State of California–Health and Human Services Agency
Department of Health Care Services

P.O. Box 989009
West Sacramento, CA 95798-9850
1.844. 580.7272

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Health Care Options, P.O. Box 989009
West Sacramento, CA 95798-9860

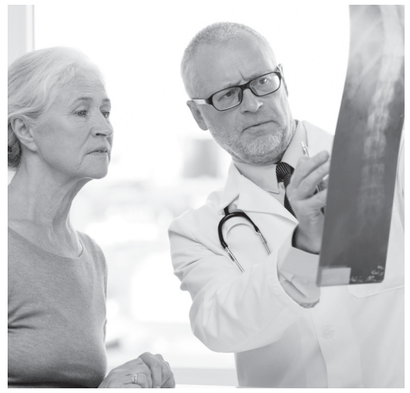
To the addressee or guardian of:

H

JOHN SAMPLE
1234 SAMPLE STREET
ANYTOWN CA 90000

Choose A Plan

See inside for choice forms



Managed Care Plan Choice Book

Cal MediConnect and Medi-Cal Managed Care Plans

CalMediConnect Your choice for complete care

Department of Health Care Services

MU_0004062_LANG_0715

H

State of California-Health and Human Services Agency
Department of Health Care Services
P.O. Box 989009, West Sacramento, CA 95798-9850

XX/XX/XXXX

RETURN SERVICES REQUESTED
To the addressee of guardian of:

JOHN SAMPLE
1234 SAMPLE STREET
ANYTOWN CA 90000

~~Welcome to Medi-Cal! We look forward to working with you to keep you healthy. That's our number one priority.~~

~~You are getting this letter because you have BOTH Medicare and Medi-Cal. Because of new requirements, you MUST choose a Cal MediConnect Plan, a Medi-Cal Managed Care Plan, or apply for PACE to cover all your Long Term Services and Supports. You have many health plans to choose from to receive your Medi-Cal benefits. You can choose a Cal MediConnect Plan, which covers all of your current Medicare and Medi-Cal benefits together under one plan, and includes extra benefits. You can also choose to keep your Medicare separate and choose a Medi-Cal Managed Care Plan for your Medi-Cal benefits, or you may be eligible to apply for a Program of All-Inclusive Care for the Elderly (PACE) plan.~~

This choice book explains the benefits of each health plan and explains how to enroll into the plan that best fits your health care needs. Please read the choice book carefully.

Enclosed in this choice book is your health plan enrollment choice form, **please complete and return the choice form by XX/XX/XXXX**.

If you do not make a choice, we will choose a Medi-Cal Managed Care Plan for you.

You can choose a plan that fits your needs at any time before XX/XX/XXXX.

After we receive your plan choice, you will receive a letter with your chosen health plan's name and start date. Your new health plan will also send you helpful information about how to get the care you need once you are enrolled. You can change your health plan at anytime by contacting Health Care Options toll-free at 1-844-580-7272.

The effective date of your plan enrollment will depend on when we receive your plan choice but it wont be later than XX/XX/XXXX.
Your plan could be effective as early as the first of next month.

If you have questions, want to enroll over the phone, or need this packet in another language or alternative format, please call Health Care Options toll-free at 1-844-580-7272, between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday. TTY/TDD users please call 1-800-430-7077.

If you need help completing the choice form, please see the Health Care Options presentation schedule inside this choice book for site locations near you or visit us online at **healthcareoptions.dhcs.ca.gov**.

Again, welcome and we look forward to working with you to keep you healthy.

Health Plan Choice Form Instructions

These instructions will help you fill out the Health Plan Choice Form on the next page to select the option that works best for you.

For help filling out the form, call Health Care Options at 1-844-580-7272.

STEP 1: Tell us about yourself
Please fill in any blanks and correct any errors. If your name and other information are correct, you do not need to do anything in this step.

STEP 2: Choose how you want your care
Please choose a plan in either Option A or Option B. If you do **NOT** make a choice, you will be automatically enrolled into a Medi-Cal Manage Care Plan.

