

2020 Outline of Coverage

INDIVIDUAL MEDICARE SUPPLEMENT PLANS



*Coverage for
every stage of life™*



Health Net Life

OUTLINE OF INDIVIDUAL MEDICARE SUPPLEMENT PLAN COVERAGE

Benefit plans A, D, F,* High Deductible Plan F*, Innovative Plan F*, G, Innovative Plan G and N are offered by Health Net Life Insurance Company (HNL)

Medicare supplement insurance can only be sold in standard plans. This chart shows the benefits included in each plan that can be sold on or after June 1, 2010. Every insurance company must offer Plan A. Some plans may not be available.



*Policies for Plans F, High Deductible F and Innovative Plan F are prohibited from sales, on or after January 1, 2020 to newly eligible Medicare beneficiaries. A newly eligible beneficiary is defined as an individual who becomes eligible for Medicare on or after January 1, 2020, because the individual attained 65 years of age on or after January 1, 2020, or the individual became eligible for Medicare benefits on or after January 1, 2020, by reason of disability, as specified.

The basic benefits included in all plans are:



Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.



Blood: First three pints of blood each year.



Hospice: Part A coinsurance.



Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount) or copayments for hospital outpatient services. Plan N requires members to pay a portion of Part B coinsurance or copayments.

A	B	C	D	F, High Deductible F, ¹ Innovative Plan F ²
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible
		Part B deductible		Part B deductible
				Part B excess (100%)
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency

G, Innovative Plan G ²	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
Skilled nursing facility coinsurance	50% skilled nursing facility coinsurance	75% skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
Part B excess (100%)				
Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
	Out-of-pocket limit \$5,880; paid at 100% after limit reached	Out-of-pocket limit \$2,940; paid at 100% after limit reached		

¹Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,340 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. These expenses include Medicare deductibles for Parts A and B but do not include the plan's separate foreign travel emergency deductible.

²Innovative Plan F and Innovative Plan G includes additional benefits not contained in other standardized Medicare Supplement Plans as outlined in the following pages.

Shaded plans are currently not offered by Health Net.

New to Part B discount

Members who apply within six months of their Part B effective date qualify for \$30 off their monthly premium for the first 12 months.

This applies to any policies with an effective date of February 1, 2020, or after.

Note: Any qualifying individual will forfeit their discount if canceled due to non-payment during the first 12 months of enrollment.

Premium information

We, Health Net Life Insurance Company (HNL), can only raise your premium if we raise the premium for all policies like yours in California. Premiums in this *Outline of Coverage* will increase periodically due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the Medicare Supplement Plan Policy will be the renewal premium in effect for your attained age. You will receive written notification of any changes in payment fees at least 30 days prior to the effective date of the new rate. Your premium will also be adjusted when you move to a county in a different rating region as set out in this *Outline of Coverage*. The adjustment will be effective on the first of the month following your change of address.

HNL provides an initial 6-month rate guarantee to members enrolling for the first time into an HNL Medicare Supplement plan. During your 6-month rate guarantee period, your premium will not increase even if HNL has a rate increase or you have a birthday which moves you into the next higher age rate bracket. If, during your 6-month rate guarantee period, you choose to enroll in a different HNL Medicare Supplement plan, your 6-month rate guarantee period will end, and you will be charged the premium for the new plan selected.

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 they are due, or within the grace period.

This plan is subject to Guaranteed Renewability.



HNL offers various payment options: monthly billing, Automatic Bank Draft (ABD) and via phone with a debit or credit card with a Visa or Mastercard logo.

Use this outline to compare benefits and premiums among policies:

Region 1 | Alameda, Contra Costa, Shasta

Age range	Nonsmoking				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$113	\$162	\$68	\$167	\$149
67-68	\$125	\$178	\$75	\$183	\$164
69-70	\$136	\$194	\$81	\$199	\$178
71-72	\$146	\$209	\$88	\$214	\$192
73-74	\$158	\$226	\$95	\$231	\$208
75-76	\$169	\$241	\$101	\$246	\$222
77-78	\$180	\$257	\$108	\$262	\$236
79-80	\$190	\$271	\$114	\$276	\$249
81-84	\$204	\$292	\$123	\$297	\$269
85+	\$229	\$327	\$137	\$332	\$301
Disabled under 65	\$229	\$327	\$137	\$332	\$301

Age range	Smoking ¹				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$132	\$188	\$79	\$193	\$173
67-68	\$146	\$208	\$87	\$213	\$191
69-70	\$159	\$227	\$95	\$232	\$209
71-72	\$171	\$244	\$102	\$249	\$224
73-74	\$184	\$263	\$110	\$268	\$242
75-76	\$197	\$281	\$118	\$286	\$259
77-78	\$210	\$300	\$126	\$305	\$276
79-80	\$221	\$316	\$133	\$321	\$291
81-84	\$239	\$341	\$143	\$346	\$314
85+	\$267	\$381	\$160	\$386	\$351
Disabled under 65	\$267	\$381	\$160	\$386	\$351

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region 1 | Alameda, Contra Costa, Shasta

