Health Net
MEDICARE PROGRAMS

Health Net Medicare Advantage
2014 Statement *of* Understanding *for Sales Appointments*

The Medicare beneficiary should initial each box confirming that the Health Net Representative/Agent has reviewed each item listed below, and that the beneficiary understands this important enrollment information.

Initial each box after reviewing	
	Health Net Representative/Agent 1. The person that is discussing Medicare health plan options with me does not represent Medicare, the Social Security Administration or any branch of the federal or state government.
	Medicare Advantage vs. Medicare Supplement 2. I understand that the Health Net Medicare Advantage (HMO/PPO/SNP) health plan _____ (print plan name) I have selected is not a Medicare Supplemental plan. Health Net will be responsible for my covered medical services and, if applicable, prescription drugs. I will use my Health Net ID card rather than my white, red and blue Medicare card to access my coverage. Should I decide to leave my Medicare Advantage plan in the future, I will retain my eligibility for Original Medicare.
	Medicare Advantage Plan Change 3. When enrolling in a Health Net Medicare Advantage Plan, I understand that I will be automatically disenrolled from any other Medicare Advantage or Part D plan. I understand that I can only be enrolled in one Medicare Advantage Prescription Drug Plan or Part D plan at a time.
	Plan Premiums 4. If my plan has a monthly premium, I understand that I must pay this premium or Health Net reserves the right to disenroll me from the plan after appropriate advance notice. I understand that I am responsible for continuing to pay the Medicare Part B premium in addition to any plan premium if applicable.
	Plan Effective Date 5. I understand that the proposed effective date on the application is not guaranteed and enrollment is not effective until my eligibility has been verified by the Centers for Medicare & Medicaid Services (CMS).
	Plan Changes 6. I have been informed by the sales agent that I may not change MA plans after December 7, 2013, unless I qualify for a Special Election Period (SEP). From January 1 through February 14, 2014, I can only disenroll from my MA plan and return to Original Medicare. I may enroll in a prescription-only drug plan at that time (subject to eligibility requirements).

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	Service Area Requirements 7. I must be a resident in the Health Net Medicare Advantage service area to enroll. I cannot remain outside the plan service area for more than 6 consecutive months. I am aware that certain plans utilize only certain contracted providers within a specific service area. If I move from the plan service area, I must inform Health Net's Member Services immediately. If I receive an out-of-area letter from Health Net, I must respond to the letter within the required time frame or I will be disenrolled from the plan.
	Other Coverage 8. I must cancel any existing employer group or Medicare Supplement coverage when enrolling in an Individual Health Net Medicare Advantage Plan. I understand that I cannot be enrolled in a Medicare Supplement plan and a Medicare Advantage plan or an employer group plan at the same time.
	Physician Selection 9. I understand that I must disclose all physicians providing my health care, including specialists, mental health providers and hospitals in order for my Health Net Representative/Agent to accurately confirm if my doctors are in-network providers who contract with Health Net. If enrolling in an HMO, I have also selected my primary care physician (PCP) _____(print physician name) to coordinate all of my medical services within my primary care medical group (PCMG) for an effective date of _____(print date).
	Physician Network and Referral 10. ☐ If enrolling in an HMO, I must use Health Net-contracted physicians, medical groups, hospitals, and other providers, and most services may require a referral or authorization prior to the service being provided. In most cases, if routine care is obtained from out-of-network providers, neither Medicare nor Health Net will be responsible for the costs associated with the care unless the care has been prior authorized by Health Net. I understand the physician's contractual relationship with Health Net is subject to change at any time and I will be notified in writing by the company. ☐ If enrolling in a PPO, I understand that when I obtain services from out-of-network providers, I may pay higher copays or coinsurance than when I obtain services from in-network providers.
	11. **Provider Specific Plan Enrollees only (If available in your area):** Not all participating provider groups (PPGs) and their affiliated primary care physicians (PCPs) and facilities are available to you in your service area for this plan. In addition, you may be limited to providers within your primary care physician's (PCP's) and/or medical group's network. This means that the PCP and/or medical group that you choose may determine the specialists and hospitals you can use. It is important to understand that Health Net offers a variety of plans in each service area; if your provider of choice is not available through this plan, the provider may be available through a different Health Net plan offering.

