

2012 OPTIONAL BENEFIT GUIDE

Routine Vision Optional Benefit

You can choose to add the Routine Vision Optional Benefit to any Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) Medicare Supplement plan for an additional monthly premium.

The Routine Vision Optional Benefit provides coverage for an annual routine eye exam and routine eyewear. Covered routine vision benefits may be obtained from in-network or out-of-network providers. In-network coverage applies when you receive covered services from providers who participate in the vision network. Your cost-sharing will generally be lower when utilizing in-network providers than when accessing care out-of-network. To find out if your provider is in the Health Net Vision network, call 1-866-392-6058 (TTY 1-866-308-5375). Or visit our webpage at www.healthnet.com > Select the *I'm a Member* tab and choose a state > Select *Doctor & Hospital Information* > Select *Supplemental Plan Provider Search* > Select *Vision*

MONTHLY PREMIUM: \$5

Benefit	In-Network	Out-of-Network
Annual routine eye exam	\$10 copay	Up to \$45 allowance ¹
Routine eyewear (frame and lenses or contact lenses)	\$250 allowance every 24 months ²	

¹ Plan pays up to the allowance amount and member is responsible for any remaining balance.

² Multi-year benefits may not be available in subsequent years.

HOW AND WHEN TO APPLY:

New members: You may submit your application for enrollment in the Routine Vision Optional Benefit at the same time you submit your application for enrollment in a Health Net of Oregon Medicare Supplement plan. The Routine Vision Optional Benefit is effective on the same date as your Medicare Supplement plan.

Current members: If you are a current member, and have never elected the Routine Vision Optional Benefit, you may submit your application for enrollment in the Optional Benefit at any time. The Routine Vision Optional Benefit is effective the first of the month following receipt of your application.

Your enrollment in the Routine Vision Optional Benefit is automatically renewed each calendar year as long as you are a member of a Health Net of Oregon Medicare Supplement plan. If you cancel the Routine Vision Optional Benefit, you will not be able to re-enroll in it for 12 months.

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HEALTH NET HEALTH PLAN OF OREGON, INC.

2012 MEDICARE SUPPLEMENT ROUTINE VISION OPTIONAL BENEFIT INDIVIDUAL APPLICATION

ROUTINE VISION OPTIONAL BENEFIT

Monthly Premium: \$5

Benefits: Routine eye exam and routine eyewear

In order to apply for the Routine Vision Optional Benefit, you must apply for or be enrolled in a Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) Medicare Supplement plan.

PLEASE PRINT

Last name:		First name:		MI:	Birth date: / /
Residential Street Address:			City:	State:	ZIP:
Mailing Address (if different from above):			City:	State:	ZIP:
Home phone: ()	Work phone: ()	Email address:			
Medicare # <i>(from red, white, & blue Medicare card)</i> :			Health Net member/subscriber Reference # (if applicable):		

Health Net of Oregon will notify you of the effective date of your Routine Vision Optional Benefit coverage.

The premium for the Routine Vision Optional Benefit is in addition to the Health Net of Oregon Medicare Supplement monthly plan premium. Premiums for the Routine Vision Optional Benefit will be added to your Medicare Supplement plan billing and set up on the same premium payment mode (i.e., check or automatic bank draft) as your Medicare Supplement plan.

I understand that to be eligible for the Routine Vision Optional Benefit, I must remain a member of a Health Net of Oregon Medicare Supplement plan. If I disenroll from my Medicare Supplement plan or my Medicare Supplement plan otherwise terminates, I will be automatically disenrolled from the Routine Vision Optional Benefit. If I discontinue payment of the Routine Vision Optional Benefit, my membership in this optional benefit will be terminated, and I will only be enrolled in the Health Net of Oregon Medicare Supplement plan. I may cancel the Routine Vision Optional Benefit at any time by providing written notification to Health Net of Oregon. Enrollment in the Routine Vision Optional Benefit will cease the first of the month after receipt of the written notification. However, once disenrolled from the Routine Vision Optional Benefit, re-enrollment cannot occur until the following calendar year.

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Please refer to the 2012 Optional Benefit Guide: Routine Vision Optional Benefit or to your Routine Vision Optional Benefit Schedule for additional information on covered benefits and eligibility.

Please complete the following:

I am applying for or currently enrolled in a Health Net of Oregon Medicare Supplement plan and wish to enroll in the Routine Vision Optional Benefit for an additional monthly premium of \$5.

I understand that my signature on this application means that I have read and understand the contents of this application.

Printed name of applicant: _____

Signature of applicant: _____ Date: __ __/__ __/_____
(M M/ D D / Y Y Y Y)

Signature of Health Net representative (*if applicable*):

_____ Date: __ __/__ __/_____
(M M/ D D / Y Y Y Y)

After you have completed this form, please mail it to:

**Health Net Health Plan of Oregon, Inc.
Attn: Medicare Supplement Plans
13221 SW 68th Pkwy., Ste. 200
Tigard, OR 97223**

Thank you for choosing Health Net of Oregon. If you have any questions about applying for a Health Net Medicare Supplement plan or for the Routine Vision Optional Benefit, please contact a Health Net Sales Representative at **1-800-709-4193** (TTY/TDD **1-800-929-9955**) Monday through Friday, 8:00 a.m. to 6:00 p.m., except holidays.

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