- **Option A** - If you want to get your Medicare and Medi-Cal benefits combined in one plan, fill in the circle (◯) to the left of the Cal MediConnect Plan you want.
- **Option B** - If you want to keep your Medicare separate from your Medi-Cal, you must choose a Medi-Cal plan for your Medi-Cal benefits. Fill in the circle (◯) to the left of the Medi-Cal plan you want.
- To qualify for the Program of All-Inclusive Care for the Elderly (PACE), you have to meet certain requirements such as:
  - Be age 55 or older,
  - Live in a certain zip code, and
  - Meet a level of need for skilled nursing home care, as determined by the PACE organization's interdisciplinary team assessment and certified by the Department of Health Care Services.

  In case you do not qualify, you **MUST** still choose a plan in Option A or Option B.

Ask your doctors and other health care providers to see which plans they work with. You may also contact the plans directly to get a list of doctors and providers. Telephone numbers for the plans are listed in the back pages of this choice book.

STEP 3: Read the important information on the back before signing.
Please read the information on the back of the form, then sign and date your completed Plan Choice Form. Use the envelope in this Health Plan Choice Book to mail your completed Health Plan Choice Form. You do not need a stamp if you use the enclosed envelope.

Blank Backer

Health Plan Choice Form

California Department of
Health Care Services
P.O. Box 989009
W. Sacramento, CA 95798-9850

Use this form to join or change a health plan. For FREE help with this form, contact Health Care Options at 1-844-580-7272. Mail completed form to California Department of Health Care Services, Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850. Please print clearly using blue or black ink.

CCIPB

STEP 1: Tell us about yourself:

First Name, Last Name

M– XXXXXXXXXA–H

Address, City

Zip Code

Date of Birth ___ ___ - ___ ___ - ___ ___

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
(Area Code) Phone Number

Sex: ○ Male ○ Female

If pregnant, estimate due date ___ ___ - ___ ___ - ___ ___
Month Day Year

STEP 2: Choose how you want your care:

OPTION A

Combine my Medicare and Medi-Cal benefits in one plan.

Choose one of these Cal MediConnect plans:

- ○ 800 L.A. Care
- ○ 801 Health Net
- ○ 816 Molina Dual Options
- ○ 817 Care1st
- ○ 818 CareMore

OR

OPTION B

Keep my Medicare the way it is now AND choose a Medi-Cal plan.

Choose one of these Medi-Cal plans to get your Medi-Cal benefits:

- ○ 304 L.A. Care Health Plan
  - Plan Partners
    - ☐ CF Care1st Partner Plan, LLC
    - ☐ LA L.A. Care Health Plan
    - ☐ BC Anthem Blue Cross Partnrshp
- ○ 352 Health Net Comm Solutions
  - Plan Partners
    - ☐ HN Health Net Comm Solutions
    - ☐ MO Molina Healthcare Partner

Program of the All-Inclusive Care for the Elderly (PACE):
You may qualify for PACE (see instructions). If you want to get your Medicare and Medi-Cal benefits combined in a PACE plan, fill out this option **in addition to Option A or B**.

If you do not qualify, you will get your care through the Option A or Option B plan that you chose above in Step 2.

PACE Plan:

- ○ 052 AltaMed Senior BuenaCare

STEP 3: Read the important information on the back before signing. I understand that by filling out and signing this form, I am choosing how to get my health care.

Applicant's Signature Date OR Authorized Representative Signature *(if any)* Date

CCIPB

Confidential

Health Plan Choice Form

California Department of
Health Care Services
P.O. Box 989009
W. Sacramento, CA 95798-9850

Read this important information before you sign the form.

If I Join the Medi-Cal KP Cal, LLC (Kaiser Permanente): I understand that Kaiser requires binding arbitration for my Medi-Cal benefits. This means that I give up my right to a jury or court trial for medical malpractice and other disagreements about benefits and services. Instead, I would help choose independent professionals who would make a decision about the problem. I can still ask for a Medi-Cal State Hearing.

If I chose PACE, I will be contacted to see if I meet the eligibility requirements for enrollment into the PACE health plan. I must meet the nursing home level of care and still be able to live safely in a community setting.

By completing this enrollment application for a Cal MediConnect Plan or by allowing the State to enroll me in a Cal MediConnect Plan, I agree to the following:

Cal MediConnect Plans are Medicare-Medicaid plans that have a contract with the State of California and the Federal government. I will need to keep my Medicare Parts A and B and Medi-Cal. I can be in only one Medicare plan at a time, and I understand that my enrollment in the plan selected will automatically end my enrollment in any other Medicare health plan or Medicare prescription drug plan.

