Health Plan Choice Form

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

CCIOB

For Free Help with this form, contact Health Care Options at 1-844-580-7272.

STEP 1: Tell us about yourself:

First Name, Last Name

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security Number

Address, City

Zip Code

___ ___ - ___ ___ - ___ ___
Date of Birth

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Sex: ○ Male ○ Female
(Area Code) Phone Number

If pregnant, 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
  - ☐ 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

Additional Health Plan Option- Program of All-inclusive Care for the Elderly (PACE)

If you are 55 or older and need a higher level of care to live at home, you may be able to join PACE. PACE provides all Medicare and Medi-Cal benefits plus extra services to help seniors who have chronic conditions live at home. For more information and to determine if you live in an area served by PACE visit: www.calpace.org.

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.

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

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Highly Confidential

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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.

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.