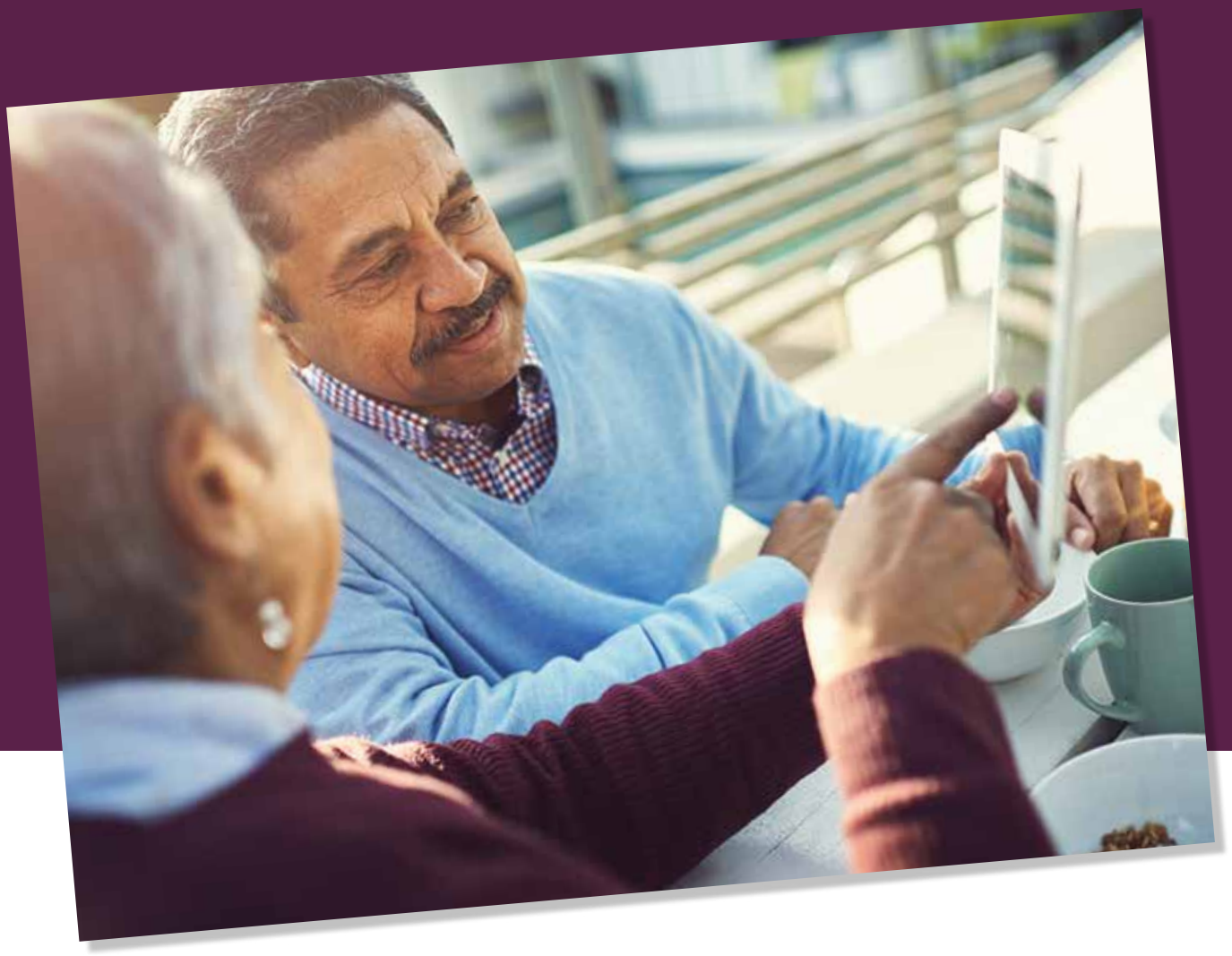
Spotlight on Medicare



Administrative Enrollment Guide for Employers in California

Health Net®
MEDICARE PROGRAMS

For more than 35 years, Health Net has provided Californians with a variety of health care services and benefit programs. Championing solutions that meet the varied coverage needs of workforces like yours isn't just our business – It's our passion. Supporting individuals and families through all stages of life gives us a deep understanding of the unique needs of our members.

