Health Net
MEDICARE PROGRAMS

Health Net Medicare Advantage Plans
2012 Optional Supplemental Benefit
Individual Enrollment Form

Health Net offers Optional Supplemental Benefits for an additional monthly premium. This form may be used only by our current members who are adding the Optional Supplemental Benefits Package to their existing Health Net Medicare Advantage plan or who are already enrolled in an Optional Supplemental Benefit Package and are switching to a different package option. Please review the plan package options listed on the back of this form before enrolling. Premium for optional supplemental benefits is paid in addition to the monthly plan premium and the Medicare Part B premium. Please keep the pink copy of this form as your temporary ID card until your new ID card is mailed to you.

Print name:_____		
Signature:_____		Date: (___ ___/___ ___/___ ___ ___ ___) M M / D D / Y Y Y Y
Your personal information:		
First name:	Middle initial:	Last name:
Home address:		
City:	State:	ZIP:
Mailing address (if different from above):		
Home telephone: ( ) –	Email address:	☐ Male Gender: ☐ Female
Date of birth: (___ ___/___ ___/___ ___ ___ ___) M M / D D / Y Y Y Y	Preferred language: ☐ English ☐ Other: _____	
Medicare #: *(from red, white and blue Medicare card)*	Health Net member/subscriber reference number:	

After you have completed this form, please mail it to:
Health Net of California, Inc.
PO Box 10420
Van Nuys, CA 91410-0420

Please complete this section if you are enrolling in an Optional Supplemental Benefits Package: I am currently enrolled in a Health Net Medicare Advantage plan paying a monthly plan premium of $_____, and wish to enroll in the Optional Supplemental Benefits Package #___ for an additional monthly premium of $_____.

Please complete this section if you are a current member and are switching Optional Supplemental Benefits Packages:
I am currently enrolled in a Health Net Medicare Advantage plan AND Optional Supplemental Benefits Package #___ and wish to switch to Optional Supplemental Benefits Package #___ for an additional monthly premium of $_____.

Please do not use this form to change Health Net Medicare Advantage Plans.

White Copy – Health Net Yellow Copy – Writing Agent Pink Copy – Member

6025675 CA78456 (9/11)
Material ID # Y0035_2012_0347 (H0562, H5439) CMS Approved 11142011

If choosing Package Plan #1 or Package Plan #3, please make a dental provider selection from the Health Net Dental provider directory. Provider name: _____ Provider ID #: _____

Please see the last page of this form for the Optional Supplemental Benefits Packages that are available with your Health Net Medicare Advantage plan.

I understand that to be eligible for the Optional Supplemental Benefits Package, I must remain a member of a Health Net Medicare Advantage plan. If I disenroll from my plan, I will be automatically disenrolled from the Optional Supplemental Benefits Package. If I discontinue payment of the Optional Supplemental Benefits Package, my membership in the Optional Supplemental Benefits Package will be terminated, and I will be automatically enrolled in the standard Health Net Medicare Advantage plan.

You may disenroll at any time from this option by providing written notice to Health Net, but once disenrolled, reenrollment during the same calendar year will be limited. The available election periods for the Optional Supplemental Benefits are from October 15, 2011, through December 31, 2011, for a January 1, 2012, effective date; January 1, 2012, through January 31, 2012, for a February 1, 2012, effective date; or from May 15, 2012, through June 30, 2012, for a July 1, 2012, effective date.

When electing the HMO option, you understand that beginning with the effective date of coverage for this Optional Supplemental Benefits Package, in order for services to be covered, you must obtain those services through Health Net contracted providers, with the exception of emergency, urgently needed services as described in the Summary of Benefits or Evidence of Coverage. The PPO Optional Supplemental Benefits Package provides two levels of coverage. In-network coverage applies when you receive services from providers within the network. Out-of-network coverage applies when you receive covered services from providers who do not participate in the network. Your cost sharing will usually be lower when utilizing in-network providers than when accessing care out-of-network. To obtain these services at the in-network level of coverage, please refer to the Summary of Benefits or Evidence of Coverage (EOC) for the plan.

If a Health Net provider denies a request for service or payment of a claim, you may appeal the denial decision by using the Medicare appeals process as described in your Evidence of Coverage (EOC). Health Net will notify you when your effective date of coverage begins.

Go Paperless! Please select which of the following Medicare materials you would like to receive online instead of by U.S. Mail:

☐ I want to receive all available documents online, not by U.S. Mail.

☐ Explanation of Benefits (EOB)

☐ Standardized Annual Notice of Change /Evidence of Coverage (ANOC/EOC)

☐ Post Enrollment Materials (Abridged Formulary, Provider Directory, Pharmacy Directory)

☐ Directory Change Pages

☐ All future available documents (You will be notified via email when a new online document type becomes available.)

You acknowledge and agree that by selecting the document(s) above, you are consenting to receive electronic delivery via www.healthnet.com, and to stop U.S. Mail delivery of the paper versions of the document(s) selected above. You agree that your consent, when issued electronically by use of your personal information or passwords, bears the same legal authority as your written signature and is binding by law. The documents selected above will be delivered to you online at www.healthnet.com, instead of by U.S. Mail. In order for us to deliver the selected documents to you electronically, you must provide us with your email address where indicated on the first page.