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$144	\$152	\$128	\$168	\$176	\$150
67-68	\$160	\$168	\$143	\$186	\$195	\$167
69-70	\$174	\$182	\$155	\$202	\$211	\$181
71-72	\$188	\$197	\$168	\$219	\$228	\$196
73-74	\$202	\$211	\$181	\$236	\$245	\$211
75-76	\$217	\$225	\$194	\$252	\$261	\$226
77-78	\$232	\$240	\$207	\$271	\$280	\$242
79-80	\$244	\$253	\$218	\$285	\$293	\$254
81-82	\$257	\$265	\$230	\$300	\$308	\$268
83-84	\$270	\$279	\$241	\$315	\$324	\$281
85-86	\$283	\$291	\$253	\$330	\$339	\$295
87-88	\$295	\$304	\$264	\$344	\$353	\$308
89-90	\$308	\$316	\$275	\$359	\$367	\$320
91-92	\$319	\$328	\$285	\$373	\$382	\$333
93-94	\$331	\$340	\$296	\$386	\$395	\$345
95+	\$350	\$358	\$312	\$408	\$417	\$364
Disabled under 65	\$350	\$358	\$312	\$408	\$417	\$364

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region 2 Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yuba

Age range	Nonsmoking				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$109	\$155	\$65	\$160	\$143
67-68	\$120	\$171	\$72	\$176	\$157
69-70	\$131	\$187	\$79	\$192	\$172
71-72	\$141	\$201	\$84	\$206	\$185
73-74	\$152	\$217	\$91	\$222	\$200
75-76	\$162	\$232	\$97	\$237	\$213
77-78	\$173	\$247	\$104	\$252	\$227
79-80	\$182	\$260	\$109	\$265	\$239
81-84	\$197	\$281	\$118	\$286	\$259
85+	\$220	\$314	\$132	\$319	\$289
Disabled under 65	\$220	\$314	\$132	\$319	\$289

Age range	Smoking ¹				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$127	\$181	\$76	\$186	\$167
67-68	\$140	\$200	\$84	\$205	\$184
69-70	\$153	\$218	\$92	\$223	\$201
71-72	\$165	\$235	\$99	\$240	\$216
73-74	\$177	\$253	\$106	\$258	\$233
75-76	\$189	\$270	\$113	\$275	\$248
77-78	\$202	\$288	\$121	\$293	\$265
79-80	\$213	\$304	\$128	\$309	\$280
81-84	\$230	\$328	\$138	\$333	\$302
85+	\$256	\$366	\$154	\$371	\$337
Disabled under 65	\$256	\$366	\$154	\$371	\$337

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region 2 Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yuba

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$136	\$145	\$122	\$159	\$167	\$142
67-68	\$151	\$159	\$135	\$176	\$184	\$157
69-70	\$164	\$172	\$147	\$192	\$200	\$171
71-72	\$178	\$187	\$159	\$208	\$216	\$186
73-74	\$192	\$200	\$171	\$224	\$232	\$200
75-76	\$205	\$214	\$183	\$239	\$248	\$214
77-78	\$219	\$228	\$196	\$256	\$265	\$229
79-80	\$231	\$240	\$206	\$269	\$278	\$241
81-82	\$244	\$252	\$218	\$285	\$293	\$254
83-84	\$256	\$265	\$229	\$299	\$307	\$267
85-86	\$268	\$276	\$239	\$312	\$321	\$279
87-88	\$280	\$289	\$250	\$326	\$335	\$292
89-90	\$292	\$300	\$261	\$340	\$349	\$304
91-92	\$302	\$311	\$270	\$353	\$362	\$316
93-94	\$313	\$322	\$280	\$366	\$375	\$327
95+	\$331	\$340	\$296	\$386	\$395	\$345
Disabled under 65	\$331	\$340	\$296	\$386	\$395	\$345

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region 3 | Los Angeles, Orange

Age range	Nonsmoking				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$124	\$177	\$74	\$182	\$163
67-68	\$137	\$195	\$82	\$200	\$179
69-70	\$149	\$213	\$89	\$218	\$196
71-72	\$160	\$229	\$96	\$234	\$211
73-74	\$173	\$247	\$104	\$252	\$227
75-76	\$185	\$264	\$111	\$269	\$243
77-78	\$197	\$282	\$118	\$287	\$259
79-80	\$208	\$297	\$125	\$302	\$273
81-84	\$224	\$320	\$134	\$325	\$294
85+	\$251	\$358	\$150	\$363	\$329
Disabled under 65	\$251	\$358	\$150	\$363	\$329

Age range	Smoking ¹				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$144	\$206	\$87	\$211	\$190
67-68	\$160	\$228	\$96	\$233	\$210
69-70	\$174	\$248	\$104	\$253	\$228
71-72	\$188	\$268	\$113	\$273	\$247
73-74	\$202	\$289	\$121	\$294	\$266
75-76	\$216	\$308	\$129	\$313	\$283
77-78	\$230	\$328	\$138	\$333	\$302
79-80	\$242	\$346	\$145	\$351	\$318
81-84	\$261	\$373	\$157	\$378	\$343
85+	\$293	\$418	\$176	\$423	\$385
Disabled under 65	\$293	\$418	\$176	\$423	\$385