For the purposes of this guide, the term "Health Net" means both Health Net of California, Inc. and Health Net Life Insurance Company, except where specifically stated.

Health Net®
MEDICARE PROGRAMS

Table of Contents

Health Net is committed to being a health plan that is easy to do business with. This guide will give you an overview of what to expect when your former employees enroll in one of Health Net's Group Retiree plans.

If you need additional information, please call the Account Services Unit (ASU) at **1-800-547-2967**.

Overview of Group Retiree Health Plan Options

This guide has been designed as a resource tool for Employer Group Retiree plan administrators. Enclosed you will find an overview of Health Net's pre- and post-enrollment processes, tools, resources available to you and your employees, important deadlines and dates, and much more.

Health Net offers a variety of Group Retiree plan types, including:

1. **Medicare Advantage (MA-only)/Seniority Plus**
   - Medical benefits only.
   - Members must go to a doctor within the Health Net network of physicians.
2. **Medicare Advantage Prescription Drug (MAPD)/Seniority Plus**
   - Medical and Part D (prescription) benefits.
   - Members must go to a doctor within the Health Net network of physicians.
3. **Medicare Coordination of Benefits (Medicare COB) and Medicare Part D Prescription Drug Plans (PDP), also known as COB/PDP**
   - Medical and prescription benefits.
   - Medicare is primary; therefore, members can go to any physician who accepts Medicare.
   - Members must be enrolled in both COB and PDP plans at the same time (with the same effective dates). The PDP portion is a standalone plan offered by Health Net's vendor, SilverScript.
4. **Health Net Group Medicare Supplement (Med Supp)**
   - Medical benefits only.
   - Medicare is primary; therefore, members can go to any physician who accepts Medicare.
   - Can be offered with a standalone Part D plan through SilverScript.

To qualify for any of the above plans, employer group health plan employees/retirees and their dependents must be Medicare-eligible. Centers for Medicare & Medicaid Services (CMS) regulations for employer group Seniority Plus and COB/PDP plans may have additional requirements.

Employer group contacts

Each employer group has an account manager and may also obtain assistance with membership and billing issues by calling our Membership Accounting Department at **1-800-224-8808**.

Medicare Department

The Health Net Medicare Department is responsible for all Medicare eligibility issues. Representatives handle the enrollment, disenrollment and group transfers for all members enrolled in a Seniority Plus, Med Supp or COB/PDP product.

Commercial Department

The Commercial Department is in charge of all Early Retiree, COBRA and Commercial Individual products. Commercial representatives handle the enrollment, disenrollment and group transfers for the above products. In addition, the department handles "Case Install," which is the implementation of the new groups.

This guide is designed to assist group administrators in understanding the regulations that CMS requires Health Net to follow for enrollment, disenrollment and plan changes. A Medicare beneficiary may only have one (1) type of Medicare-managed prescription drug coverage at once. If a Medicare-eligible retiree is enrolled in one type of Medicare-managed prescription drug plan (Retiree Subsidy Discount (RDS), Seniority Plus or COB/PDP) and submits an enrollment for another type of Medicare-managed prescription drug plan (RDS, Seniority Plus or COB/PDP), then they will be automatically disenrolled by CMS from the previous prescription plan and enrolled into the new prescription plan.

Eligibility Requirements

Seniority Plus requirements

In order to be eligible for a Health Net Seniority Plus plan, applicants must:

- Be eligible for Medicare Part A and enrolled in Medicare Part B.
- Comply with CMS enrollment guidance regarding end-stage renal disease (ESRD).
- Permanently reside in one of Health Net's Seniority Plus service areas.

Per the Medicare Managed Care Guide, individuals who develop ESRD while enrolled in a health plan (a commercial or group health plan, or a Medicaid plan) offered by the MA organization are eligible to elect an MA plan offered by that organization within the same state. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an MA organization (Health Net) and the start of coverage in the MA plan (Health Net) offered by the same organization. If an employer or union group beneficiary with ESRD ages into Medicare, he or she may enroll in an employer- or union-sponsored MA plan (Health Net) regardless of prior commercial coverage.

