Qualified Medicare Beneficiary (QMB), or (3) for other Medicaid medical benefits?

Yes  No

**V. Health Statement Requirement/Medicare Supplement Open Enrollment and Guaranteed Issue Periods**

If you are in a Medicare Supplement Open Enrollment Period (OEP) or think you qualify for guaranteed issuance of a Medicare Supplement plan, please check the appropriate OEP or Guaranteed Issue Period below.

If you check one or more of the boxes below, you do NOT need to complete Section VI, the "Current health statement" portion of this application.

Please attach any supporting documents related to your OEP or Guaranteed Issue Period.

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 under age 65 and newly entitled to Medicare Part B because of disability.

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.

You disenrolled from a Medicare Supplement Plan to enroll for the first time in a Medicare Select or Medicare Advantage Plan, and then voluntarily disenrolled within 12 months of coverage.

You enrolled in a Medicare Advantage Plan, but coverage was terminated because the Plan terminated its Medicare Advantage contract, or the Plan discontinued offering coverage in your service area, or you no longer reside in the Medicare Advantage service area.

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**V. Health Statement Requirement/Medicare Supplement Open Enrollment and Guaranteed Issue Periods (continued)**

- You are enrolled in Medicare Part B, and have received a notice of termination or have been terminated from an employer-sponsored health plan, employer-sponsored retiree health plan (including coverage under COBRA), or are no longer eligible for employer-sponsored health plan coverage due to the divorce or death of a spouse.
- You are enrolled in Medicare Part B and enrolled in a Medicare Select Plan, but you can no longer retain the coverage because you moved outside the plan’s service area.
- You enrolled in a Medicare Supplement Plan but coverage stopped because the company filed 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 enrolled in a Medicare Advantage Plan but stopped coverage because the company, or an agent acting on its behalf, materially misrepresented a provision of the plan.

**If you checked any of the boxes above,** do not complete the health statement that follows. Go to page 6. Complete Section VII, “Payment options.” Read, sign and date Section VIII, “Conditional authorization to use and disclose Protected Health Information” section.

**If you have not checked any of these boxes,** you must complete Section VI, “Current health statement.”

**NOTE:** If you are transferring from one Health Net of Oregon Medicare Supplement plan to another Health Net of Oregon Supplement plan, you must complete the health statement below and on the next two pages.

If you are unsure if you should complete the health statement, please call **1-800-709-4193 (TTY 1-800-929-9955)** for help from a Health Net Sales Representative.

**VI. Current health statement**

**Genetic Information and Non-discrimination Act of 2008 (GINA) compliance statement**

This insurance application is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

**Answer the following health questions to the best of your knowledge. If you need more space for additional information, please attach a separate sheet.**

Current height:	Current weight:
-----------------	-----------------

**Medications:** List all medications that you are currently taking.

Medication name	Name/address/telephone of prescriber	Date prescribed

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Date of last treatment</b>
Alcohol/chemical/drug abuse/habit	<input type="checkbox"/>	<input type="checkbox"/>	
Liver condition/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Knee/shoulder/hip/other joints	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes/sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach disorders/ulcer/acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder/urinary tract	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive system disorder/infertility	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate/elevated PSA/prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS/ARC/HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus/chronic muscle pain/muscle injury or disease, or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition/disease/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke/paralysis/seizures	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure (If "Yes," please record last reading.): _____	<input type="checkbox"/>	<input type="checkbox"/>	
Heart/chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine/gland/hormone system	<input type="checkbox"/>	<input type="checkbox"/>	
Disease or injury of eye/cataract/glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic ear/nose/throat/tonsil condition/disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema/asthma/chronic lung disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	

**Additional health questions**

Have you had any medical advice, diagnosis, care or treatment – including prescribed medications – recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above?  Yes  No

Have you had chronic cough, fatigue, diarrhea or enlarged glands?  Yes  No

Have you been advised to have or contemplated having an operation or medical procedure not yet performed?  Yes  No

Have you been scheduled to see a health care provider?  Yes  No

Have you taken any prescription medication on a regular basis?  Yes  No

**VII. Payment options**

**Initial payment:**

You will be billed for your initial premium upon acceptance.