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region
3 Orange

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$159	\$167	\$142	\$185	\$193	\$165
67-68	\$176	\$184	\$157	\$205	\$214	\$183
69-70	\$192	\$200	\$171	\$224	\$232	\$200
71-72	\$208	\$216	\$186	\$243	\$251	\$217
73-74	\$224	\$232	\$200	\$260	\$269	\$233
75-76	\$239	\$248	\$214	\$279	\$288	\$249
77-78	\$256	\$265	\$229	\$299	\$307	\$267
79-80	\$269	\$278	\$241	\$314	\$323	\$281
81-82	\$284	\$292	\$253	\$331	\$340	\$296
83-84	\$298	\$307	\$266	\$348	\$357	\$311
85-86	\$312	\$321	\$279	\$364	\$373	\$325
87-88	\$326	\$334	\$291	\$380	\$389	\$340
89-90	\$339	\$348	\$303	\$396	\$405	\$354
91-92	\$352	\$361	\$315	\$411	\$420	\$367
93-94	\$365	\$374	\$326	\$425	\$434	\$380
95+	\$385	\$394	\$344	\$450	\$459	\$402
Disabled under 65	\$385	\$394	\$344	\$450	\$459	\$402

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

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

Age range	Nonsmoking				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$121	\$173	\$73	\$178	\$159
67-68	\$134	\$192	\$81	\$197	\$177
69-70	\$146	\$209	\$88	\$214	\$192
71-72	\$158	\$225	\$95	\$230	\$207
73-74	\$169	\$242	\$102	\$247	\$223
75-76	\$181	\$259	\$109	\$264	\$238
77-78	\$193	\$276	\$116	\$281	\$254
79-80	\$204	\$291	\$122	\$296	\$268
81-84	\$220	\$314	\$132	\$319	\$289
85+	\$246	\$351	\$147	\$356	\$323
Disabled under 65	\$246	\$351	\$147	\$356	\$323

Age range	Smoking ¹				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$141	\$202	\$85	\$207	\$186
67-68	\$156	\$223	\$94	\$228	\$205
69-70	\$170	\$243	\$102	\$248	\$224
71-72	\$183	\$262	\$110	\$267	\$241
73-74	\$198	\$283	\$119	\$288	\$260
75-76	\$211	\$302	\$127	\$307	\$278
77-78	\$225	\$322	\$135	\$327	\$296
79-80	\$237	\$339	\$142	\$344	\$312
81-84	\$256	\$366	\$154	\$371	\$337
85+	\$286	\$409	\$172	\$414	\$376
Disabled under 65	\$286	\$409	\$172	\$414	\$376

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

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

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$150	\$158	\$134	\$175	\$183	\$156
67-68	\$167	\$175	\$149	\$194	\$203	\$174
69-70	\$181	\$189	\$162	\$211	\$220	\$189
71-72	\$197	\$206	\$176	\$229	\$238	\$205
73-74	\$211	\$220	\$189	\$247	\$256	\$221
75-76	\$227	\$235	\$202	\$264	\$273	\$236
77-78	\$243	\$251	\$217	\$283	\$291	\$253
79-80	\$255	\$264	\$228	\$297	\$306	\$265
81-82	\$268	\$277	\$240	\$313	\$322	\$280
83-84	\$282	\$291	\$252	\$329	\$338	\$294
85-86	\$295	\$304	\$264	\$344	\$353	\$308
87-88	\$309	\$317	\$276	\$359	\$368	\$321
89-90	\$321	\$330	\$287	\$375	\$383	\$335
91-92	\$334	\$342	\$298	\$389	\$398	\$347
93-94	\$346	\$355	\$309	\$403	\$412	\$360
95+	\$365	\$374	\$326	\$425	\$434	\$380
Disabled under 65	\$365	\$374	\$326	\$425	\$434	\$380

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region 5 | El Dorado, Fresno, Imperial, Placer, Sacramento, San Joaquin, Santa Cruz, Solano, Stanislaus, Tulare, Yolo

Age range	Nonsmoking				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$101	\$144	\$60	\$149	\$132
67-68	\$111	\$159	\$67	\$164	\$146
69-70	\$122	\$174	\$73	\$179	\$160
71-72	\$131	\$187	\$79	\$192	\$172
73-74	\$141	\$202	\$85	\$207	\$186
75-76	\$151	\$215	\$90	\$220	\$198
77-78	\$161	\$230	\$97	\$235	\$212
79-80	\$169	\$242	\$102	\$247	\$223
81-84	\$183	\$261	\$110	\$266	\$240
85+	\$204	\$292	\$123	\$297	\$269
Disabled under 65	\$204	\$292	\$123	\$297	\$269

Age range	Smoking ¹				
	Plan A	Plan F	High Deductible Plan F	Innovative Plan F	Plan G
65-66	\$118	\$168	\$71	\$173	\$155
67-68	\$130	\$186	\$78	\$191	\$171
69-70	\$141	\$202	\$85	\$207	\$186
71-72	\$153	\$218	\$92	\$223	\$201
73-74	\$165	\$235	\$99	\$240	\$216
75-76	\$176	\$251	\$105	\$256	\$231
77-78	\$188	\$268	\$113	\$273	\$247
79-80	\$197	\$282	\$118	\$287	\$259
81-84	\$214	\$305	\$128	\$310	\$281
85+	\$239	\$341	\$143	\$346	\$314
Disabled under 65	\$239	\$341	\$143	\$346	\$314