Medicare COB/PDP plan eligibility

In order to be eligible for Health Net's COB plan, potential members must:

- Be eligible for Medicare Part A and enrolled in Medicare Part B.
- Permanently reside in one of Health Net's COB service areas.
- Be concurrently enrolled in a Medicare Part D PDP plan. Members must be enrolled in both COB and PDP plans at the same time (with the same effective dates). The PDP portion is a standalone plan offered by Health Net's vendor, SilverScript.

Health Net Group Medicare Supplement (Med Supp) eligibility requirements

In order to be eligible for Health Net's Med Supp plan, potential members must:

- Be eligible for Medicare Part A and/or enrolled in Medicare Part B.
- Reside in California upon enrollment.

Obtaining Medicare Part A or Part B

Prospects wishing to enroll in Part A or Part B need to contact their local Social Security office, visit www.socialsecurity.gov on the Web or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If they receive benefits from the Railroad Retirement Board (RRB), they should call their local RRB office or 1-877-772-5772. TTY users should call 1-312-751-4701.

ID card information

All retirees and their dependents must qualify for these plans individually under their own Medicare number (found on their red, white and blue Medicare identification card). Each member will be issued a Health Net ID card and reference number. SilverScript will issue the PDP member ID card.

Ways to Enroll

All fields on the enrollment forms, unless indicated as optional, must be filled out. The effective date of coverage cannot be prior to the date the application was filled out/signed.

If an applicant has an authorized representative sign or assist with filling out the application, they are advised to include a copy of the documentation that designates them as the beneficiary's representative. This includes, but is not limited to, Durable Powers of Attorney (DPOA), Power of Attorney for Healthcare (POA-H) or Healthcare Conservator.

Seniority Plus enrollment

In order to enroll in an Employer Group Seniority Plus plan, all applicants must completely fill out a group enrollment form. Group employees/retirees and their dependents requesting enrollment into our Employer Group Seniority Plus plans need to use the appropriate calendar year's version of the employer group enrollment form. Employees/Retirees and their Medicare-eligible dependents (if applicable and eligible to receive group benefits) need to complete separate Health Net employer group enrollment forms.

For Seniority Plus Enrollment forms being sent via fax, the fax number is 1-844-222-3180. Please include a cover sheet indicating the following:

- group name
- sender information (phone and email address)
- number of enrollment forms attached
- request for fax receipt confirmation via email (email address needed)

COB/PDP enrollment

Two separate forms will be required for COB/PDP enrollment: the Health Net COB and the SilverScript PDP. Both forms must be completed and submitted together at the time of enrollment. (SilverScript will provide the PDP enrollment form and PDP Summary of Benefits.) Currently, Health Net cannot support, and therefore does not accept, electronic enrollments for COB/PDP plans.

For COB/PDP enrollment forms being sent via fax, the fax number is 1-844-222-3180. Please include a cover sheet indicating the following:

- group name
- sender information (phone and email address)
- number of enrollment forms attached
- request for fax receipt confirmation via email (email address needed)

Group Medicare Supplement (Med Supp) enrollment

Employees/Retirees and their Medicare-eligible dependents (if applicable and eligible to receive group benefits) need to complete separate Health Net Employer group Med Supp enrollment forms.

For Med Supp enrollment forms being sent via fax, the fax number is 1-844-222-3180. Please include a cover sheet indicating the following:

- group name
- sender information (phone and email address)
- number of enrollment forms attached
- request for fax receipt confirmation via email (email address needed)

All enrollments can also be mailed via USPS:
Health Net Life Insurance Company
PO Box 2020
Farmington, MO 63640-2021

If a prospect completes an "Individual" Medicare Enrollment form, they will be enrolled into an Individual Medicare plan, which may not include your group's enhanced benefits.

Enrollment Effective Dates

For all employer groups, Seniority Plus and COB enrollments are verified with the employer group. A Medicare Eligibility representative will reach out to the employer group administrator/contact to confirm the requested effective date and group number. If direct contact cannot be made, the effective date will be assumed as the first of the month following Health Net's earliest received date.

Seniority Plus and COB/PDP enrollment effective dates

The requested enrollment effective date cannot be prior to the date the employer group enrollment form was completed/signed by the enrollee. If the enrollment form is received by Health Net, signed by the enrollee but not dated, Health Net will use the earliest received date as the signature date. If there is a delay between Health Net receiving the application and the beneficiary signing the application, Health Net will provide feedback to the group. In addition, Health Net will contact the member to verify intent to enroll. If an enrollment form is received with a signature date older than 30 days, Health Net will also contact the enrollee to verify intent to enroll. If Health Net is unable to contact the member, then the enrollment will be processed using the earliest received date.