**Future payment (check box):**

Mail-in premium payment  Automatic Bank Draft/Premium payment

**Health Net of Oregon may change or amend this policy upon prior approval from the Oregon Insurance Division by giving the subscriber thirty (30) days’ notice before the change is effective.**

**VIII. Certification of completion and correctness**

I affirm that the answers given in this application are complete and correct. I have provided these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

**Conditional authorization to use and disclose Protected Health Information**

**Note: All applicants must sign and date the following authorization.**

*To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:*

I authorize you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about me. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed, and it remains in effect as follows:

- For information used to process this application – 30 months.
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

Printed name: \_\_\_\_\_

Date: \_\_\_\_\_

Applicant’s signature: \_\_\_\_\_

(MM / DD / YYYY)

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**INSURANCE PRODUCER USE ONLY**

I certify that the information supplied by the applicant has been truly and accurately recorded and that I have made no representation about benefits, conditions, or limitations of the contract except through written material furnished by Health Net of Oregon. I have provided the applicant with a notice regarding replacement of Medicare supplement coverage if applicable.

Sales Rep name (please print):

Phone: (            )

Sales Rep ID #:

Sales Rep signature:

Insurance Producer name (please print):

Phone: (            )

Producer ID #:

Email address:

FMO/GA/Agency name:

FMO/GA/Agency ID #:

Insurance Producer signature:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM / DD / YYYY)**Health Net®**

Health Net Health Plan of Oregon, Inc.  
13221 SW 68th Pkwy., Ste. 200  
Tigard, OR 97223

To speak to a Health Net Sales Representative,  
please call **1-800-709-4193 (TTY 1-800-929-9955)**.

**[www.healthnet.com](http://www.healthnet.com)**

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# Automatic Bank Draft Authorization Form

Health Net Medicare Supplement

Subscriber / Reference ID #		Medicare claim #:		Group #:	
Subscriber last name:			First name:		MI:
Subscriber street address:					
City:		State:	ZIP:	Home telephone #: ( _ _ _ ) _ _ - _ _ _ _	
<i>Billing information</i>					
Account holder name (if different):			Account holder telephone # (if different): ( _ _ _ ) _ _ - _ _ _ _		
Account holder address (if different):			City:	State:	ZIP:
The monthly premium charge can be withdrawn directly from your personal checking or savings account. Please select your account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings					
Transit routing number (9 digits):			Account #:		
Bank name:					
City:			State:	ZIP:	
Signature of account holder (required to process):					

I hereby authorize Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) to debit the account shown above for my (the subscriber's) Health Net of Oregon coverage when my premium payment is due. I authorize the bank or financial institution shown above to accept such debits without responsibility for their correctness.

I may terminate this Automatic Bank Draft Authorization at any time by giving Health Net of Oregon written notification of termination or by calling **1-888-802-7001 (TTY/TDD 1-800-929-9955)** Monday through Friday, 7:30 a.m. to 5:00 p.m., except holidays, to request termination. I understand that such notification will become effective after Health Net of Oregon has received the termination request and has had a reasonable amount of time to act on it (up to approximately thirty (30) days).

If the amount of my Health Net of Oregon premium should change for any reason, I will be notified in writing by Health Net of Oregon at least thirty (30) calendar days prior to my account being debited.

Please mail this form to: Health Net Health Plan of Oregon, Inc.  
Medicare Supplement Enrollment Services  
PO Box 10420  
Van Nuys, CA 91410-0420

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Subscriber last name:	First name:	MI:
Medicare claim #:		

Automatic Bank Draft (ABD) transmissions are submitted to the bank on approximately the 6th of every month for that month's premium. Therefore, your premium should be submitted with your request for ABD, and/or manual payment should continue to be submitted to Health Net of Oregon by the first of the month for each month, until such time that you receive confirmation of ABD commencement in writing from Health Net of Oregon.