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Region 5 | El Dorado, Fresno, Imperial, Placer, Sacramento, San Joaquin, Santa Cruz, Solano, Stanislaus, Tulare, Yolo

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$125	\$133	\$112	\$145	\$154	\$130
67-68	\$138	\$147	\$124	\$161	\$170	\$144
69-70	\$151	\$159	\$135	\$176	\$184	\$157
71-72	\$164	\$172	\$147	\$191	\$199	\$171
73-74	\$176	\$184	\$157	\$205	\$214	\$183
75-76	\$188	\$197	\$168	\$219	\$228	\$196
77-78	\$202	\$210	\$180	\$235	\$244	\$210
79-80	\$212	\$221	\$190	\$247	\$256	\$221
81-82	\$224	\$232	\$200	\$260	\$269	\$233
83-84	\$235	\$243	\$210	\$274	\$282	\$245
85-86	\$246	\$255	\$220	\$287	\$296	\$257
87-88	\$257	\$265	\$230	\$300	\$308	\$268
89-90	\$268	\$276	\$239	\$311	\$320	\$278
91-92	\$277	\$286	\$248	\$324	\$333	\$289
93-94	\$288	\$297	\$257	\$335	\$344	\$300
95+	\$304	\$313	\$272	\$354	\$363	\$316
Disabled under 65	\$304	\$313	\$272	\$354	\$363	\$316

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Plans D, N and Innovative Plan G – Los Angeles and San Diego Regions

Region 1

To determine the premium that you will pay, locate your zip code below under Region 1, 2 or 3 for Los Angeles or Region 1 or 2 for San Diego county. Refer to the corresponding premium chart for Region 1, 2, or 3, then locate your plan selection; D, G or N under nonsmoking or smoking, then locate your age to obtain your premium rate.

Los Angeles County Region 1 (NPI) Zip Codes: 90001, 90004, 90005, 90006, 90007, 90009, 90011, 90012, 90013, 90014, 90015, 90017, 90021, 90022, 90023, 90026, 90027, 90029, 90030, 90031, 90032, 90033, 90039, 90040, 90041, 90042, 90050, 90053, 90054, 90055, 90057, 90058, 90060, 90063, 90065, 90071, 90074, 90081, 90083, 90084, 90086, 90087, 90088, 90090, 90091, 90096, 90099, 90189, 90201, 90202, 90239, 90240, 90241, 90242, 90254, 90255, 90266, 90267, 90270, 90274, 90275, 90277, 90278, 90280, 90295, 90296, 90501, 90503, 90504, 90505, 90507, 90508, 90509, 90510, 90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609, 90610, 90623, 90630, 90631, 90637, 90638, 90639, 90640, 90650, 90651, 90652, 90660, 90661, 90662, 90670, 90671, 90701, 90702, 90703, 90704, 90706, 90707, 90711, 90712, 90713, 90714, 90715, 90716, 90717, 90723, 90731, 90732, 90733, 90734, 90748, 90755, 90801, 90802, 90803, 90804, 90806, 90807, 90808, 90809, 90813, 90814, 90815, 90822, 90831, 90832, 90833, 90834, 90835, 90840, 90842, 90844, 90846, 90847, 90848, 90853, 90899, 91010, 91016, 91030, 91105, 91204, 91205, 91206, 91702, 91706, 91709, 91710, 91711, 91714, 91715, 91716, 91722, 91724, 91731, 91732, 91733, 91734, 91735, 91744, 91745, 91746, 91747, 91748, 91749, 91750, 91754, 91755, 91756, 91765, 91766, 91767, 91768, 91769, 91770, 91771, 91772, 91773, 91776, 91780, 91788, 91789, 91790, 91791, 91792, 91793, 91709, 91710, 92821, 92823

San Diego County Region 1 (NPI) Zip Codes: 91901, 91902, 91903, 91905, 91906, 91908, 91909, 91910, 91911, 91912, 91913, 91914, 91915, 91916, 91917, 91921, 91931, 91932, 91933, 91934, 91935, 91941, 91942, 91943, 91944, 91945, 91946, 91947, 91948, 91950, 91951, 91962, 91963, 91976, 91977, 91978, 91979, 91980, 91987, 92003, 92004, 92007, 92008, 92009, 92010, 92011, 92013, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92033, 92036, 92040, 92046, 92049, 92051, 92052, 92054, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92065, 92066, 92067, 92068, 92069, 92070, 92071, 92072, 92075, 92078, 92079, 92081, 92082, 92083, 92084, 92085, 92086, 92088, 92090, 92091, 92096, 92143, 92153, 92154, 92155, 92170, 92173, 92179