Example 1: For an Employer Group Enrollment form signed July 5 and received by Health Net on July 12, the enrollment will be processed for an effective date of August 1.

Example 2: If an Employer Group Enrollment form is signed by the enrollee June 2, received by Health Net July 20, and the group requests an effective date of June 1, Health Net can only process the enrollment for a July 1 effective date (due to the signature date).

Enrollment forms received after the requested effective date

Health Net can process an enrollment form with an effective date up to 90 days prior to the Health Net received date. **Please note:** The enrollment form must be signed prior to the requested effective date.

Example: For an employer group enrollment form received on July 12 with a signature date of May 3, the group can request an effective date of June 1, July 1 or August 1.

Enrollment forms received more than 30 days in advance of the requested effective date

Employer group enrollment forms may also be processed for an effective date up to 90 days after the month in which the enrollment form is received if a future date is requested.

Example: For an employer group enrollment form received on July 12, the group can request an effective date of August 1, September 1 or October 1.

Acknowledgment receipt of enrollment (by Health Net) and CMS confirmation of enrollment (for Seniority Plus and COB/PDP plans)

Once Health Net receives an employer group enrollment form and eligibility is verified (within 7 calendar days of receipt), the enrollee's data is entered into the enrollment/membership system. An *Acknowledgment* letter is mailed to the enrollee advising that Health Net has received the enrollment application and will notify them of their proposed effective date. Within 7–10 business days, an ID card will be created and mailed to the enrollee. Enrollment information is electronically transmitted to CMS on a daily basis.

If the enrollment form is not complete or eligibility cannot be verified, an *Enrollment Pending* letter will be generated and mailed to the enrollee requesting additional information. CMS requires that Health Net receive the additional information within 21 calendar days from the date of the *Enrollment Pending* letter. If the information is received and the enrollment can be deemed "complete and eligible," please refer to the paragraph above. If the information is not received within the 21 calendar days and/or the applicant is determined to be ineligible for the plan based on information received, the enrollment will be denied. An *Enrollment Denial* letter will be generated and mailed to the enrollee. Currently, Health Net is not able to send copies of enrollee letters to the employer group, unless the enrollee authorizes Health Net to release a copy of their letter to the group. If CMS denies the enrollment, the enrollee will receive a letter explaining the reason for denial. If there were any services used, the enrollee will be held responsible for the cost of those services. The response time from CMS can vary, up to 30 calendar days. This is dependent on the time of year, the total volume of enrollments and plan changes CMS is processing (not just from Health Net, but from every health insurance carrier who offers Medicare plans).

Official confirmation/acceptance of enrollment into one of Health Net's Seniority Plus plans can only be granted by CMS through an electronic transaction reply reporting process. Once Health Net receives the confirmation, a *Confirmation of Enrollment* letter is generated and mailed to the member. The process of transmission to CMS and response from CMS is approximately 7–14 calendar days.

Med Supp enrollment effective dates

For enrollments submitted via hard copy enrollment form

If the enrollment form is received by Health Net, and signed by the enrollee but not dated, Health Net will use the earliest received date as the signature date.

Enrollment forms received after the requested effective date

Health Net can process an enrollment for the first of the previous month if the application is received by the 7th day of the current month and the signature date is before the effective date.

Example 1: Application has a signature date of March 31 and was received on April 5, and the applicant is requesting an April 1 effective date. The application will be processed with the April 1 effective date since the application is received within the first 7 days of the month.

Example 2: Application is received on April 12 and the applicant is requesting an April 1 effective date. The application will be processed with the May 1 effective date since the application is received after the first 7 days of the month.

Enrollment form received more than 30 days in advance of the requested effective date

Health Net can process an enrollment for an effective date up to 90 days after the month in which the enrollment form is received, if a future date is requested.

Example: Application is received on May 5 and the applicant is requesting an August 1 effective date. The application will be processed with the August 1 effective date since the effective date is within the 90-day time frame.