I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll be able to receive at least one 30-day supply of the prescription drugs I currently take anytime during the first 90 days of coverage in a Cal MediConnect Plan. I understand that I may be able to continue seeing the doctors I go to now for a period up to six (6) months for Medicare services and a period of up to twelve (12) months for Medi-Cal services from the effective date of enrollment in a Cal MediConnect Plan. I must contact the Cal MediConnect Plan for information on how to do this. I further understand that the Cal MediConnect Plan has providers and pharmacies that I must use to get health care services, except for non-routine, emergency situations.

Cal MediConnect Plans serve a specific service area. If I move out of the area covered by the plan chosen, I need to notify the plan so I can disenroll and find a new plan in my new area.

I understand that beginning on the date my Cal MediConnect coverage begins, I must get all of my health care from my new plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by my Cal MediConnect Plan and other services contained in my plan's Evidence of Coverage document will be covered. Without authorization, NEITHER Medicare, Medi-Cal NOR my Cal MediConnect Plan WILL PAY FOR THE SERVICES.

Release of Information: By joining this Medicare and Medicaid plan, I acknowledge that the plan I selected will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that my Cal MediConnect Plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of California on this application) means that I've read and understand the contents of this application. If signed by an authorized individual, this signature certifies: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Privacy Statement

The Department of Health Care Services will keep the information you provide. It is used only to enroll and/or disenroll people that are eligible for Medi-Cal managed care. The laws that allow this are in the Welfare and Institutions Code, Section 10416.5, 14016.6, 14087.305, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96, 14088, 14089, 14089.5, and 14631, and California Code of Regulations, Section 51085.5.

Only other government agencies that relate to the Medi-Cal program can see the information you provide. However, any information that is being used in an investigation or lawsuit cannot be seen. If you want to see your Medi-Cal file, contact the Department of Health Care Services at the address on the other side of this form.

Health Information Form

1010

DHCS

You are receiving this form because you are eligible to enroll in a new Medi-Cal health plan. Your new plan will use this form to make sure you get needed care.

Please fill in the circle with black or blue pen for the answers that apply to you. Complete one form for each person in your family who is enrolling in a new Medi-Cal health plan.

If you have questions, please call Health Care Options, toll free at 1-800-430-4263 Monday through Friday, between 8:00 a.m. and 5:00 p.m. TDD/TTY users should dial 1-800-430-7077.

Please return completed form with your Medi-Cal Choice Form or mail separately to:

CA Department of Health Care Services
Health Care Options - PO Box 989009
West Sacramento, CA 95798-9850

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Born In:

Name of Person Completing Form: ____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|

1. Do you need to see a doctor within the next 60 days? ○ Yes ○ No
2. Do you take 3 or more prescription medicines each day? ○ Yes ○ No
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? ○ Yes ○ No
4. Have you been to the emergency room two or more times in the last 12 months? ○ Yes ○ No
5. Have you been admitted to the hospital in the last 12 months? ○ Yes ○ No
6. Have you needed help with personal care, such as bathing, getting dressed, or changing bandages in the last 6 months? ○ Yes ○ No
7. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? ○ Yes ○ No
8. Do you have a condition that limits your activities or what you can do? ○ Yes ○ No
9. Are you pregnant? ○ Yes ○ No
   9a. If Yes, are you currently seeing a doctor for this pregnancy? ○ Yes ○ No
10. Do you see a doctor regularly for a chronic medical condition? ○ Yes ○ No

If Yes, fill in all that apply:

○ a. Asthma ○ b. Cancer ○ c. Cystic Fibrosis ○ d. Diabetes
○ e. Heart Problems ○ f. Hepatitis ○ g. High Blood Pressure ○ h. HIV or AIDS
○ i. Kidney Disease ○ j. Seizures ○ k. Sickle Cell Anemia ○ l. Tuberculosis
○ m. Other ____|____|____|____|____|____|____|____|____|____|____|

When you become a health plan member, DHCS will send this information to your Medi-Cal health plan.

If you think you need to see a doctor before your Medi-Cal health plan contacts you, you should go to the doctor or hospital at that time.

