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.

1-844-580-7272

For TDD Users, call 1-800-430-7077
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.

1-844-580-7272
For TDD Users, call 1-800-430-7077
Welcome to Medi-Cal Managed Care!

We’re happy to welcome you and your family member(s) to Medi-Cal Managed Care. We look forward to working with you to keep your entire family healthy. That’s our number one concern.

The beneficiary(ies) listed on the enclosed choice form must choose a health plan and doctor. You have until May 10, 2014 to complete and return the choice form.

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 or want to enroll over the phone, 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 the packet for site locations near your home or visit us on-line. Go to www.healthcareoptions.dhcs.ca.gov. For TDD/TTY users, call 1-800-430-7077.

Take the first step toward providing yourself and your family with health care by completing a choice form today! Get a good start on the road to health!
Table of Contents

The material in this packet will help you choose or change a Medi-Cal Managed Care Health Plan.

• Medi-Cal Choice Form
• Health Information Form, if available
• How To Fill Out The Medi-Cal Choice Form
• Postage-Paid Envelope
• Medi-Cal Managed Care Health Plan Comparison Chart(s)
• A Guide to the Quality of Medi-Cal Health Plan(s) in your area, if available
• Health Care Options Presentation Schedule
• About Medi-Cal Managed Care Health Plans
• Health Plan Benefits
• How To Choose A Health Plan
• Join or Change A Health Plan
• Emergencies and Family Planning
• Working With Your Health Plan
• How To Get An Exemption/Waiver
• Exemption Forms
• Special Services, if available
• A List of Useful Words
Making a Health Plan Choice is EASY!

Call Toll Free

Call toll free 1-844-580-7272 Monday through Friday, 8:00 am to 5:00 pm. For TDD/TTY 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 TDD/TTY 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 1-844-880-7272.

Mail completed form to: California Department of Health Care Services • Health Care Options • Box 988009, 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.

JOHN SAMPLE

1) Head of Household Name (First Name, Last Name)
2) Sex
3) Telephone Number
4) Home Address (House Number, Street, Apartment Number, City, and Zip Code)

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

JOHN SAMPLE

5) Applicants Name (First Name, Last Name)
6) Sex

I wish to JOIN or change my plan to:

- 079 KP Cal, LLC
- 068 Health Net Comm Solutions
- 167 Care1st Partner Plan, LLC
- 131 Molina Healthcare Partner
- 029 Community Hlth Grp Partner

Enter plan change reason code:

I wish to JOIN or change my plan to:

- 079 KP Cal, LLC
- 068 Health Net Comm Solutions
- 167 Care1st Partner Plan, LLC
- 131 Molina Healthcare Partner
- 029 Community Hlth Grp Partner

Enter plan change reason code:

I wish to JOIN or change my plan to:

- 079 KP Cal, LLC
- 068 Health Net Comm Solutions
- 167 Care1st Partner Plan, LLC
- 131 Molina Healthcare Partner
- 029 Community Hlth Grp Partner

Enter plan change reason code:

*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 country
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.
Please use the following example when you fill in the form:

PLEASE PRINT IN CAPITAL LETTERS ONLY.

1234567890, ABCDEFGHIJKLMNOPQRSTUVWXYZ

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.
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 95798-9853.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE DIALS 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) 2) Sex 3) Telephone Number

1 2 3 4  S A M P L E  S T R E E T,  S A M P L 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. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

4) I wish to JOIN or change my plan to:
   ○ 079 KP Cal, LLC
   ○ 068 Health Net Comm Solutions
   ○ 167 Care1st Partner Plan, LLC
   ○ 131 Molina Healthcare Partner
   ○ 029 Community Hlth Grp Partner

Enter plan change reason code: 

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

5) I wish to JOIN or change my plan to:
   ○ 079 KP Cal, LLC
   ○ 068 Health Net Comm Solutions
   ○ 167 Care1st Partner Plan, LLC
   ○ 131 Molina Healthcare Partner
   ○ 029 Community Hlth Grp Partner

Enter plan change reason code: 