In the interim, if a manual payment is received after the bank transmission has occurred (the 6th of the month), it may not be captured on the ABD transmit to the bank. Consequently, based upon the outstanding balance due at the time of transmission, your account may be drafted for more than one month's premium payment. If this occurs, your Health Net of Oregon account will reflect the collected manual and automatic withdrawal premiums on the current billing statement/period. Conversely, if you manually pay your premium due before the 6th of the month, your payment may be processed, whereby there will be no outstanding balance for the ABD to draft or process.

Once any outstanding balance is collected (if applicable), only your monthly premium will be deducted from your account on, or about, the 6th of the month for which payment is due. **Insufficient funds on Automatic Bank Drafts are subject to a \$15.00 return fee.**

Subscriber signature:	Date:
Additional signature (as needed):	Date:

Please include a voided bank check with your authorization.  
This will be used to verify bank information.

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# Notice to Applicant Regarding Replacement of Medicare Supplement Insurance

**SAVE A COPY OF THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Health Net Health Plan of Oregon, Inc. Your new policy allows 30 days with which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, PRODUCER OR OTHER REPRESENTATIVE:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage Plan. The replacement policy is being purchased for the following reason or reasons:

- Additional benefits that are: \_\_\_\_\_
- No change in benefits, but lower premiums
- Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
- Disenrollment from a Medicare Advantage Plan. Reasons for disenrollment:  
\_\_\_\_\_
- Fewer benefits and lower premiums
- Other reasons specified here: \_\_\_\_\_

If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

State law provides that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy or coverage for similar benefits to the extent such a time period was spent or depleted under the original policy.

*(continued)*

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If you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

Applicant's signature:	Date:
Printed name of applicant:	
Medicare claim #:	
Signature of insurance producer or representative (not required for direct response sales):	Date:
Printed name of insurance producer or representative:	

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# Informed Consent Form

*for Medicare Supplement Plans*

## *HIV Antibody Test*

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

### **What you need to know:**

Before you consent to testing, please read the following important information:

1. **Purpose:** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive test results:** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. **Accuracy:** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
  - a. **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
  - b. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.
4. **Possible adverse effects of test:** A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

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5. **Disclosure of results:** A positive test result will be disclosed to you or the physician or county health department that you designate.
6. **Confidentiality:** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. Certain disclosures of your test results may occur, however, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, oral specimen or urine test may be reported to the Medical Information Bureau, a national insurance data bank, as a nonspecific abnormality determined by the testing of blood, oral specimen or urine.
7. **Prevention:** Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information:** Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at **(503) 223-AIDS** and outside the Portland area at **1-800-777-AIDS**. Health insurance may be available through the Oregon Medical Insurance Pool for persons who are not otherwise able to obtain coverage. The telephone number for the Oregon Medical Insurance Pool is **1-800-848-7280**.

I have read the above information, or it has been read to me in my primary language. By signing, I indicate that I understand the information about HIV/AIDS and the HIV test, and I have been given full opportunity to ask questions and received satisfactory answers to my questions.

*A consent form signed by an applicant is valid for six months following the date that the consent form was signed. If, after six months, the test is not performed or retesting is needed, a new signed consent form must be obtained.*

Printed name of applicant: \_\_\_\_\_

Signature of applicant: \_\_\_\_\_ Date: (\_\_\_\_/\_\_\_\_/\_\_\_\_)  
M M / D D / Y Y Y Y

Medicare claim #: \_\_\_\_\_

Signature of person explaining consent (if applicable): \_\_\_\_\_ Date: (\_\_\_\_/\_\_\_\_/\_\_\_\_)  
M M / D D / Y Y Y Y

I authorize the following person(s), other than those permitted by Oregon law, to receive the test results. If none, specify "None."

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

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