Post-Enrollment Activities and Processes

Identification (ID) cards

Cards are created and mailed out to new enrollees within 7–10 business days of a member's enrollment. Other triggers of ID cards include physician or medical group changes, reinstatements, and effective date changes. Members are encouraged to present their most current ID card at every point of service, including pharmacy visits. The current ID card will have the most accurate data when seeking medical or pharmacy services.

MAPD and Med Supp enrollees will each receive one ID card. Each new COB/PDP enrollee will receive two ID cards.

- One for the COB plan
- One for the PDP plan

Enrollee/Member access to services (medical and prescription drug)

After Health Net has processed a completed and verified eligible employer group enrollment, the enrollee will be added to our membership system. Enrollees will be able to access medical care and prescription drug benefits (if applicable) as of their effective date of coverage. If urgent/medically necessary prescriptions are needed and the pharmacy indicates the enrollee/member is not yet active with Health Net, please bring this issue to your Medicare Eligibility representative's attention. **Please note:** Enrollees are notified of their proposed effective date of coverage with Health Net via an *Acknowledgment* letter.

Address changes

Address changes should be communicated by the member to the Health Net Customer Contact Center using the toll-free phone number listed on their Health Net ID card. If a member permanently moves outside a Health Net-covered service area, they will no longer meet eligibility requirements for the MA or MAPD plan and must be disenrolled from the plan. Address change notifications can also be communicated by a member's legally authorized representative. These include but are not limited to Durable Powers of Attorney (DPOA), Power of Attorney for Healthcare (POA-H) or Healthcare Conservator. These representatives need to be able to provide the documentation, which grants them this authority, to Health Net or CMS upon request.

Discrepancy resolution and reporting

Some groups communicate changes via electronic tape files weekly, biweekly, monthly, or quarterly. Others use emailed Excel files. Commercial and Medicare Eligibility representatives process these adds, terminations or changes within five (5) business days of receipt and will notify the group of any discrepancy and the action needed to resolve the discrepancy.

Accounting reconciliation

Accounting representatives, Commercial Eligibility representatives and Medicare Eligibility representatives work together monthly to address any eligibility issues which are identified during the account reconciliation process. Representatives research these discrepancies within seven (7) business days of receipt and will notify the group of any discrepancy, and the action needed to resolve the issue.

Urgent/Escalated eligibility issues

Each employer group has a specific Medicare Group Eligibility representative. These representatives can assist with all urgent eligibility-related issues, including pharmacy access problems. Eligibility representatives can be contacted by calling the Member Services number listed on the back page. They are available Monday through Friday, 7:00 a.m. to 4:30 p.m.

MA, MAPD and Med Supp Disenrollment Request

There are five different ways that Health Net can receive MA, MAPD or Med Supp disenrollments:

- A voluntary disenrollment request by the member.
- An involuntary request to disenroll the member by the employer group.
- A group terminates its contract with Health Net.
- CMS sends Health Net a request to disenroll the member (excludes Med Supp).
- The member's legal representative/POA can request voluntary disenrollment.

Voluntary disenrollment request initiated by the member

If Health Net receives a disenrollment request signed by the member that was submitted either directly from the member or through the employer group, Health Net will disenroll the member the first day of the following month after Health Net's earliest received date and will submit the transaction to Medicare.

Involuntary disenrollment request by the group to disenroll the member

This happens when the employer group requests disenrollment of the member due to nonpayment or for internal group reasons. If there is no signed disenrollment request from the member, CMS requires that Health Net notify the member that the employer group intends to disenroll them a minimum of 21 days prior to processing the disenrollment. This means that the requested disenrollment will be processed 21 days from the date of the letter with a disenrollment effective date of the first of the following month. Health Net will process all group-requested disenrollments within seven (7) calendar days of receipt.

Due to CMS compliance, Health Net strongly encourages employer groups to submit disenrollment requests at least 45 days prior to the disenrollment date. If Health Net receives written notice from an employer group to disenroll less than 30 days prior to the requested disenrollment date, Health Net will extend the disenrollment date for the member in order to meet the required time frame for the member notification stated above.

Employer group contract termination

When an employer group is terminating their contract with Health Net, CMS requires that Health Net notify employer group members at least 21 days prior to the disenrollment date of an employer group's planned termination. Employer group plan members are notified of the option to enroll in an Individual Medicare Advantage plan offered by Health Net. Due to CMS compliance, Health Net strongly encourages employer groups to submit termination requests at least 45 days prior to the termination date. This will also avoid extension of the employer group's plan contract. If Health Net receives written notice from an employer group to terminate their contract 21 days or less prior to the requested termination date, Health Net will extend the termination date for such an employer group contract by one month in order to meet the required time frame for the member notification stated above.