5) I wish to JOIN or change my plan to:
   ○ 079 KP Cal, LLC
   ○ 068 Health Net Comm Solutions
   ○ 167 Care1st Partner Plan, LLC
   ○ 131 Molina Healthcare Partner
   ○ 029 Community Hlth Grp Partner

Enter plan change reason code: 

*PLAN CHANGE REASON CODES:

Code 1: I could not choose the doctor or dentist I wanted
Code 2: The health plan did not meet my needs
Code 3: My doctor/ dentist did not meet my needs
Code 4: Too far to go
Code 5: 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. I/We acknowledge that Kaiser also agrees to these binding neutral arbitration rules. 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

Highly Confidential

2549158064

DHCS
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.
Health Information Form

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 1-844-580-7272 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.

JOHN SAMPLE
Born In: 2007

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:

      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
How To Fill Out the Medi-Cal Choice Form

Use the MEDI-CAL CHOICE FORM(S) in this packet. You can use each form for up to three family members. You can get more forms by calling 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.

1. HEAD OF HOUSEHOLD NAME
   Print your full name (First and Last Name).

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

3. TELEPHONE NUMBER
   Write your home area code and telephone number.

4. HOME ADDRESS
   Print your home address including the House Number, Street, Apartment Number, City, and Zip Code.

Choosing a Health Plan

Before going on with the form, choose a health plan for each family member. You can choose different plans for each family member. You can also choose different doctors in the same health plan for each family member. After you have made your health plan choice, you can complete the Medi-Cal Choice Form.
Join or Change a Health Plan

Please complete sections for all members who must join or want 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. 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.

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 a 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”.  

• If the “No Plan Change” oval is available:
Fill in the oval for “No Plan Change” if any member of the family listed on the choice form does not want to change health plans.
• **Doctor/Clinic Code:**
  Write the code number for the doctor or clinic. This information can be found in the Plan Provider Directory. If there is no number, leave this blank.
  *For example, the code number may be listed in the Provider Directory as:*
  - **Doctor’s Provider #**
  - **PCP #**
  - **Identification Number (ID)**
  - **Doctor I.D. Number**
  - **PIN (Provider Identification Number)**
  - **Provider 0000 (ex. provider 3322)**
  - **# 0000, * 00000 or 00000** (ex. # 3322 above or next to the Dentist's name)

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

<table>
<thead>
<tr>
<th>Head of Household's Signature</th>
<th>Date</th>
<th>Other Adult's Signature</th>
<th>Date</th>
<th>Other Adult's Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Highly Confidential**

**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

There are also meetings you can attend to discuss health plan choices. See the Health Care Options Presentation Schedule in this packet.

**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.**
Making a Health Plan Choice is EASY!

Call Toll Free

Call toll free 1-844-580-7272 Monday through Friday, 8:00 am to 5:00 pm. For TDD/TTY 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 TDD/TTY 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
Do not put more than 4 forms in this envelope

1. Insert form
2. Peel off this strip
3. Seal the flap

Please make sure to:

10Z-0003491-ENG2-1012
Making a Health Plan Choice is EASY!

