



**Health Net Life Insurance Company
Medicare Supplement Plan
Policy/Certificate**

PLAN G

Table of Contents

NOTICE TO BUYER:	5
TERM, RENEWABILITY AND CONTINUATION PROVISIONS	5
COVERED PERSON'S RIGHT TO CANCEL.....	5
NOTICE TO MEDICARE SUPPLEMENT PLAN POLICYHOLDER.....	6
DEPARTMENT OF INSURANCE	6
GRIEVANCE AND ARBITRATION.....	7
APPEAL TO MEDICARE.....	8
COVERED SERVICES	9
EXTENSION OF BENEFITS	10
EXCLUSIONS.....	10
DEFINITIONS	10
AUTOMATIC ADJUSTMENT WITH MEDICARE BENEFIT CHANGES	11
ELIGIBILITY PROVISIONS	12
SUSPENSION OF BENEFITS AND PREMIUM	12
TERMINATION PROVISIONS	13
GRACE PERIOD	13
PREMIUM	14
KEY ITEMS TO REMEMBER	14
REGULATION	14
ENDORSEMENT OF CHANGE	14

BENEFITS NOT TRANSFERABLE	14
TIME LIMIT ON CERTAIN DEFENSES	15
NOTICE	15
NONDISCRIMINATION	15

NOTICE TO BUYER:

THIS MEDICARE SUPPLEMENT PLAN POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

TERM, RENEWABILITY AND CONTINUATION PROVISIONS

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. Health Net Life (HNL) reserves the right to change your premium if it raises the premium for all policies like yours in California. Premium changes will occur periodically as you attain an age requiring a rate increase. The renewal premium for the Medicare Supplement Plan Policy will be adjusted on the first day of the month you attain an age requiring a premium change. You will receive written notification of any upcoming changes in premium at least 30 days prior to the effective date of the new rate.

This Medicare Supplement Plan Policy is guaranteed renewable and noncancelable. HNL will not cancel or nonrenew this Medicare Supplement Plan Policy solely on the grounds of the health status.

COVERED PERSON'S RIGHT TO CANCEL

IF, AFTER EXAMINATION OF THIS DOCUMENT, YOU ARE NOT SATISFIED FOR ANY REASON, YOU HAVE THE RIGHT TO CANCEL YOUR MEDICARE SUPPLEMENT PLAN POLICY. 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.

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 Life 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:

Health Net Life Claims
P.O. Box 14702
Lexington, KY 40512

You may request a Health Net claim form by contacting the Member Services number provided on your identification card or you can access the claim form on our website www.healthnet.com.

NOTICE TO MEDICARE SUPPLEMENT PLAN POLICYHOLDER

This Medicare Supplement Plan Policy is designed to supplement Medicare benefits in and out of the Hospital. This Medicare Supplement Plan Policy pays certain Hospital and Medical expenses, not payable by Medicare. Read this Medicare Supplement Plan Policy Certificate carefully to learn the important details of the coverage provided.

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
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013
1 (800) 927-HELP**

GRIEVANCE AND ARBITRATION

Please Note: Medicare has specific procedures for the portion of the bill they pay. For additional information, please see the “Appeal to Medicare” section of this Medicare Supplement Plan Policy Certificate.

Grievance Procedures

If you are not satisfied with the efforts to solve a problem with HNL, you must first file a grievance and/or appeal against HNL by calling our Member Services Department at **1-800-926-4178**. You may also file your complaint in writing by sending information to:

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

Please include all the information from your HNL Medicare Supplement Plan Identification Card (ID card) and the details of the concern or problem.

We will:

- Confirm in writing within five business days that we received your request.
- Review your complaint and inform you of our decision in writing within 30 days.
- Inform you if additional time is necessary to complete our investigation.

If you continue to be dissatisfied after the grievance procedure has been completed, you may then initiate binding arbitration, as described below. Binding arbitration is the final process for the resolution of disputes.

Final Step – Neutral, Binding Arbitration

If you or your personal representative does not agree with the HNL determination, you or your personal representative can request neutral, binding arbitration in accordance with the California Arbitration Act (California Code of Civil Procedure Sections 1280, *et seq.*).

Arbitration is the final process for resolving any dispute between you and HNL, which arise out of or relate to coverage under this Medicare Supplement Plan Policy.

As a condition of coverage under this Medicare Supplement Plan Policy, you agree that disputes will be decided by neutral arbitration, and also agree to give up your right to a jury or court trial for the settlement of disputes. The decision of the arbitrator shall be final and binding.