These beneficiary protections are required by CMS for any Medicare Advantage employer group disenrollment, whether the employer group chooses to disenroll the entire contract or only certain service areas or counties within the contract.

Voluntary retroactive disenrollment request

If a voluntary disenrollment request is not received by Health Net prior to the requested disenrollment effective date (as specified on the request), Health Net will process the disenrollment for the first of the following month after the actual date received. In addition, the request will be forwarded to the Health Net Reconciliation Team so that they can process the retroactive disenrollment request with CMS. In anticipation of CMS approval, Health Net will update our membership system to reflect the requested disenrollment date (providing the member's request meets the eligibility requirements for the retroactive disenrollment).

CMS guarantees review of all retroactive requests within 45 days of receipt. Health Net will notify the member via letter of CMS's acceptance or rejection of their retroactive request. If there is no specific disenrollment effective date requested, the effective date will be based upon the earliest Health Net received date and will be processed for the first of the month following receipt.

COB/PDP Disenrollment Request

All disenrollment requests must come directly to Health Net. Health Net will notify the SilverScript account manager via secure/encrypted email of any involuntary termination or disenrollment provided by the employer group or their administrator. SilverScript is responsible for processing all PDP disenrollment transactions with CMS.

Voluntary disenrollments

Enrollees who request to disenroll from their employer group health plan must disenroll in writing. Written requests from enrollees can be accepted via mail or fax and must be dated and signed. Health Net must notify SilverScript of all voluntary disenrollments via secure/encrypted email twice a week, on Monday and Thursday. A SilverScript account manager must notify the Health Net Membership representative of all voluntary disenrollments from the transaction reply report via secure FTP each Monday and Thursday. A Health Net Membership representative will update Health Net's system, and the respective Membership representative will send a follow-up email to their counterpart confirming receipt of the disenrollment request. When the PDP portion of the plan is canceled, the COB suffix is automatically canceled as well.

Involuntary disenrollments

Employer groups must proactively notify their enrollees of the prospective disenrollment. SilverScript must notify all enrollees no less than 29 calendar days prior to the effective date of the enrollee's disenrollment from the Employer Group Health Plan (EGHP) Contract. Such notices are prospective, not retroactive. Health Net must provide SilverScript all required disenrollment data no less than 45 days in advance of the disenrollment effective date.

Group termination

An employer group may voluntarily disenroll its entire group from the EGHP Contract. The group must provide Health Net all required disenrollment data no less than 45 days in advance of the disenrollment effective date.

In the event that an EGHP contract is terminated or a class of eligible persons is terminated, Health Net will notify SilverScript of the action and, if deemed appropriate and necessary, the reason. Notice will be provided within 5 days of Health Net's knowledge of the termination, and at least 45 days prior to the actual effective date of termination. Initial notice will be verbal, followed by written documentation via secure/encrypted email.

Additional Information

Enrollment materials

Health Net creates a variety of pre- and post-enrollment Group Medicare materials, including enrollment forms, letters/notices, provider directories, brochures, and flyers. These documents are reviewed and approved by Health Net's internal Medicare Document Review team, or CMS if applicable. (Most approved documents will include a Material ID # and an approved date.)

There may be instances where the employer may develop their own retiree materials, such as handouts outlining employer contributions, enrollment procedures, special benefits, etc. Be sure to check with your Health Net account manager first to make sure these materials do not require review and approval by Health Net's Medicare Document Review team.

Note: Employer Group Medicare health plans are not required to submit informational copies of their dissemination materials to CMS at the time of use. However, as a condition of CMS providing particular waivers or modifications to employer group plans, CMS reserves the right to request and review these materials in the event of beneficiary complaints or for any other reason it determines to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

Questions about your statement? Please call **1-800-224-8808**.

Group billing statements

Billing options:

- **Separate physical bills** for each group ID.
- **Consolidated physical bill** that organizes by group ID (for multiple group IDs).
- **"Positive listing" billing:** Based on internal records, groups send Health Net listings of all the subscribers they wish to pay for. This listing is considered to be a positive indication of the subscribers they intend to be active in the Health Net system. Normally this occurs when groups prefer not to utilize Health Net's bill.