Region 1 | Los Angeles and San Diego

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$144	\$152	\$128	\$168	\$176	\$150
67-68	\$160	\$168	\$143	\$186	\$195	\$167
69-70	\$174	\$182	\$155	\$202	\$211	\$181
71-72	\$188	\$197	\$168	\$219	\$228	\$196
73-74	\$202	\$211	\$181	\$236	\$245	\$211
75-76	\$217	\$225	\$194	\$252	\$261	\$226
77-78	\$232	\$240	\$207	\$271	\$280	\$242
79-80	\$244	\$253	\$218	\$285	\$293	\$254
81-82	\$257	\$265	\$230	\$300	\$308	\$268
83-84	\$270	\$279	\$241	\$315	\$324	\$281
85-86	\$283	\$291	\$253	\$330	\$339	\$295
87-88	\$295	\$304	\$264	\$344	\$353	\$308
89-90	\$308	\$316	\$275	\$359	\$367	\$320
91-92	\$319	\$328	\$285	\$373	\$382	\$333
93-94	\$331	\$340	\$296	\$386	\$395	\$345
95+	\$350	\$358	\$312	\$408	\$417	\$364
Disabled under 65	\$350	\$358	\$312	\$408	\$417	\$364

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Plans D, N and Innovative Plan G – Los Angeles and San Diego Regions

Region 2 To determine the premium that you will pay, locate your zip code below under Region 2 or 3 for Los Angeles or Region 2 for San Diego county. Refer to the corresponding premium chart for Region 2 or 3, then locate your plan selection; D, G or N under nonsmoking or smoking, then locate your age to obtain your premium rate.

Los Angeles County Region 2 (NPI) Zip Codes: 91001, 91003, 91006, 91007, 91008, 91009, 91011, 91012, 91017, 91020, 91021, 91023, 91024, 91025, 91031, 91041, 91042, 91043, 91046, 91066, 91077, 91101, 91102, 91103, 91104, 91106, 91107, 91108, 91109, 91110, 91114, 91115, 91116, 91117, 91118, 91121, 91123, 91124, 91125, 91126, 91129, 91182, 91184, 91185, 91188, 91189, 91199, 91201, 91202, 91203, 91207, 91208, 91209, 91210, 91214, 91221, 91222, 91224, 91225, 91226, 91310, 91321, 91322, 91326, 91327, 91350, 91351, 91354, 91355, 91380, 91381, 91382, 91383, 91384, 91385, 91386, 91387, 91390, 91394, 91501, 91502, 91503, 91504, 91507, 91508, 91510, 91521, 91522, 91523, 91526, 91723, 91740, 91741, 91759, 91775, 91778, 91801, 91802, 91803, 91804, 91896, 91899, 92397, 93243, 93510, 93532, 93534, 93535, 93536, 93539, 93543, 93544, 93550, 93551, 93552, 93553, 93560, 93563, 93584, 93586, 93590, 93591

San Diego County Region 2 (NPI) Zip Codes: 92014, 92037, 92038, 92039, 92064, 92074, 92092, 92093, 92101, 92102, 92103, 92104, 92105, 92106, 92107, 92108, 92109, 92110, 92111, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92127, 92128, 92129, 92130, 92131, 92132, 92134, 92135, 92136, 92137, 92138, 92139, 92140, 92142, 92145, 92147, 92149, 92150, 92152, 92158, 92159, 92160, 92161, 92162, 92163, 92164, 92165, 92166, 92167, 92168, 92169, 92171, 92172, 92174, 92175, 92176, 92177, 92178, 92182, 92184, 92186, 92187, 92190, 92191, 92192, 92193, 92194, 92195, 92196, 92197, 92198, 92199

Region 2 | Los Angeles and San Diego

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$144	\$145	\$122	\$168	\$167	\$142
67-68	\$160	\$159	\$135	\$186	\$184	\$157
69-70	\$174	\$172	\$147	\$202	\$200	\$171
71-72	\$188	\$187	\$159	\$219	\$216	\$186
73-74	\$202	\$200	\$171	\$236	\$232	\$200
75-76	\$217	\$214	\$183	\$252	\$248	\$214
77-78	\$232	\$228	\$196	\$271	\$265	\$229
79-80	\$244	\$240	\$206	\$285	\$278	\$241
81-82	\$257	\$252	\$218	\$300	\$293	\$254
83-84	\$270	\$265	\$229	\$315	\$307	\$267
85-86	\$283	\$276	\$239	\$330	\$321	\$279
87-88	\$295	\$289	\$250	\$344	\$335	\$292
89-90	\$308	\$300	\$261	\$359	\$349	\$304
91-92	\$319	\$311	\$270	\$373	\$362	\$316
93-94	\$331	\$322	\$280	\$386	\$375	\$327
95+	\$350	\$340	\$296	\$408	\$395	\$345
Disabled under 65	\$350	\$340	\$296	\$408	\$395	\$345

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Plans D, N and Innovative Plan G Zip Codes

Region 3 3 Los Angeles

To determine the premium that you will pay, locate your zip code below under Region 3 for Los Angeles county. Refer to the corresponding premium chart for Region 3, then locate your plan selection; D, G or N under nonsmoking or smoking, then locate your age to obtain your premium rate.