	Medicare and Medicaid or Medi-Cal Coverage 12. **Dual Eligible Special Needs Plan (DE-SNP) Enrollees Only (If available in your area):** a. I qualify for enrollment in Health Net's Dual Eligible Special Needs (HMO DE-SNP) Plan by meeting one of the income eligibility requirements governed by the federal government and/or my state of residence. I have_____ /have not_____ provided written proof of my eligibility to the Health Net Representative/Agent. b. I have been informed by the Health Net Representative/Agent and understand that Health Net has additional health care management requirements, governed by federal regulation, for members who are enrolled in a Medicare Advantage DE-SNP. I agree to work with Health Net to meet these requirements to the best of my ability. c. I have been informed by my Health Net Representative/Agent that by enrolling in Health Net's Dual Eligible Special Needs Plan, Health Net will be responsible for my covered medical services and/or prescription drugs. I will present both my Health Net ID card and Medicaid/Medi-Cal /AHCCCS ID (as applicable to my state) card to obtain my health care and prescription drug coverage. Health Net is my primary insurer and Medicaid/Medi-Cal/AHCCCS (as applicable to my state) provides secondary coverage for some items/services not covered by Health Net. I must contact my primary care physician (PCP) to coordinate all my medical services with Health Net within my participating provider group (PPG). Once enrolled, I will be automatically disenrolled from any standalone Prescription Drug Plan coverage. d. I have been informed by my Health Net Representative/Agent that a change in my Medi-Cal/AHCCCS (as applicable to my state) eligibility status may effect my enrollment and/or cost-sharing.
	13. **Chronic Special Needs Plan (C-SNP) Enrollees only:** a. I qualify for enrollment in Health Net's Chronic Special Needs Plan (HMO SNP) by meeting at least one of the eligibility requirements governed by the federal government. I have initialed next to the health condition that applies to me: _____ Chronic heart failure (CHF) _____ Diabetes _____ Cardiovascular disorders b. I have been informed by the sales agent and understand that Health Net has additional health care management requirements, governed by federal regulation, for members who are enrolled in a Medicare Advantage C-SNP. I agree to work with Health Net to meet these requirements to the best of my ability.
	Health Net Representative/Agent Requirements 14. The Health Net Representative/Agent has: a. Reviewed the summary of benefits and other required information in the enrollment packet with me in a language which I understand. I am comfortable enrolling in the plan. b. Informed me of the time frames that I may enroll or disenroll in Medicare Advantage plans, (i.e., Annual Election Period, Annual Disenrollment Period and Lock-in periods). c. Designated the primary care physician (PCP) and primary care medical group (PCMG) accurately on the enrollment form, if I am enrolling in an HMO. d. Provided me with his or her business card with a business phone number if I have additional questions. e. Provided me with a copy of the completed application, all required materials and a copy of this form. f. Verbally explained how or where to find out which prescription drugs are covered, explained prescription drug pricing (including where to look up prescription drug pricing) and described the prescription drug coverage gap or "donut hole" or where to find its description, if applicable. g. Discussed the Optional Supplemental Benefit packages with me, including the covered benefits, noncovered benefits, copayments and premiums if available with my plan.

	Legal or Other Representative Assistance 15. I attest there is no other legal representative, power of attorney (POA) or other individual(s) that needs to be present to assist me with my health care decisions. If I do not have legal or other representative assistance, then this question is not applicable (N/A).
	16. **Notes:** _____ _____

Enrollee statement: By signing this form, I certify that my Health Net Representative/Agent has reviewed this information with me, answered all of my questions and that the information I have supplied to the Health Net Representative/Agent has been accurately recorded here.

Enrollee's name:	Medicare #: ___ ___ ____ ___ ___ ___ ___ ___ ___ ___
Enrollee phone #:	Plan selected:
Legal representative name (or N/A):	Legal representative phone #:
Enrollee's or legal representative's signature:	Today's date: (__ __ __ __ __ __ __ __) (M M D D Y Y Y Y)
Health Net Representative/Agent statement: I certify that I have reviewed this document, the Summary of Benefits for the selected product, and other Health Net or CMS required information with the enrollee; that the information on the application has been provided to me by the enrollee and/or their legal representative; and that the enrollee or legal representative has signed the enrollment application.	
Health Net Representative/Agent name:	Health Net Representative/Agent signature:
Health Net Representative/Agent #:	Today's date: (__ __ __ __ __ __ __ __) (M M D D Y Y Y Y)

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