If your group does not use the physical billing statement and uses a monthly membership "positive listing," you will be notified to take a credit after the monthly account reconciliation has been completed.

Low Income Subsidy (LIS) for MAPD and PDP members

LIS is a program to help people with limited income and resources pay their prescription drug costs. Once a Medicare beneficiary has been deemed eligible to receive this help and they join a Medicare prescription drug plan, Medicare will contribute toward their Medicare prescription drug plan premium by paying the health plan directly. If any of your employees/retirees have received this type of assistance from Medicare, you will be notified either via the billing statement or by your Accounting representative during the monthly account reconciliation process. LIS credits will show on the billing statement on the "Adjustments to Membership" page. The member who received the LIS credit will be listed and the reason for the credit will be "LIS."

Late Enrollment Penalty (LEP) for MAPD and PDP members

If a Medicare beneficiary does not join a Medicare drug plan when they are first eligible for Medicare Part A and/or B and they go without creditable prescription drug coverage for 63 continuous days or more, they may have to pay a Late Enrollment Penalty (LEP) to join a plan at a later date. This penalty amount changes every year and will be assessed as long as they are enrolled in Medicare prescription drug coverage. An LEP is calculated when you join a Medicare drug plan. To estimate the penalty amount, multiply 1% of the national base beneficiary premium by the number of full months you were eligible to join a Medicare drug plan but didn't. Round this amount to the nearest ten cents to get the LEP amount. This penalty amount is added each month to the Medicare drug plan's premium for as long as the plan is active.

Creditable prescription drug coverage

Prescription drug coverage (for example, from an employer or union) that is equal to or better than Medicare's standard prescription drug coverage is considered to be "creditable" by CMS. If an employer or union stops offering prescription drug coverage that is creditable, the beneficiaries affected won't have to pay an LEP if they join a Medicare drug plan, and their coverage begins before they go 63 days without coverage. During the enrollment process, these beneficiaries may be asked to provide proof of their prior creditable coverage and when it ended. Health Net attempts to verify any and all uncovered months of Medicare prescription drug coverage prior to transmitting the information to Medicare.

Retiree Drug Subsidy (RDS)

Retiree Drug Subsidy (RDS) programs were designed to encourage employers and unions to continue providing high-quality prescription drug coverage to their retirees. RDS prescription plans require employer groups to apply and maintain direct ongoing communication and reporting with CMS regarding the employees/retirees participating in the program. For more information, please visit https://www.rds.cms.hhs.gov.

RDS is flexible enough to enable employers and unions to obtain the subsidy without disrupting their current coverage.

A Medicare beneficiary may only have one (1) type of Medicare-managed prescription drug coverage. Therefore, if an enrollee is enrolled in an employer group RDS plan and they apply for a Health Net MAPD (medical and prescription benefits) plan, they will need to confirm that they understand enrollment into the Health Net MAPD will result in the automatic cancellation of the RDS prescription plan. This confirmation will be requested of them after they complete their enrollment form or CMS rejects the enrollment transaction. Once CMS rejects the enrollment transaction, Health Net will call the member to obtain verification. If no contact is made, then a notice is sent to the beneficiary to provide confirmation of enrollment into the MAPD plan. The beneficiary has 30 calendar days to respond with their confirmation. If no response is received by the end of the 30th day, Health Net will cancel the MAPD enrollment request per CMS guidelines. In addition, Health Net will send a notice of enrollment cancellation to the beneficiary. If an enrollee has an RDS prescription plan and is applying for an MA-only (medical benefits only) plan, the RDS prescription plan is not affected and the enrollee will not be contacted. The national base beneficiary premium changes each year and is determined by CMS.

Need answers?
Find them here.

Health Net Seniority Plus Plans
PO Box 10420
Van Nuys, CA 91410-0420
1-800-275-4737

Health Net Coordination of Benefits (COB) Plans
PO Box 10198
Van Nuys, CA 91410-0198
1-800-522-0088

Health Net Life Medicare Supplement (Med Supp) Plans
PO Box 10420
Van Nuys, CA 91499
1-800-926-4178

TTY users should call 711.

www.healthnet.com/employer

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