I understand that this information will be disclosed to Health Care Options and my new plan.

Signature: _____ Date Signed: ____|____ - ____|____ - ____|____|____|____

If not signed by beneficiary, specify relationship: ☐ Parent of minor ☐ Guardian ☐ Other representative

CONFIDENTIAL

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Medi-Cal Managed Care
Non-Medical Exemption

Request for Non-Medical Exemption from Plan Enrollment
American Indians or Beneficiaries with HIV/AIDS in Coordinated Care Initiative Counties

Dear Medi-Cal Beneficiary: If you are receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you are a qualified individual for this exemption and you want to receive medical services through your choice of facility or provider, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through a service facility or provider of your choice.

To be excused from plan enrollment you must have a service facility or provider representative complete this form, certifying that you are or will be receiving services from a service facility or provider of your choice. The facility representative must submit this completed form to Health Care Options.

Dear Service Facility or Provider: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The exemption form is valid until the individual chooses to enroll in a Medi-Cal Managed Care health plan. This form may be submitted for beneficiaries who are receiving Medi-Cal services in a Coordinated Care Initiative County and has operating Cal MediConnect health plans and: 1) are American Indian, or 2) have been diagnosed with HIV or AIDS.

Mail completed form to:
Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or Fax this form to:
(916) 364-0287

If you have any questions regarding this form, please call HCO at 1-844-580-7272; TTY/TDD users, call 1-800-430-7077.

Please Print or Type (Ink Only)
Each area of this non-medical exemption form must be completed or the form will be returned unprocessed.

1. Beneficiary Name: Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
3. Name of Service Facility or Provider I certify that the information I have provided on this form is correct. I understand that the Department of Health Care Services may audit this form to determine if the information provided is accurate.	
4a. Authorized Signature of Medi-Cal Provider	4b. Date signed ___ ___ / ___ ___ / ___ ___ ___ ___ Month Day Year
4c. Printed name of Medi-Cal Provider Last Name First Name M.I.	4d. NPI Number **used to bill the Medi-Cal Program for this beneficiary** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
5. Telephone number of Medical Provider (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	6. Fax number of Medical Provider (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
7. Telephone number of Medical Physician (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	8. Fax number of Medical Physician (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Blank Backer

TEAR HERE

TEAR HERE

DID YOU REMEMBER TO . . .

Sign and date your Choice Form?

Keep the last copy?

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NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

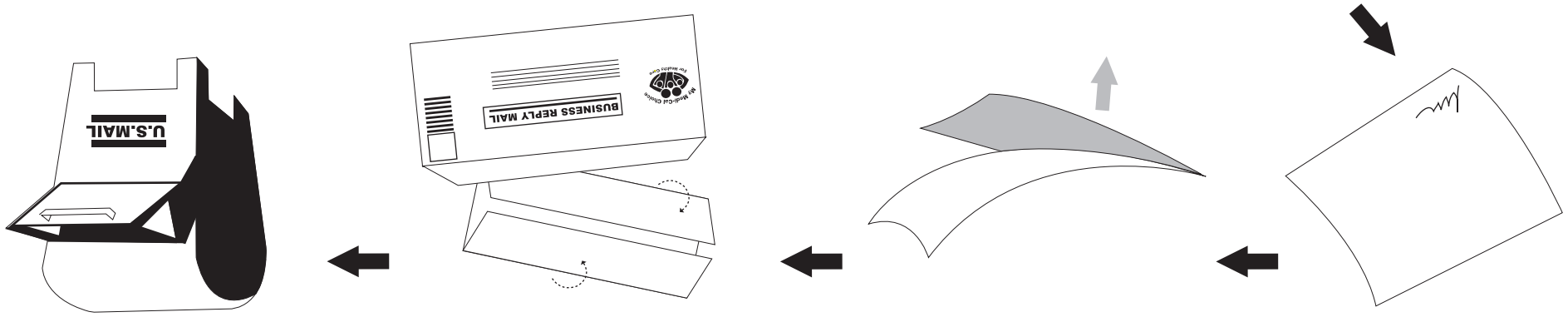
My Medi-Cal Choice
For Healthy Care

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 238 WEST SACRAMENTO, CA

POSTAGE WILL BE PAID BY ADDRESSEE

CA DEPARTMENT OF HEALTH CARE SERVICES
HEALTH CARE OPTIONS
PO BOX 989009
WEST SACRAMENTO, CA 95798-9850



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PEEL OFF

PEEL OFF

Health Care Options Presentations

Attend an informative session at one of these convenient locations.

