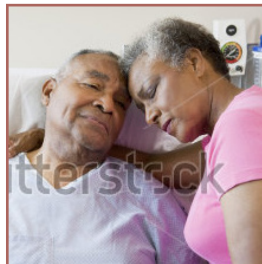
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Health Care Options, P.O. Box 989009
West Sacramento, CA 95798-9860

RETURN SERVICES REQUESTED
To the addressee or guardian of:

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

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

Health Plan Choice Book



State of California — Health and Human Services

Department of Health Care Services

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

RETURN SERVICES REQUESTED

XX/XX/XXXX

To the addressee or guardian of:

Mr. John Sample
1234 Sample Street
Anytown, CA 90000

Welcome to Medi-Cal Managed Care!

We're happy to welcome you to Medi-Cal Managed Care. We look forward to working with you to keep you healthy. That's our number one concern.

The beneficiary listed on the enclosed choice form **must** choose a health plan. If you do not make a choice, we will choose one of the health plans for you. **You have until XX/XX/XXXX to complete and return the choice form.**

Enrolling in a Medi-Cal health plan:
Does NOT change your Medicare services or benefits.
Does NOT change your Medicare doctors.
Does NOT change your Medi-Cal eligibility or cost you extra.
Does NOT cut any of your Medi-Cal services or benefits.

Your Medi-Cal plan will coordinate all your Medi-Cal covered services, including Long-Term Services and Supports. Your Medi-Cal plan will pay for certain Medicare cost-sharing, and other benefits that are not covered by Medicare, such as some medical transportation, certain medical supplies, and certain prescriptive drugs.

You can make a plan choice at any time before the date listed above. The effective date of your plan enrollment will depend on when we receive your plan choice. Your plan choice could be effective as early as the first of the next month. After your plan choice has been received and processed, you will receive a letter with your chosen health plan's name and start date. Your new health plan will also send you some information once you are enrolled.

If you have any 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. If you need personal assistance, take a look at the presentation schedule in this packet for site locations near your home or visit us on-line at www.healthcareoptions.dhcs.ca.gov. For TTY/TDD users, call 1-800-430-7077.

Medi-Cal Plans for Long Term Services and Supports

Medi-Cal Plan benefits.

If you need any of the services below, you can ask your Medi-Cal plan for help.

The **In-Home Supportive Services (IHSS)** program provides personal care and other services for people who need help to live safely at home.

- **If you get IHSS**, your services will not change when you are in a health plan. You will keep your IHSS providers and can still hire, fire, and manage them. The county IHSS social worker will still assess your needs and approve your IHSS hours. Your rights to appeal stay the same.

Daytime health care is available at Community-Based Adult Services (CBAS) centers that provide nursing, therapy, activities, and meals for people with certain chronic health conditions.

Through the Multipurpose Senior Services Program (MSSP) people age 65 and older can get care coordination. Care coordination helps you work with your doctors, specialists, and other providers. It also helps you get needed equipment and services.

Nursing home care is long term care provided in a facility.

Medical equipment and supplies like walkers or wheelchairs, and medical supplies, like bandages and adult diapers.

Medical Transportation is a service covered by your plan.

Medi-Cal pays your Medicare deductibles and up to 20% cost sharing, when applicable.

I don't use Medi-Cal Long Term Services and Supports. Why must I join a plan?

It is now mandatory to join a plan. Medi-Cal health plans will pay any Medicare costs that the state pays today, like your deductibles. Also, the Medi-Cal plans provide medical equipment, transportation and a 24-hour nurse advice line. The health plan will be able to help you if you ever do need Long Term Services and Supports.

Making a Health Plan Choice is EASY!

Call Toll Free

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

Or

Visit Us in Person

Find an Enrollment Specialist near you by using one of the following tools:

- See the *Health Care Options Presentations* page in this booklet;
- Call Health Care Options at 1-844-580-7272 for information. For TTY/TDD users, call 1-800-430-7077;
- Visit www.healthcareoptions.dhcs.ca.gov and click “Presentation Sites” option.

Or

Mail In Your Choice Form

Complete the Medi-Cal Choice Form in this booklet and mail in the postage paid envelope provided.