Los Angeles County Region 3 (NPI) Zip Codes: 90002, 90003, 90008, 90010, 90016, 90018, 90019, 90020, 90024, 90025, 90028, 90034, 90035, 90036, 90037, 90038, 90043, 90044, 90045, 90046, 90047, 90048, 90049, 90051, 90052, 90056, 90059, 90061, 90062, 90064, 90066, 90067, 90068, 90069, 90070, 90072, 90073, 90075, 90076, 90077, 90078, 90079, 90080, 90082, 90089, 90093, 90094, 90095, 90209, 90210, 90211, 90212, 90213, 90220, 90221, 90222, 90223, 90224, 90230, 90231, 90232, 90233, 90245, 90247, 90248, 90249, 90250, 90251, 90260, 90261, 90262, 90263, 90264, 90265, 90272, 90290, 90291, 90292, 90293, 90294, 90301, 90302, 90303, 90304, 90305, 90306, 90307, 90308, 90309, 90310, 90311, 90312, 90401, 90402, 90403, 90404, 90405, 90406, 90407, 90408, 90409, 90410, 90411, 90502, 90506, 90710, 90744, 90745, 90746, 90747, 90749, 90805, 90810, 90895, 91040, 91301, 91302, 91303, 91304, 91305, 91306, 90307, 91308, 91309, 91311, 91313, 91316, 91324, 91325, 91328, 91329, 91330, 91331, 91333, 91334, 91335, 91337, 91340, 91341, 91342, 91343, 91344, 91345, 91346, 91352, 91353, 91356, 91357, 91361, 91362, 91364, 91365, 91367, 91371, 91372, 91376, 91392, 91393, 91395, 91396, 91401, 91402, 91403, 91404, 91405, 91406, 91407, 91408, 91409, 91410, 91411, 91412, 91413, 91416, 91423, 91426, 91436, 91470, 91482, 91495, 91496, 91499, 91505, 91506, 91601, 91602, 91603, 91604, 91605, 91606, 91607, 91608, 91609, 91610, 91611, 91612, 91614, 91615, 91616, 91617, 91618, 93599

Age range	Nonsmoking			Smoking ¹		
	Plan D	Innovative Plan G	Plan N	Plan D	Innovative Plan G	Plan N
65-66	\$159	\$167	\$142	\$185	\$193	\$165
67-68	\$176	\$184	\$157	\$205	\$214	\$183
69-70	\$192	\$200	\$171	\$224	\$232	\$200
71-72	\$208	\$216	\$186	\$243	\$251	\$217
73-74	\$224	\$232	\$200	\$260	\$269	\$233
75-76	\$239	\$248	\$214	\$279	\$288	\$249
77-78	\$256	\$265	\$229	\$299	\$307	\$267
79-80	\$269	\$278	\$241	\$314	\$323	\$281
81-82	\$284	\$292	\$253	\$331	\$340	\$296
83-84	\$298	\$307	\$266	\$348	\$357	\$311
85-86	\$312	\$321	\$279	\$364	\$373	\$325
87-88	\$326	\$334	\$291	\$380	\$389	\$340
89-90	\$339	\$348	\$303	\$396	\$405	\$354
91-92	\$352	\$361	\$315	\$411	\$420	\$367
93-94	\$365	\$374	\$326	\$425	\$434	\$380
95+	\$385	\$394	\$344	\$450	\$459	\$402
Disabled under 65	\$385	\$394	\$344	\$450	\$459	\$402

¹A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

Read your Medicare Supplement Plan Policy very carefully

This is only an outline describing your Medicare Supplement Plan Policy's most important features. The Policy is your contract. You must read the Policy itself to understand all of the rights and duties of both you and HNL.

30-day right to return the Medicare Supplement Plan Policy

If you find you are not satisfied with your Medicare Supplement Plan Policy, you may return it to HNL Medicare Supplement Plan at:

PO Box 10420
Van Nuys, CA 91499
Attn.: Membership Accounting

If you send the Medicare Supplement Plan Policy back to us within 30 days after you receive it, we will treat the Contract as if it had never been issued and return all of your payments, less any payments made on claims.

Medicare Supplement Plan Policy replacement

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

Disclosures

This Policy may not fully cover all your medical costs. Neither HNL nor any of its agents are connected with Medicare. This *Outline of Coverage* does not give all the details of Medicare coverage. Contact your local Social Security office or consult the *Medicare Handbook* for more details. For additional information concerning Policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

Complete answers are very important

You do not need to answer questions about your medical and health history if you are applying for coverage during an open enrollment or guaranteed issue period.

When you fill out the application for an HNL Medicare Supplement plan, be sure to truthfully and completely answer all questions about your medical and health history. HNL may have the right to cancel your Medicare Supplement Plan Policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.



AN EXAMPLE SHOWING A DOCTOR'S CHARGES

The following are examples of how the plans pay benefits for Part B charges, assuming a doctor bill of \$2,000 and the annual Medicare Part B deductible of \$198 has been met.

Plan: A, D, and N	Doctor accepts assignment	Doctor does not accept assignment
Charges approved for payment by Medicare	\$1,850	\$1,850
Medicare pays 80% of approved charges	\$1,480	\$1,480
This policy pays	\$370	\$370
You pay coinsurance	\$0	\$150

If your doctor accepts assignment of Medicare benefits, the difference between your doctor's charge (\$2,000) and the Part B charges approved for payment by Medicare (\$1,850) is absorbed by your doctor and you pay no coinsurance. If your doctor does not accept assignment of Medicare benefits, you pay the Part B excess charges.