Call Toll Free

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

Or

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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
<table>
<thead>
<tr>
<th><strong>Care 1st Partner Plan</strong></th>
<th><strong>Community Health Group Partnership Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Benefits</strong></td>
<td>Medi-Cal Covered Services</td>
</tr>
<tr>
<td><strong>Plan Network Hospitals</strong></td>
<td>Fallbrook Hospital</td>
</tr>
<tr>
<td></td>
<td>Paradise Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Palomar Medical Center</td>
</tr>
<tr>
<td></td>
<td>Pomerado Hospital</td>
</tr>
<tr>
<td></td>
<td>Rady Children’s Hospital San Diego</td>
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<tr>
<td></td>
<td>Scripps Green Hospital</td>
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<tr>
<td></td>
<td>Scripps Memorial Hospital-Encinitas</td>
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<tr>
<td></td>
<td>Scripps Memorial Hospital-La Jolla</td>
</tr>
<tr>
<td></td>
<td>Scripps Mercy Hospital</td>
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<td></td>
<td>Scripps Hospital-Chula Vista</td>
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<tr>
<td></td>
<td>Sharp Chula Vista Medical Center</td>
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<td></td>
<td>Sharp Coronado Hospital</td>
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<tr>
<td></td>
<td>Sharp Gossmont Hospital</td>
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<td></td>
<td>Sharp Memorial Hospital</td>
</tr>
<tr>
<td></td>
<td>Sharp Mary Birch Hospital for Women</td>
</tr>
<tr>
<td></td>
<td>and Tri City Medical Center</td>
</tr>
<tr>
<td><strong>Doctors you can go to</strong></td>
<td>Please call Member Services at 1-800-605-2556 for a directory or assistance in choosing a doctor, or you can go online to <a href="http://www.care1st.com">www.care1st.com</a> for all network information.</td>
</tr>
<tr>
<td><strong>Urgent Care Centers</strong></td>
<td>Call your provider during business hours. After hours, call 1-800-605-2556.</td>
</tr>
<tr>
<td></td>
<td>Community Health Group offers after-hours access to urgent care.</td>
</tr>
<tr>
<td><strong>Pharmacies</strong></td>
<td>The Care1st Health Plan pharmacy network includes most of the large chains such as CVS, Rite Aid and Walgreens along with many neighborhood pharmacies.</td>
</tr>
<tr>
<td></td>
<td>Our network includes 400 pharmacies, many chain and independent pharmacies. Please look in Community Health Group’s Provider Directory for a pharmacy near your home.</td>
</tr>
<tr>
<td><strong>Vision Plan</strong></td>
<td>Care1st Health Plan offers access to vision services through March Vision.</td>
</tr>
<tr>
<td></td>
<td>Vision Service Plan for your vision benefits. If you are 21 years of age or older, some limitations may apply.</td>
</tr>
<tr>
<td><strong>Assistance with Public Transportation</strong></td>
<td>Free transportation to your doctor’s appointments. Some restrictions may apply. Call 1-877-433-2178 from 8:00 am to 6:00 pm, Monday - Friday.</td>
</tr>
<tr>
<td></td>
<td>24-hour emergency transportation services. For non-emergent transportation, contact Community Health Group.</td>
</tr>
<tr>
<td><strong>Health Education</strong></td>
<td>Care1st Health Plan offers Asthma Management, Healthy Start (Comprehensive Prenatal and Post Partum), Quitting Smoking and Weight Management programs.</td>
</tr>
<tr>
<td></td>
<td>• Health Education Classes and Community Events in your area;</td>
</tr>
<tr>
<td></td>
<td>• Member Newsletters</td>
</tr>
<tr>
<td><strong>Languages</strong></td>
<td>Spanish, Russian, Mandarin, Vietnamese, Armenian, Hmong, Cantonese. Other languages available through the language line services. Call Member Services: 1-800-605-2556</td>
</tr>
<tr>
<td></td>
<td>Our Member Services staff speaks English, Spanish, Vietnamese and Arabic and many more through the use of the Language Line.</td>
</tr>
<tr>
<td><strong>Member Services Hotline</strong></td>
<td>1-800-605-2556</td>
</tr>
<tr>
<td></td>
<td>Member Service Department 1-800-224-7766. TTY 1-800-735-2929; 24 hours a day, 7 days a week. Telephone Advice Nurse 1-800-647-6966.</td>
</tr>
</tbody>
</table>
# Medi-Cal Managed Care Comparison Chart

The information is being provided for INFORMATION purposes only. To order an enrollment package, or for assistance filling one out, call 1-844-580-7272. Translators are available. For TDD/TTY users, call 1-800-430-7077.