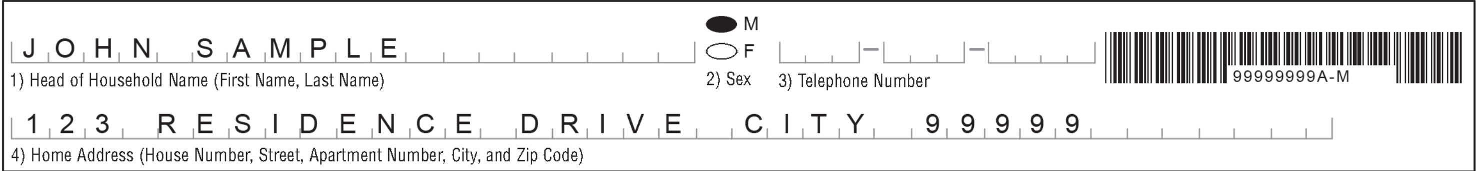
For more information about your health care choices, visit
www.healthcareoptions.dhcs.ca.gov

MEDI-CAL CHOICE FORM

Use this form to join or change health plans. If you need help filling out this form, call 1-844-580-7272.

Mail Completed form to: California Department of Health Care Services • Health Care Options • Box 989009, W. Sacramento, CA 95798-9850.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS ⬬ TO INDICATE YOUR CHOICE. SEE BACK FOR EXAMPLE



J O H N S A M P L E

1) Head of Household Name (First Name, Last Name)

⬬ M ◯ F 2) Sex

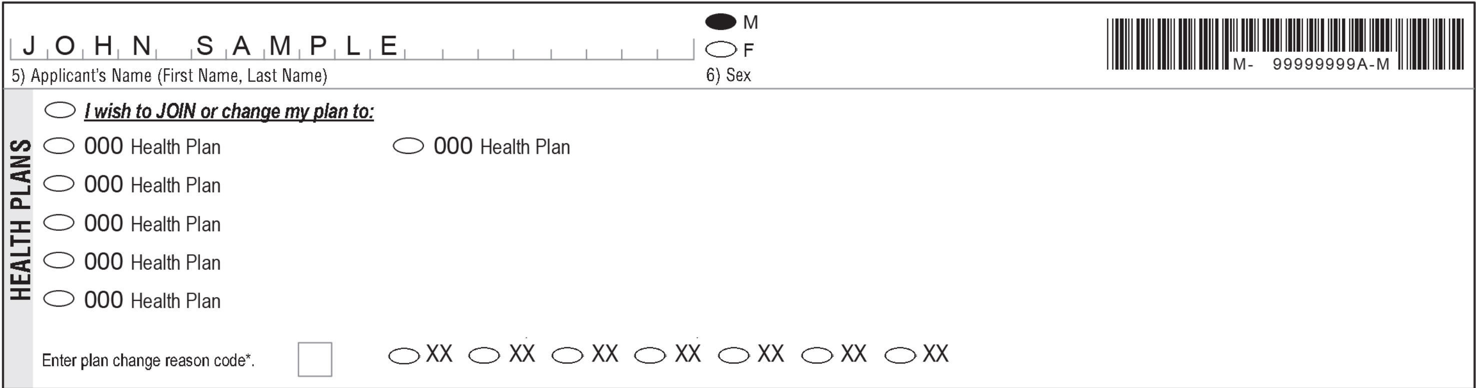
3) Telephone Number

99999999A-M

1 2 3 R E S I D E N C E D R I V E C I T Y 9 9 9 9 9

4) Home Address (House Number, Street, Apartment Number, City, and Zip Code)

Please choose a Health Plan from the list for each member listed.



J O H N S A M P L E

5) Applicant's Name (First Name, Last Name)

⬬ M ◯ F 6) Sex

M- 99999999A-M

HEALTH PLANS

◯ ***I wish to JOIN or change my plan to:***

◯ 000 Health Plan ◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

Enter plan change reason code*. ☐ ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX

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5) Applicant's Name (First Name, Last Name)

◯ M ◯ F 6) Sex

6a) Due Date (if pregnant)

6b) Social Security Number

HEALTH PLANS

◯ ***I wish to JOIN or change my plan to:***

◯ 000 Health Plan ◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

Enter plan change reason code*. ☐ ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX

---

5) Applicant's Name (First Name, Last Name)

◯ M ◯ F 6) Sex

6a) Due Date (if pregnant)

6b) Social Security Number

HEALTH PLANS

◯ ***I wish to JOIN or change my plan to:***

◯ 000 Health Plan ◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

◯ 000 Health Plan

Enter plan change reason code*. ☐ ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX ◯ XX

INTERNAL USE ONLY

***PLAN CHANGE REASON CODES:**

Code 1: I could not choose the doctor or dentist I wanted
Code 2: The health/dental plan did not meet my needs
Code 3: My doctor/dentist did not meet my needs
Code 4: Too far to go
Code 5: I did not choose this plan
Code 6: Moving out of the county
Code 7: Indian Health Program Exemption
Code 8: Medical/Dental Exemption
Code 9: Other

NOTICE: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services. If I pick Kaiser, I give up my right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

CHOICE STATEMENT: I/We have made written choice to receive Medi-Cal benefits through the medical plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement. I/We understand that in order to change my/our current Medi-Cal Health plan, I/we must complete this form.

