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

RETURN SERVICES REQUESTED
To the addressee or guardian of:

▶S-◀

John B. Sample
1234 Any Street
ANY CITY, CA 90000




Cal MediConnect Plan Choice Book

Medicare and Medi-Cal

CalMediConnect
Your choice for complete care

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

MU_0003987_ENG_1213

LOS ANGELES COUNTY

Cal MediConnect Plans

These plans cover both Medicare and Medi-Cal.

Health Net Cal MediConnect
1-888-788-5395 • (TTY: 711)
www.healthnet.com/calmediconnect

Molina Dual Options
1-855-665-4627 • (TTY: 711)
www.molinahealthcare.com/duals

L.A. Care
1-888-522-1298 • (TTY: 1-888-212-4460)
www.calmediconnectla.org

CareMore
1-888-350-3447 • (TTY: 711)
www.duals.caremore.com

Care 1st Cal MediConnect Plan
1-855-905-3825 • (TTY: 711)
www.care1st.com/ca/calmediconnect

Medi-Cal Health Plans

These plans cover only Medi-Cal.

Health Net
1-888-327-0502 • (TTY: 1-800-431-0964)
www.healthnet.com

Molina Health Plan
1-888-665-4621 • (TTY: 1-800-479-3310)
www.molinahealthcare.com

L.A. Care
1-888-839-9909 • (TTY: 1-866-522-2731)
www.lacare.org

Anthem Blue Cross
1-800-407-4627 • (TTY: 1-888-757-6034)
www.anthem.com

Care 1st Health Plan
1-800-605-2556 • (TTY: 1-800-735-2929)
www.care1st.com

Kaiser Permanente
1-800-464-4000 • (TTY: 1-800-777-1370)
www.kp.org

How to Make a Health Plan Choice

Call Toll Free by XX/XX/XXXX

- Call toll free at 1-844-580-7272, Monday through Friday, 8:00 am to 5:00 pm. For TTY users, call 1-800-430-7077. A representative can help you sign-up for a health plan or change your health plan.

Visit us in Person

- Find an Enrollment Specialist near you by using one of the following tools:
  - Call California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 to talk to a health insurance counselor about these changes and your choices.
  - Call Health Care Options at 1-844-580-7272 for information. For TTY users, call 1-800-430-7077.
  - Visit www.healthcareoptions.dhcs.ca.gov and click "Presentation Sites" option.

Mail In Your Choice Form by XX/XX/XXXX

- Complete the Choice Form in this book and mail in the postage paid envelope provided.

What are my choices?

You must choose one of these options. Your choices are listed below. There is no cost to join a health plan.

- **Cal MediConnect Plans**

  Get both your Medicare and Medi-Cal benefits in one plan. You will get all your Medicare Part A, Part B and Part D benefits and your Medi-Cal benefits, including Long Term Services and Supports, through a plan of your choice. Get your Long Term Services and Supports (LTSS), including In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), nursing home care, supplies, some durable medical equipment, non-medical transportation, and vision.

  You can choose to stay in regular Medicare. If you choose to stay in regular Medicare, you will still need to choose a Medi-Cal plan. If you are already in a Medi-Cal plan and choose to stay in regular Medicare, you will stay in that Medi-Cal plan.

- **Medi-Cal Plans for Long Term Services and Supports**

  Get your Long Term Services and Supports, including transportation, IHSS, MSSP, CBAS nursing home care, supplies, and some durable medical equipment. Medi-Cal pays your Medicare deductibles and cost sharing, when applicable. Medi-Cal benefits will not change.

- **Program of All-Inclusive Care for the Elderly (PACE)**

  You may qualify for a Program of All-Inclusive Care for the Elderly (PACE) Plan, where you get Medicare and Medi-Cal benefits together.
  In order to qualify you must:

  - ☐ Be 55 years of age or older;
  - ☐ Meet the requirement for skilled nursing home care as determined by the PACE organization's interdisciplinary team assessment and certified by the Department of Health Care Services;
  - ☐ Live in a service area (county and zip code) served by a PACE program, and;
  - ☐ Be able to live in the community without jeopardizing your health or safety.

  Reminder: *While you are being assessed for PACE, you will not be enrolled in Cal MediConnect. However, you must still choose a Cal MediConnect Plan or a Medi-Cal health plan. We need to know your choice just in case you do not qualify to join PACE.*

Health Plan Choice Form Instructions

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

If you do nothing, you will be enrolled in a Cal MediConnect plan.

❶ Personal Contact Information

- Do nothing if your name and other information are correctly filled in.
- If there are errors, please correct them on this form.
- If there are any blanks, fill them in.

❷ If Pregnant

Fill in the month, day, and year the baby is expected to be born (example 12-23-14).

❸ Pick a Cal MediConnect plan

If you want to get both Medicare and Medi-Cal benefits in one plan so they can work together, fill in the circle (◯) to the left of the Cal MediConnect plan you want. To learn more about Cal MediConnect Plans, look in the Cal MediConnect Health Plan Guidebook on pages 8-10. For more help, use the information in this packet of materials or call Heath Care Options at 1-844-580-7272.

❹ Pick a doctor or clinic

If you choose a CalMediConnect plan, you can fill out the doctor or clinic code. To find the doctor or clinic code, contact the health plan for their provider directory. This doctor or clinic code is next to or under the doctor or clinic name. The doctor or clinic code can also be called a PCP#, a PCP ID#, NPI, or #. All codes are 10 characters or less. To find your doctor or clinic code visit www.healthcareoptions.dhcs.ca.gov and click *"Provider Information Network (PIN)"* in the middle of the page under Hot Topics and the Latest News.