Plan: F, G and Innovative Plan G	Doctor accepts assignment	Doctor does not accept assignment
Charges approved for payment by Medicare	\$1,850	\$1,850
Medicare pays 80% of approved charges	\$1,480	\$1,480
This policy pays	\$370	\$520
You pay coinsurance	\$0	\$0

Unlike plans A, D, and N, plans F and G pay Part B excess charges. Part B excess charges are the difference between doctor charges and the charges approved for payment by Medicare.

Plan **A** Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,408	\$0	\$1,408 (Part A ded.)
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	\$0	Up to \$176 a day
101st day and after	\$0	\$0	All costs
Blood First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan **A** Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment , such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan **D** Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0
101st day and after	\$0	\$0	All costs
Blood First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan **D** Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Reminder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan **F** Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after: • While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used: – Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0
101st day and after	\$0	\$0	All costs
Blood First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan **F** Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Innovative Plan **F** Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0
101st day and after	\$0	\$0	All costs
Blood First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Innovative Plan **F** Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Innovative Plan

Innovative benefits – Not covered by Medicare or standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine eye exam (with dilation as needed) once every 12 months	\$0	In-network: 100% after the copayment Out-of-network: Up to \$45 allowance	In-network: \$10 copay Out-of-network: Any amounts remaining after the plan pays
Frame and lens package (Any frame and lens available at provider location) – once every 24 months	\$0	Up to \$250 allowance for frame and lens package	80% of the remaining balance
• Contact lenses – Includes materials only, once every 24 months – Conventional	\$0	Up to \$250 allowance	85% of the remaining balance
– Disposable	\$0	Up to \$250 allowance	100% of the remaining balance
– Medically Necessary	\$0	Medically: \$0 copay, paid in full	Up to \$250
Routine hearing benefit Hearing exam – Coverage for up to (1) routine hearing exam every 12 months	\$0	\$0	\$0
Hearing aids • Two hearing aids every calendar year • All sizes and styles offered by Hearing Care Solutions. • Four levels of technology to choose from. All instruments are fully digital. • Covered when determined to be medically necessary based on a hearing exam	\$0	\$0	Level 4 – \$1,580 Level 3 – \$1,125 Level 2 – \$700 Level 1 – \$0

High Deductible Plan **F** Medicare (Part A)

Hospital services – per benefit period

This high deductible plan pays the same benefits as Plan F after one has paid a \$2,340 calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare pays	After you pay \$2,340 ded., plan pays	In addition to \$2,340 ded., you pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Services	Medicare pays	After you pay \$2,340 ded., plan pays	In addition to \$2,340 ded., you pay
101st day and after	\$0	\$0	All costs
Blood First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

High Deductible Plan **F** Medicare (Part B)

Medical services – per calendar year

This high deductible plan pays the same benefits as Plan F after one has paid a \$2,340 calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare pays	After you pay \$2,340 ded., plan pays	In addition to \$2,340 ded., you pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	After you pay \$2,340 ded., plan pays	In addition to \$2,340 ded., you pay
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	After you pay \$2,340 ded., plan pays	In addition to \$2,340 ded., you pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used: – Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Innovative Plan Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used: – Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Innovative Plan Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Innovative Plan

Innovative benefits – Not covered by Medicare or standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine eye exam (with dilation as needed) once every 12 months	\$0	In-network: 100% after the copayment Out-of-network: Up to \$45 allowance	In-network: \$10 copay Out-of-network: Any amounts remaining after the plan pays
Frame and lens package (Any frame and lens available at provider location) – once every 24 months	\$0	Up to \$250 allowance for frame and lens package	80% of the remaining balance
• Contact lenses – Includes materials only, once every 24 months – Conventional	\$0	Up to \$250 allowance	85% of the remaining balance
– Disposable	\$0	Up to \$250 allowance	100% of the remaining balance
– Medically Necessary	\$0	Medically: \$0 copay, paid in full	Up to \$250
Routine hearing benefit Hearing exam – Coverage for up to (1) routine hearing exam every 12 months	\$0	\$0	\$0
Hearing aids • Two hearing aids every calendar year • All sizes and styles offered by Hearing Care Solutions. • Four levels of technology to choose from. All instruments are fully digital. • Covered when determined to be medically necessary based on a hearing exam	\$0	\$0	Level 4 – \$1,580 Level 3 – \$1,125 Level 2 – \$700 Level 1 – \$0
Routine Chiropractic and Acupuncture benefit Routine chiropractic services are covered at 100%. Coverage up to 20 visits each calendar year, visit limit is combined with acupuncture services.	\$0	\$0	\$0

Plan **N** Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,408	\$1,408 (Part A ded.)	\$0
61st through 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$0
• Once lifetime reserve days are used:	\$0	100% of Medicare-eligible expenses	\$0 ²
– Additional 365 days	\$0	\$0	All costs
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$176 a day	Up to \$176 a day	\$0
101st day and after	\$0	\$0	All costs
Blood First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice care You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

¹A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

²**Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan **N** Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment , such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood First 3 pints	\$0	All costs	\$0
Next \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign travel – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Eligibility provisions

You are eligible for enrollment in one of HNL's Medicare Supplement plans if you are 65 or older and entitled to Medicare on the basis of Social Security disability benefits and do not have end-stage renal disease (ESRD), are enrolled in Medicare Parts A and B, and reside within the State of California. Your continued eligibility to participate in this health plan depends on your continued Medicare enrollment. You may be eligible for guaranteed issuance of a Medicare Supplement Plan Policy with HNL. Please call Health Net Life Medicare Inside Sales for more details at **1-800-944-7287**.