Head of Household's Signature Date

Other Adult's Signature Date

Other Adult's Signature Date

Please use the following example when you fill in the form:

PLEASE PRINT IN CAPITAL LETTERS ONLY.

1	2	3	4	5	6	7	8	9	0	,	A	B	C	D	E	F	G	H
I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	-

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, Sections 14016.5, 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. If any information asked for on the choice form is missing, then someone on the form may not be able to join a health plan, get out of a plan, or choose the plan he or she wants.

Only other government agencies that relate to the Medi-Cal program can see the information you provide. The persons listed on the form can look at the files that Medi-Cal keeps on them. 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.

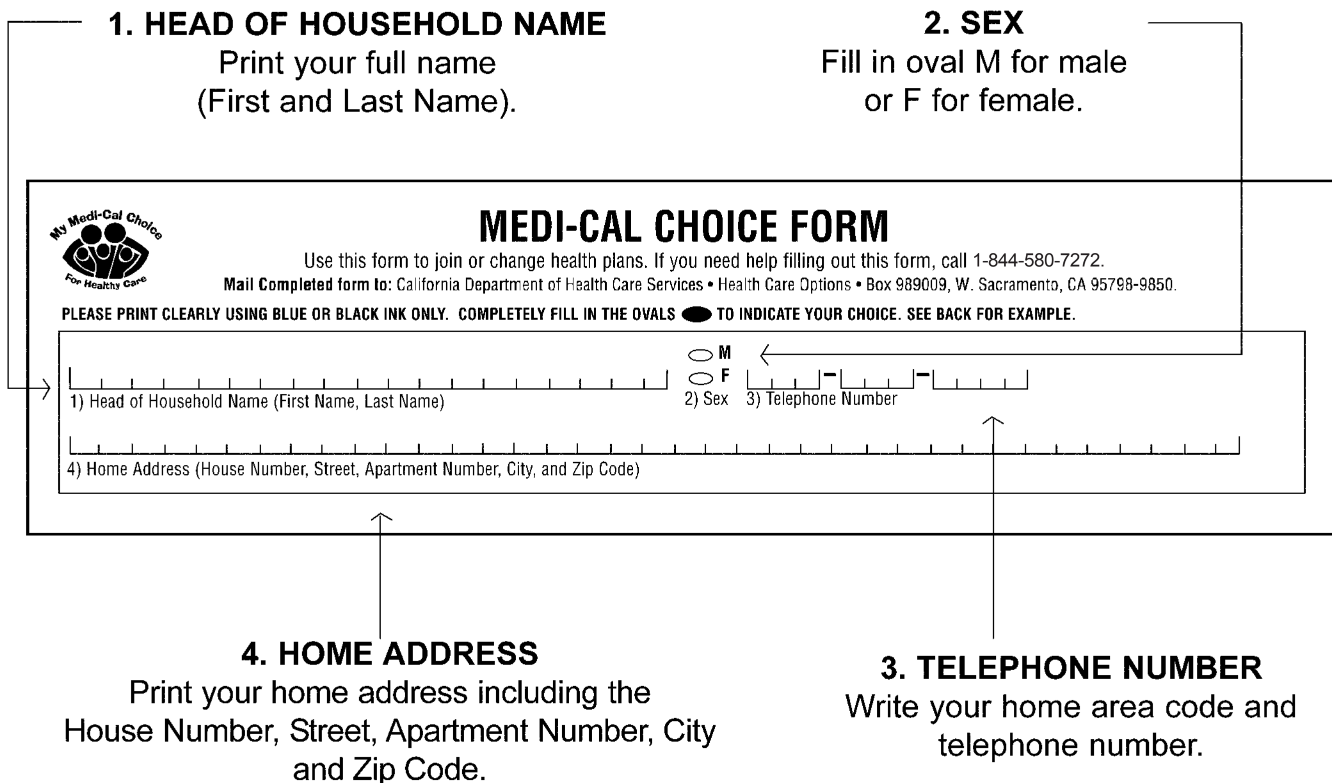
How To Fill Out the Medi-Cal Choice Form

Use the **MEDI-CAL CHOICE FORM(S)** in this packet. If you need additional forms, you can call Health Care Options at 1-844-580-7272.