California Health Care Options (HCO) Presentation Sites
Los Angeles County
August 2015 Schedule

- **In-Person Medi-Cal Managed Care Information**
- **No Appointment Necessary**
- **Free Help To Complete Forms**

Just ask for the "Health Care Options" Representative

CITY	LOCATION	ZIP CODE	DAY	HCO SITE HOURS	LANGUAGES
Canyon Country	**County of LA Dept of Public Social Services Santa Clarita Branch 27233 Camp Plenty Road**	**91351**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
Chatsworth	County of LA Dept of Public Social Services DPSS West Valley Family Service Center 21415 Plummer Street	91311	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
Compton	**County of LA Dept of Public Social Services 211 E. Alondra Boulevard**	**90220**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
Cudahy	County of LA Dept of Public Social Services 8130 S. Atlantic Avenue	90201	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
El Monte	**County of LA Dept of Public Social Services San Gabriel Valley Family Service Center 3350 Aerojet Avenue**	**91731**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish Vietnamese / Cantonese / Mandarin**
	County of LA Dept of Public Social Services San Gabriel Valley Family Service Center 3352 Aerojet Avenue	91731	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish Vietnamese / Cantonese / Mandarin

Presentation times, dates, and locations are subject to change. Please contact the Health Care Options toll-free number **1 (800) 430-4263** to verify the schedule before attending. Additional sites may be available at the time of your call. **Health Care Options will not be conducting presentations on August 21st due to a staff meeting.**

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CITY	LOCATION	ZIP CODE	DAY	HCO SITE HOURS	LANGUAGES
Glendale	**Los Angeles County Dept of Public Social Services 4680 San Fernando Road**	**91204**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish / Armenian / Russian / Farsi**
Lancaster	Los Angeles County Dept of Public Social Services 349-B East Avenue K-6	93535	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
Los Angeles	**Dept of Public Social Services County of Los Angeles 5445 Whittier Boulevard**	**90022**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
	Exposition Park Family Service Center County of Los Angeles 3833 S. Vermont Avenue	90037	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
	County of LA Dept of Public Social Services 1740 E. Gage Avenue	**90001**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
	Los Angeles County Dept of Public Social Services 4077 N. Mission Road	90032	T & W	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
			TH	8:00am - 12:30pm	
	Dept of Public Social Services County of LA 2855 E. Olympic Blvd	**90023**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**

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Los Angeles	County of Los Angeles 2615 S. Grand Avenue	90007	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
	County of LA Dept of Public Social Services 2601 Wilshire Boulevard	**90057**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
	Metro Special District #70 2707 S. Grand Avenue	90007	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
	Dept of Public Social Services Rancho Park District 11110 W. Pico Blvd	**90064**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
	Ben F Peery Building County of LA Dept of Public Social Services 10728 S. Central Avenue	90059	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
	County of LA Administration Building 8300 S. Vermont Ave	**90044**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
	County of LA Dept of Public Social Services Southwest Special District 1819 W. 120th Street	90047	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish

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Los Angeles	**Dept of Public Social Services County of LA 2415 W. 6th Street**	**90057**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
Norwalk	Norwalk 12727 Norwalk Blvd.	90650	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
Panorama City	**County of LA Dept of Public Social Services 14545 Lanark Street**	**91402**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
Pasadena	LA County Dept of Public Social Services Child Support Services 955 N. Lake Avenue	91104	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
Pomona	**LA County Dept of Public Social Services 2040 W. Holt Avenue**	**91768**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
Rancho Dominguez	County of LA Dept of Public Social Services Paramount District Office 2961 East Victoria Street	90221	M - F	8:00am - 12:30pm 1:30pm - 5:00pm	English / Spanish
	County of LA Dept of Public Social Services 17600 "A" Santa Fe Ave.	**90221**	**M - F**	**8:00am - 12:30pm 1:30pm - 5:00pm**	**English / Spanish**
			T & TH		**Cambodian**

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