<table>
<thead>
<tr>
<th>Health Net Community Solutions, Inc. (Health Net)</th>
<th>KP Cal, LLC (Kaiser Permanente)</th>
<th>Molina Healthcare of California Partner Plan, Inc. (Molina)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alvarado Hospital Medical Center</td>
<td>Kaiser Permanente Hospitals</td>
<td>Fallbrook Hospital</td>
</tr>
<tr>
<td>Rady Children’s Hospital</td>
<td>Hospital and Medical Offices: 4647 Zion Ave.</td>
<td>Rady Children’s Hospital San Diego</td>
</tr>
<tr>
<td>Scripps Green Hospital</td>
<td></td>
<td>Scripps-Mercy Hospital</td>
</tr>
<tr>
<td>Scripps Memorial Hospital - Encinitas</td>
<td></td>
<td>Scripps-Mercy Hospital-Chula Vista</td>
</tr>
<tr>
<td>Scripps Memorial Hospital - La Jolla</td>
<td></td>
<td>Sharp-Chula Vista Medical Center</td>
</tr>
<tr>
<td>Scripps Mercy Hospital</td>
<td></td>
<td>Sharp-Coronado Hospital</td>
</tr>
<tr>
<td>Scripps Mercy Hospital - Chula Vista</td>
<td></td>
<td>Sharp-Grossmont Hospital</td>
</tr>
<tr>
<td>Tri-City Medical Center</td>
<td></td>
<td>Sharp-Mary Birch Hospital for Women</td>
</tr>
<tr>
<td>UCSD Medical Center - Hillcrest</td>
<td></td>
<td>Sharp Memorial Hospital</td>
</tr>
<tr>
<td>UCSD Medical Center - Thornton</td>
<td></td>
<td>Tri-City Medical Center</td>
</tr>
<tr>
<td><em>Covers emergency services anywhere.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our provider directory can help you choose from several participating primary care providers and specialists or call Member Services at 1-800-675-6110.</td>
<td>Per Kaiser Permanente Provider Directory/EOC Primary Care Physician (PCP) Assignment and PCP Re-selection through Member Services 1-800-464-4000.</td>
<td>Over 1,900 Primary Care Physicians and Specialists. Call 1-888-665-4621 for a directory or assistance in finding a doctor.</td>
</tr>
<tr>
<td>Call Member Services Department 24 hours/7 days for assistance.</td>
<td>Urgent Care is offered at most sites: Through most clinics (as identified in the Provider Directory) Through Medical Services ERs/EDs.</td>
<td>24-hour statewide emergency services at over 70 locations, as well as 24-hour Nurse Advice Line at 1-888-275-8750.</td>
</tr>
<tr>
<td>Choose from a large selection of chain and independent pharmacies including CVS, K-Mart, Rite Aid, Target, Vons, Walgreens, Wal-Mart, and many others.</td>
<td>Pharmacies at every Kaiser location: San Diego, Bonita, Carlsbad, Clairemont, Eastlake, El Cajon, Escondido, La Mesa, Mission Bay, Otay Mesa, Point Loma, Rancho Bernardo, San Marcos and Vista. Call 1-800-464-4000.</td>
<td>6,000 pharmacies state-wide, including convenient neighborhood pharmacies like CVS, Rite Aid, and Walgreens.</td>
</tr>
<tr>
<td>Our provider directory can help you find an eye care professional. Call us at 1-800-675-6110.</td>
<td>Vision Services are available at all clinic locations. Phone numbers, appointments, and addresses are published in the Provider Directory.</td>
<td>Members have access to March Vision’s Provider Network, with many vision care service locations.</td>
</tr>
<tr>
<td>24-Hour Emergency Transportation is available. Call Health Net Member Services at 1-800-675-6110 if you need assistance with non-emergency transportation.</td>
<td>Directions, phone numbers and maps to all sites are in the Provider Directory. Directions are also available at 1-800-464-4000.</td>
<td>When medically necessary, Molina offers 24-hour emergency and pre-arranged non-emergency transportation.</td>
</tr>
<tr>
<td>Materials on many health topics. Programs in weight management, nutrition, smoking cessation, asthma, diabetes and more. Call 1-800-804-6074 for more information.</td>
<td>Health Education Centers are available at all clinic sites. Call Member Services at 1-800-464-4000 for the telephone numbers.</td>
<td>Programs and materials available including: stop smoking, weight control, chronic diseases like diabetes and asthma, and Motherhood Matters Pregnancy Program.</td>
</tr>
<tr>
<td>Our representatives speak Spanish, Hmong, and other languages. TDD/TTY: 1-800-431-0964. Call 1-800-675-6110 for assistance.</td>
<td>Most languages are supported by clinic sites through Kaiser staff, contracted interpreter services or AT&amp;T interpreter services (online).</td>
<td>Multi-lingual staff available. We offer interpreters (including Sign Language) to meet you at doctor visits and telephone interpreter services in over 160 languages.</td>
</tr>
<tr>
<td>Call our Member Services Department 24/7 at 1-800-675-6110. Call 1-800-327-0502 for answers about Medi-Cal Managed Care.</td>
<td>Provided for all sites. Listed in the Provider Directory by location, hours and phone number.</td>
<td>1-888-665-4621 (M-F, 7am – 7pm). Deaf and hard of hearing members TDD/TTY 1-800-479-3310 or dial 711 (Calif. Relay Services).</td>
</tr>
</tbody>
</table>
Making a Health Plan Choice is EASY!