Please print clearly, using blue or black ink only. Write in block letters, and completely fill in all areas to indicate your choice. **See the backside of the choice form for an example.**

Head of Household Name

This section is to be completed by the Medi-Cal head of household.



Choosing a Health Plan

Before continuing with the form, choose a health plan that will best fit your health care needs. After you have made your health plan choice, you can complete the Medi-Cal Choice Form.

Join or Change a Health Plan

Please complete all sections to change a health plan. Parts of this section may already be filled out for you.

5. APPLICANT'S NAME
Print the full name (First and Last Name) of an individual member of your family.

6. SEX
Fill in oval M for male or F for female.

6a. IF YOU ARE PREGNANT, DUE DATE
The due date is the day the baby is expected to be born. Please write the due date by month, day, and year. For example, December 2, 2003 would be entered as 12/02/03.

6b. SOCIAL SECURITY NUMBER
Do nothing if there is a barcode in this space. Otherwise, enter your Social Security Number.

M
F
5) Applicant's Name (First Name, Last Name) 6) Sex 6a) Due Date (if pregnant) 6b) Social Security Number

HEALTH PLANS
I wish to JOIN or change my plan to:
000 Health Plan
000 Health Plan
000 Health Plan
000 Health Plan
000 Health Plan
Enter plan change reason code* XX XX XX XX XX XX XX

***PLAN CHANGE REASON CODES:**
Code 1: I could not choose the doctor or dentist I wanted
Code 2: The health/dental plan did not meet my needs
Code 3: My doctor/dentist did not meet my needs
Code 4: Too far to go
Code 5: I did not choose this plan
Code 6: Moving out of the county
Code 7: Indian Health Program Exemption
Code 8: Medical/Dental Exemption
Code 9: Other

Join or Change A Health Plan

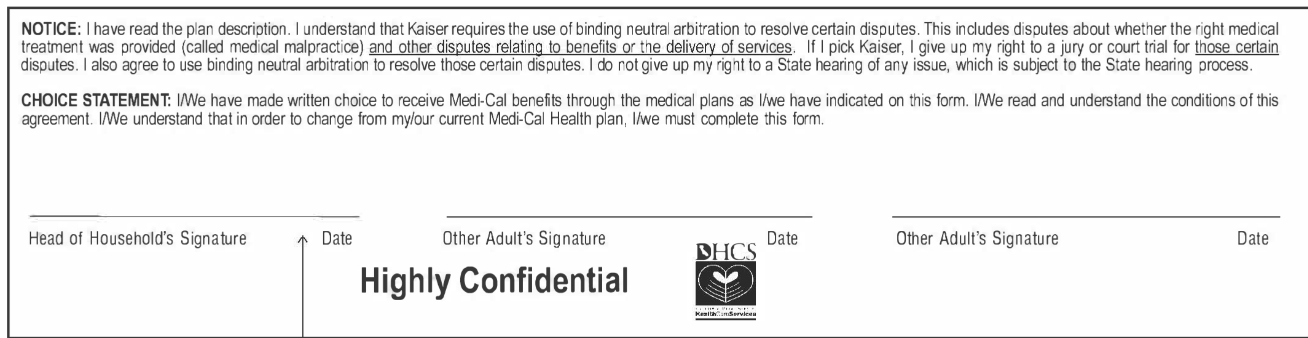
• Join a Health Plan:

Fill in the oval next to "I wish to JOIN or change my plan to:". Then, fill in the oval for your health plan choice.

• Change in Health Plan:

Choose a reason for leaving the health plan from the shaded box called "* PLAN CHANGE REASON CODES" located at the bottom of the form. Write this code number in the box next to "Enter plan change reason code*".

Completing and Mailing the Form



NOTICE: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services. If I pick Kaiser, I give up my right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

CHOICE STATEMENT: I/We have made written choice to receive Medi-Cal benefits through the medical plans as I/we have indicated on this form. I/We read and understand the conditions of this agreement. I/We understand that in order to change from my/our current Medi-Cal Health plan, I/we must complete this form.

Head of Household's Signature Date | Other Adult's Signature Date | Other Adult's Signature Date

Highly Confidential

DHCS

SIGNATURE

Make sure that you and any other adults listed on the form SIGN and date the form on the bottom.

You're Done!

Use the envelope included in this packet to mail the form. It does not need a stamp. Keep the last copy of the form for your records.