To initiate arbitration proceedings, you serve a written demand for arbitration to HNL at the following address:

Health Net Life
Litigation Administrator
Post Office Box 4504
Woodland Hills, CA 91365-4505

The written demand shall contain a detailed statement of the matter and the facts supporting the demand and include copies of all related documents. The arbitration shall be conducted at a mutually agreed location by a single, neutral arbitrator who is licensed to practice law. The parties shall select a neutral arbitrator to conduct the arbitration.

At least 30 days before the arbitration, the parties must exchange lists of witnesses, including any experts, and copies of all exhibits to be used at the arbitration.

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 Medicare Supplement Plan Policy.

APPEAL TO MEDICARE

In addition to the above procedures, Medicare has specific appeals procedures for the portion of the bill they pay. Please contact Medicare at **1-800-MEDICARE (1-800-633-4227)** for information regarding appeals.

COVERED SERVICES

All services or treatment determined to be medically necessary and covered by Medicare will also be considered medically necessary and covered by HNL and the applicable coinsurance and deductibles will be covered. Services or treatment not approved or covered by Medicare will only be paid by HNL if specified under this section of the Medicare Supplement Plan Policy Certificate.

If you are enrolled in this health plan, you are entitled to the benefits described in this section.

Hospital Expenses as follows:

- Coverage of Part A Hospital Medicare Eligible Expenses incurred to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
- Coverage of Part A Hospital Medicare Eligible Expenses incurred to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
- Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, coverage of Part A Hospital Medicare Eligible Expenses, subject to a lifetime maximum benefit of an additional 365 days.

Blood: Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

Hospice: Coverage of the cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Medical Expenses: Coverage for the coinsurance or copayment (outpatient hospital services) amount of Medicare Eligible Expenses under Part B regardless of Hospital confinement after you have paid the \$147 Medicare Part B deductible.

Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

Part B Excess Charges: Coverage for all of the differences between the actual Medicare Part B charge as billed, not to exceed any limiting charge established by the Medicare program or State law, and the Medicare approved Part B charge.

Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which would have been covered by Medicare if provided in the United States and which 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

dollar benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Skilled Nursing Facility Care: 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.

EXTENSION OF BENEFITS

Termination of this Medicare Supplement Plan Policy shall be without prejudice to any continuous loss which commenced while the Medicare Supplement Policy was in force. However, the extension of benefits beyond the period during which the Medicare Supplement Plan Policy was in force is subject to the Covered Person's continuous total disability, and is limited to the duration of the Medicare Supplement Plans Policy's Benefit Period, or any payment of the maximum benefits.

EXCLUSIONS

This Medicare Supplement Plan Policy does not cover any expenses not covered by Medicare except as otherwise specified in this Medicare Supplement Plan Policy Certificate.

DEFINITIONS

Agreement: The HNL Medicare Supplement Plan Policy Certificate, Outline of Coverage, Individual Application and Statement of Health, Notice of Acceptance, HNL Medicare Supplement Plan ID card and any addenda, endorsements or amendments thereto, are hereby incorporated by reference as if set forth in full herein.

Benefit Period: The way that Medicare measures your use of Hospital and Skilled Nursing Facility services. A benefit period begins the day you go to a Hospital or Skilled Nursing Facility. The benefit period ends when you have not received Hospital or Skilled Nursing care for 60 days in a row. There is no limit to the number of benefit periods you can have.

Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility: Facilities as defined in the Medicare program.

Covered Person: An individual who meets all applicable eligibility requirements, is enrolled hereunder and for whom the required premium actually have been received and accepted by HNL.

Covered Services: Medicare approved services and other health care services covered under this health plan.

Deductible: A set amount you pay each Calendar Year for specified Covered Expenses before Health Net pays any benefits for those Covered Expenses.

Hospital: A facility approved by Medicare as a hospital or approved by Medicare for Medicare hospital benefits.

It does not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent hospital, a place for rest or the aged, a facility for drug addicts or alcoholics.

A Skilled Nursing Facility as defined under Medicare, is not considered a Hospital.

Medicare: The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, Title I, Part I of Public Law 89-97, enacted by the 89th United States Congress; as then constituted or as later amended.

Medicare Eligible Expenses: Expenses of the kind covered by Medicare Parts A and B.

Physician: A doctor of medicine (M.D.) or osteopathy (D.O.) or other provider as defined by Medicare who is licensed to practice where the care is provided and who is approved by Medicare.