IF YOU ARE 64 OR YOUNGER

You may be able to enroll in one of HNL's Medicare Supplement plans, under the following conditions:

- You are a resident of California.
- You are enrolled in Medicare Parts A and B at the time you apply.
- You qualify for guaranteed acceptance in an HNL plan according to HNL's guidelines.
- You do not have end-stage renal disease.

Claims reimbursement

HNL Medicare Supplement plans feature electronic claims processing, a claims payment process between HNL and Medicare. Medicare-certified and Medicare-accepting providers bill Medicare for services provided and, upon processing, Medicare then sends claims electronically to HNL for secondary payment. Electronic claims processing is provided with your membership in an HNL Medicare Supplement plan. There is no registration necessary.

For claims for services covered by your HNL Medicare Supplement plan, but not by Medicare, such as foreign travel emergency care, you or your medical provider should submit the claims directly to HNL at:

Health Net Claims
P.O. Box 9040
Farmington, MO 63640-9040

You may request an HNL claim form by contacting the Member Services number provided on your HNL member identification card.

How to apply

You may apply by completing the application and returning it in the enclosed envelope. You may enroll in your choice of plans A, D, F, High Deductible Plan F, Innovative Plan F, G, Innovative Plan G and N. You may be eligible for guaranteed issuance of a Medicare Supplement Plan Policy with HNL. Please call Health Net Life Medicare Inside Sales for more details at **1-800-944-7287**.

Termination provisions

You can terminate your enrollment in this health plan by giving written notice to HNL that you wish to disenroll at least 30 days prior to the month in which you wish to end your enrollment.

HNL can terminate your coverage:

- If your premium is not paid within the allowed grace period, your coverage will be canceled on the last day of the month for which the premium was last received and accepted by HNL.

- If you make a false statement as to your health status – or obtain or attempt to obtain Covered Services by means of false, misleading or fraudulent information, acts or omissions – HNL may terminate your coverage upon 30 days’ notice, except that no such termination shall be allowed after the expiration of two years from your initial effective date of coverage under this Policy.

If your coverage is terminated by HNL and you have reason to believe that the termination was based upon your health status or requirements for health care services, you may request a review of the termination by the Commissioner of the California Department of Insurance. Information relative to this procedure is available by contacting the Member Services Department.

In the event of cancellation by either HNL (except in the case of fraud or deception in the use of services of this health plan or knowingly permitting such fraud or deception by another) or yourself, HNL shall, within 30 days, return to you the prorated portion of the money paid to HNL which corresponds to any unexpired period for which payment had been received. The amounts shall be adjusted to reflect amounts due on claims, if any.

Grace period

A grace period of 45 days is allowed after each premium due date. When payment is not received within the first two weeks of the month for which it is due, a final bill showing the amount owed will be sent to you. If payment is not received within 30 calendar days after the final bill is sent, your coverage will be terminated on the last day of the month for which premiums were last received and accepted by HNL.

Health Net Life Medicare Inside Sales

Once you have had a chance to review the information presented here, please feel free to call Health Net Life Medicare Inside Sales at **1-800-944-7287**. We’ll be glad to talk to you about this plan and all the benefits it offers you.

Grievance and arbitration

If you have a grievance against HNL, or are ever dissatisfied with our services, and our HNL Medicare Supplement Plan Member Services Department is not able to solve the problem, there is a procedure for appealing the issue. You may write a letter explaining the problem to:

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

HNL uses neutral, binding arbitration to settle disputes that arise out of or relate to coverage under the Policy. When you enroll in an HNL Medicare Supplement Plan, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

This binding arbitration provision does not apply to claims, disputes or controversies relating to alleged professional negligence (medical malpractice) and applies only to matters arising under this Policy.

Medicare has specific appeals procedures for the portion of the bill it pays. If you feel a decision made on a claim is incorrect, any Social Security office can help you request a review.

Department of Insurance

If the covered person is unable to resolve a dispute with HNL, the covered person may wish to contact:

California Department of Insurance
300 South Spring St.
Los Angeles, CA 90013
1-800-927-HELP

For more information, please contact Health Net Life Insurance Company (Health Net Life)



Health Net Life
Medicare Supplement Plan
PO Box 10420
Van Nuys, CA 91499

HEALTH NET LIFE MEDICARE INSIDE SALES

1-800-944-7287

HEALTH NET LIFE MEMBER SERVICES

1-800-926-4178

PARA LOS QUE HABLAN ESPAÑOL

1-800-926-4178

ASSISTANCE FOR THE HEARING AND SPEECH IMPAIRED

TTY users call 711.

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