White Copy – Health Net Yellow Copy – Writing Agent Pink Copy – Member

We will email you when a new document is available. To view documents online, you'll need to register and log on to www.healthnet.com using your user name and password. You may change your document delivery preferences at any time online or by calling Health Net at the number listed on this form.

Release of information:

I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan, and I allow the Plan, Plan's doctors and clinics, or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program. I also give the Plan authorization to release necessary or other relevant information about me to service providers.

I understand that my signature on this application means that I have read and understand the contents of this application and agree to abide by the plan rules concerning the Optional Supplemental Benefits Plans. (Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with Health Net.)

Print name: _____		
Signature: _____		Date: (___ ___/___ ___/___ ___ ___ ___) M M / D D / Y Y Y Y
If you are the authorized representative, you must provide the following information:		
First name:	Middle initial:	Last name:
Address:		
City:	State:	ZIP:
Relationship to applicant:	Phone number: (_____)_____–_____	

Thank you for choosing Health Net. If you have questions regarding Health Net Seniority Plus (HMO) or Healthy Heart (HMO), please call 1-800-275-4737 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., seven days a week. If you have questions regarding Health Net Violet (PPO), please call 1-800-960-4638 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., seven days a week.

Office use only

Group #:	Effective date:
Correction of member information:	

This information is available for free in other languages. Please contact our customer service number at 1-800-275-4737 for additional information. Our hours of operation are 8:00 a.m. to 8:00 p.m., seven days a week. TTY/TDD users call 1-800-929-9955.

Esta información está disponible en forma gratuita en otros idiomas. Comuníquese con el número de nuestro servicio al cliente al 1-800-275-4737 para obtener información adicional. Nuestro horario de atención es de 8:00 a.m. a 8:00 p.m., los siete días de la semana. Los usuarios de TTY/TDD deben llamar al 1-800-929-9955.

本資訊備有其他語言版本，可免費提供。請致電 1-800-275-4737 向我們的客戶服務部查詢其他資訊。
每週 7 天，每天上午 8:00 到下午 8:00 均提供服務。聽 / 語障人士請致電 1-800-929-9955。

6025675 CA78456 (9/11)

White Copy – Health Net Yellow Copy – Writing Agent Pink Copy – Member

Please review the plan package options before enrolling in an optional supplemental benefits package.

Health Net Seniority Plus Green (HMO), Health Net Seniority Plus Ruby (HMO), Health Net Healthy Heart (HMO) and Health Net Violet (PPO) Optional Supplemental Benefit Plan Packages:

Counties	Green Plan	Healthy Heart Plan	Ruby Plan	Violet Plan
Alameda	Plan #1 or Plan #2	Plan #1 or Plan #2		
Contra Costa	Plan #1 or Plan #2	Plan #1 or Plan #2		Plan #4
Fresno		Plan #1 or Plan #2		
Kern			Plan #1 or Plan #2	
Los Angeles		Plan #3 or Plan #5[2]	Plan #1 or Plan #2	
Orange		Plan #3 or Plan #5[2]	Plan #1 or Plan #2	
Placer[1]	Plan #1 or Plan #2	Plan #1 or Plan #2		
Riverside		Plan #3 or Plan #5[2]	Plan #1 or Plan #2	
Sacramento	Plan #1 or Plan #2	Plan #1 or Plan #2		Plan #4
San Bernardino		Plan #3 or Plan #5[2]	Plan #1 or Plan #2	
San Diego		Plan #3 or Plan #5[2]	Plan #1 or Plan #2	Plan #4
San Francisco	Plan #1 or Plan #2	Plan #1 or Plan #2		
San Joaquin	Plan #1 or Plan #2		Plan #1 or Plan #2	
San Mateo	Plan #1 or Plan #2	Plan #1 or Plan #2		
Santa Barbara[1]	Plan #1 or Plan #2			
Santa Clara	Plan #1 or Plan #2		Plan #1 or Plan #2	
Santa Cruz	Plan #1 or Plan #2			
Solano	Plan #1 or Plan #2	Plan #1 or Plan #2		
Sonoma	Plan #1 or Plan #2	Plan #1 or Plan #2		
Stanislaus	Plan #1 or Plan #2	Plan #1 or Plan #2		
Yolo	Plan #1 or Plan #2	Plan #1 or Plan #2		

Please refer to the Summary of Benefits or Evidence of Coverage for detailed information, service areas, benefits premium and costs associated with each plan. Some plans are not available in all service areas.

Package Plan #1 Monthly plan premium: $19
Benefits: Chiropractic/Acupuncture, HMO Comprehensive Dental, Eyewear and Health Club Membership/Fitness

Package Plan #2 Monthly plan premium: $29
Benefits: Chiropractic/Acupuncture, PPO Dental, Eyewear and Health Club Membership/Fitness

Package Plan #3 Monthly plan premium: $17
Benefits: Chiropractic/Acupuncture, HMO Comprehensive Dental and Eyewear[2]

Package Plan #4 Monthly plan premium: $27
Benefits: Chiropractic/Acupuncture, PPO Dental and Eyewear

Package Plan #5 Monthly plan premium: $27
Benefits: Chiropractic/Acupuncture, PPO Dental and Eyewear[2]

[1]Indicates partial county.

[2]Health Club Membership/Fitness is available as a general benefit and is not included in the Optional Supplemental Benefit Plan Packages.

6025675 CA78456 (9/11)