Sickness: Illness or disease.

Skilled Nursing Facility: A facility that provides skilled nursing or rehabilitation services to help you recover after a Hospital stay.

AUTOMATIC ADJUSTMENT WITH MEDICARE BENEFIT CHANGES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment or coinsurance amounts. The amount of the premium may be modified upon 30 days' notice.

All services or treatment determined to be medically necessary by Medicare will also be considered medically necessary by HNL and the applicable coinsurance and deductibles will be covered.

ELIGIBILITY PROVISIONS

You are eligible for enrollment in this health plan if you are 65 or older or under 65 and entitled to Medicare on the basis of receiving Social Security disability benefits but do not have end-stage renal disease (ESRD), are enrolled in Medicare Parts A and B, and reside within the State of California at the time of enrollment. 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**.

Completion of an application and health statement is required and enrollment requires underwriting approval except when you qualify under the rules of guaranteed issuance set out in the California insurance code.

SUSPENSION OF BENEFITS AND PREMIUM

Benefits and premium under this Medicare Supplement Plan Policy shall be suspended at your request for the period (not to exceed 24 months) in which you have applied for and been determined to be entitled to medical assistance under Title XIX of the federal Social Security Act (known as Medi-Cal in California), but only if you notify HNL within 90 days after the date you become entitled to such assistance. Upon receipt of timely notice, HNL shall return to you that portion of the premium attributable to the period of Medi-Cal eligibility, subject to adjustment for paid claims.

If such suspension occurs and if you lose entitlement to such medical assistance, this Medicare Supplement Plan Policy shall be automatically reinstated effective as of the termination of such entitlement. You must provide notice of loss of such entitlement 90 days after the date of such loss and pay the premium attributable to the period, effective as of the date of termination of such entitlement or equivalent coverage shall be provided if the prior form is no longer available.

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 were 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 pro-rated 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.

PREMIUM

This health plan offers various payment options for your convenience. If you choose to pay monthly, you will receive a statement approximately the 15th of the month prior to the month the premium is due. Automatic Bank Draft is available whereby a monthly payment is automatically withdrawn from your bank or financial institution approximately on the 6th of each month. The amount of the premium is set forth in the Outline of Coverage you have received separately. Returned checks or insufficient funds on Automatic Bank Drafts are subject to a \$15.00 return fee.

KEY ITEMS TO REMEMBER

- An identification card will be issued by HNL. Carry your HNL Medicare Supplement Plan ID card with you at all times. Present your card each time you visit a provider or obtain medical services.
- When you receive an Explanation of Medical Benefits from Medicare for services provided by any provider, keep it for your records.
- When you have questions or problems, call us. The Member Services Department telephone number is listed on your HNL Medicare Supplement Plan ID card.

REGULATION

This HNL Plan is subject to the requirements of the California Insurance Code and its implementing regulations which are applicable to Medicare Supplement plans. Any provisions required to be in this Medicare Supplement Plan Policy by either of the above sources of law shall bind HNL whether or not provided in this Medicare Supplement Plan Policy Certificate.

ENDORSEMENT OF CHANGE

No agent of HNL, is authorized to change the form or content of this Medicare Supplement Plan Policy Certificate in any manner or degree other than by duly executed endorsement issued to form a part hereof.

BENEFITS NOT TRANSFERABLE

No person other than the Covered Person is entitled to receive benefits to be furnished by HNL under this Medicare Supplement Plan Policy. Such right to benefits is not transferable.

TIME LIMIT ON CERTAIN DEFENSES

After this Medicare Supplement Plan Policy has been in force for a period of two years, no statements relating to insurability made by any Covered Person eligible for coverage under this Medicare Supplement Plan Policy can be contested or used to deny any claim.

NOTICE

Any notice required of HNL shall be sufficient if mailed to the Covered Person at the address appearing on the records of HNL; and if notice is required of the Covered Persons, it will be sufficient if mailed to Member Services, P.O. Box 10198, Van Nuys, CA 91410.

NONDISCRIMINATION

HNL hereby agrees that no person who is otherwise eligible for coverage under this Medicare Supplement Plan Policy shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age health status, or physical or mental handicap.

For more information, please contact us at:

Health Net Life Insurance Company
Medicare Supplement Plan
Member Services
Post Office Box 10198
Van Nuys, California 91410

Member Services
1-800-926-4178

Para los que hablan español
1-800-926-4178

Telecommunications Device for the Deaf
1-800-929-9955