If you have questions or need help filling out this form, call Health Care Options at 1-844-580-7272. Visit www.healthcareoptions.dhcs.ca.gov and click the "Presentation Sites" option.

DO NOT CALL YOUR ELIGIBILITY WORKER IF YOU HAVE QUESTIONS ABOUT YOUR MEDI-CAL CHOICE FORM. Your Eligibility Worker can only help you with questions about Medi-Cal benefits or eligibility.

TEAR HERE TEAR HERE

DID YOU REMEMBER TO . . .

Sign and date your Choice Form?
Keep the last copy?

1OZ_0003491_ENG1_0211a

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 238 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

Health Care Options Presentations

Attend an informative session at one of these convenient locations.

California Health Care Options (HCO) Presentation Sites
Los Angeles County
June 2014 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 **1-844-580-7272** 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 June 20th due to a staff meeting.**

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Los Angeles County
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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
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CITY	LOCATION	ZIP CODE	DAY	HCO SITE HOURS	LANGUAGES
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 County
June 2014 Schedule

- ◆ **In-Person Medi-Cal Managed Care Information**
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- ◆ **Free Help To Complete Forms**

Just ask for the "Health Care Options" Representative

CITY	LOCATION	ZIP CODE	DAY	HCO SITE HOURS	LANGUAGES
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
Rancho Dominguez	**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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Common Terms and Definitions

Appeal
A request for a review of a health plan's denial to provide or pay for medical care.

Fair Hearing
An official meeting with a judge about a Medi-Cal appeal or grievance. You must ask for a Fair Hearing within 90 days after the date that your Medi-Cal benefits were denied, reduced, or stopped.

Formulary
A list of medications covered by a health plan offering prescription drugs.

Grievance
A way to write or tell the health plan about your unhappiness with your provider or medical care service.

Medi-Cal
This is what the Medicaid program is called in California. Medicaid is a government insurance program for persons of all ages with limited income and resources or with certain chronic conditions.

Choice Form
The form you fill out to choose or change your health plan.

Continuity of Care
This refers to the ability of a new health plan member to continue to receive Medicare up to 6 months and Medi-Cal services from their existing provider for up to 12 months without a break in service if the doctor and the health plan agree.

Health Care Options
Agency responsible for processing plan enrollment and disenrollments in all counties except San Mateo County.

Health Risk Assessment
Health plans use a number of predefined metrics to assess the health of a new member and develop a plan of care.

Member
A person enrolled in a managed care health plan, also called an "enrollee."

Medicare
The federal health program to provide health care for people aged 65 and older, people younger than 65 with certain disabilities, and people with certain diseases.

Medicare Part A covers inpatient hospital services and other services, such as skilled nursing facilities, and home health agencies.

Medicare Part B covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies.

Medicare Part D provides coverage for most prescription drugs.

Medicare Advantage Plans
A type of Medicare health plan that covers Medicare Part A and B benefits. Some plans also cover Part D, prescription drugs.

Preferred Drug List
A select list of medications covered by a health plan offering prescription drugs.

Primary Care Provider
This is your doctor or other provider you see first for most health problems. They make sure you get the care you need to keep you healthy. They help connect you to other doctors and services you need.

Provider Directory
A list of doctors, clinics, pharmacies, and hospitals that are in a health plan's network. You must use the providers in your health plan's network.

213M211C-000001

If you or your family member(s) have any questions,
call HEALTH CARE OPTIONS, toll-free, at the numbers listed below.

Representatives are available between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

LANGUAGE		TELEPHONE	LANGUAGE		TELEPHONE
ENGLISH		1-844-580-7272	한국어	(Korean)	1-844-580-7272
العربية	(Arabic)	1-844-580-7272	國語	(Mandarin)	1-844-580-7272
ՀԱՅԵՐԵՆ	(Armenian)	1-844-580-7272	Русский	(Russian)	1-844-580-7272
ខ្មែរ	(Cambodian)	1-844-580-7272	ESPAÑOL	(Spanish)	1-844-580-7272
粵語	(Cantonese)	1-844-580-7272	TAGALOG	(Tagalog)	1-844-580-7272
فارسی	(Farsi)	1-844-580-7272	Tiếng Việt	(Vietnamese)	1-844-580-7272
HMOOB	(Hmong)	1-844-580-7272	LANGUAGES NOT LISTED		1-844-580-7272
For TTY/TDD users, call 1-800-430-7077					

PLEASE TEAR OFF CARD AND KEEP FOR YOUR REFERENCE!

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