❺ Pick a Medi-Cal plan for your Medi-Cal Services

If you do not pick a Cal MediConnect plan, you must pick a Medi-Cal plan. Your Medicare will not change. If you are already in a Medi-Cal plan, you can choose to stay in that plan or you can pick a new plan.

To pick a Medi-Cal plan and keep your Medicare, fill in the circle (◯) to the left of the Medi-Cal plan you want. If there are plan partners listed below the Medi-Cal plan and you want to pick a plan partner, fill out the square (☐) next to the plan partner you want to pick.

To learn more about Medi-Cal Plans, look in the Cal MediConnect Health Plan Guidebook on pages 11 and 12. For more help, use the information in this packet of materials or call Health Care Options at 1-844-580-7272.

❻ Changing your health plan

If you are already in a plan but choosing a different plan, please help us understand the reason for this change. Look at the Reason Codes below and choose the Reason Code that best describes the reason for your health plan change. Fill out a Reason Code number you selected in the box ⌊__⌋ in ❻. If you are not changing plans, leave ❻ blank.

- Reason Code 1 I could not choose the doctor I wanted
- Reason Code 2 The health plan did not meet my needs
- Reason Code 3 My doctor did not meet my needs
- Reason Code 4 Too far to go
- Reason Code 5 I did not choose this plan
- Reason Code 6 Moving out of the county
- Reason Code 9 Other

❼ Program of All-Inclusive Care for the Elderly (PACE)

If you are age 55 or older and live in an applicable zip code, then PACE may be a choice for you. If PACE ❼ is listed on your Health Plan Choice Form and you pick a PACE plan, you must also pick a Cal MediConnect plan from ❸ **or** a Medi-Cal plan from ❺. We need to know your choice just in case you do not qualify to join PACE.

Sign and date your completed Health 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.

Health Plan Choice Form

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

For free help filling out this form, call **1-844-580-7272**

CCIOA

Please print all CAPITAL LETTERS. Use a blue or black pen. Fill in the ○ or ☐ completely to show your choice.

JOHN SAMPLE
❶ First Name, Last Name

M- -99999999A-H

1234 SAMPLE STREET SAMPLE CITY
Address, City

99999 Zip Code

12-14-11 Date of Birth

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

Sex: ○ Male ○ Female

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

PLEASE READ the Instructions and Guidebook before completing this form.

❸ Cal MediConnect Plans:

- ○ 800 L.A. Care
- ○ 801 Health Net
- ○ 816 Molina Dual Options
- ○ 817 Care 1st
- ○ 818 CareMore

❹ Health plan doctor or clinic code. (See instructions)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

❺ Medi-Cal Plans:

- ○ 304 L.A. Care Health Plan
  Plan Partners
  - ☐ CF Care1st Partner Plan, LLC
  - ☐ KA KP Cal, 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

❻ If you are changing your health plan, enter your plan change reason code number. (See instructions) ___

❼ PACE Plan:

- ○ 052 AltaMed Senior BuenaCare

STOP! Read the important information on the back before you sign this form.

I understand that by filling out and signing this form, I am choosing how to get my health care.

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

CCIOA

Highly 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.

TEAR HERE

TEAR HERE

DID YOU REMEMBER TO...

Sign and date your Choice Form?

Keep the last copy?

MU_0003491_ENG_1207

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

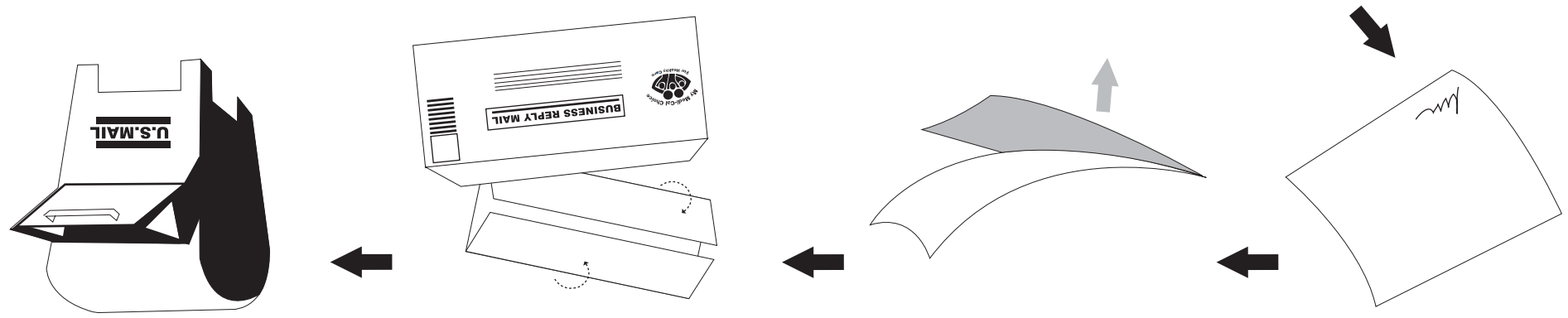
My Medi-Cal Choice
For Healthy Care

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



FOLD HERE

PEEL OFF

FOLD HERE

PEEL OFF

CalMediConnect

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
(TTY:1-800-430-7077)

MU_0003988_ENG_1213