Call Toll Free

Call toll free 1-844-580-7272 Monday through Friday, 8:00 am to 5:00 pm. For TDD/TTY 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 TDD/TTY 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
A guide to help you
Choose the Best Medi-Cal Health Plan
for you and your family

My Medi-Cal Choice
For Healthy Care

Look inside this guide for this helpful information:

Page 2 How this guide can help you
Page 2 Help for people who speak little or no English
Page 3 Programs to help you stay healthy
Page 4 How Medi-Cal plans compare on quality of care for children
Page 5 How Medi-Cal plans compare on quality of care for adults
Last Page Where to get answers if you have questions
How this guide can help you

When you sign up for Medi-Cal, you may have to choose a health plan. The more you know about your plan, the easier it is to get the best care for you and your family.

Please take a minute to read through this guide. You will learn about quality of care and important services in your plan. You may want to save this guide in case you have questions later.

If you are ready to sign up for a Medi-Cal health plan, you will need to fill out the Medi-Cal Choice Form in the Medi-Cal enrollment booklet. (This booklet is called My Medi-Cal Choice for Healthy Care.) This booklet is mailed in a packet with plan Provider Directories. These Provider Directories have other important information, like the names of the doctors and hospitals in each plan.

You will probably have some questions. The last page of this guide tells you how to get answers to your questions.

Help for people who speak little or no English

If you need help understanding English, your Medi-Cal health plan must make sure you have a qualified interpreter any time you need medical care. Your plan must provide an interpreter no matter what language you speak. This is true even when you need medical care at night. This service is free – you do not have to pay when your plan provides an interpreter.

You should ask for an interpreter any time you need to talk to a doctor or nurse about a medical problem or talk to someone at the plan.

There are different ways that plans might provide an interpreter for you:

- The plan can help you find a doctor's office where the doctor, a nurse or other person in the office speaks your language.
- The plan might have an interpreter meet you at the doctor's office.
- The plan might have a person interpret by talking to you and your doctor on the telephone.

Usually, it is best if you use the plan's interpreter. If you want to use an adult family member or friend to interpret instead, you must sign a paper saying that you did not want to use the plan's interpreter.

Your health plan has written information that tells you about the health plan's services and programs and tells how to get medical care. In your county, written information is available in these languages:

- Arabic
- English
- Spanish
- Vietnamese

If the plan does not send you materials in your language, you should ask for them. If you cannot read or understand the materials, you should ask for an interpreter who will explain what the materials say.

If you have trouble getting an interpreter when you need one, or if you have trouble getting written information translated, you have the right to file a grievance. Look at the last page of this guide to learn how to file a grievance.
Programs to help you stay healthy

Each Medi-Cal health plan has programs to help you and your family stay healthy and manage illness. These are called health education programs. You do not have to pay to join these programs when you are enrolled in a Medi-Cal health plan.

Medi-Cal health plans offer programs that help you learn how to:

- Stay healthy when you are pregnant
- Keep your children safe and healthy
- Maintain good nutrition and exercise
- Manage and control your weight
- Manage and control your asthma
- Manage and control your diabetes
- Keep your heart healthy
- Control high blood pressure and cholesterol
- Quit smoking
- Prevent sexually transmitted disease and HIV/AIDS
- Prevent unplanned pregnancy
- Use new parenting skills
- Prevent dependence on drugs and alcohol

Plans offer these programs in lots of different ways. You might like one way better than another. The different ways that you can join a health education program are:

<table>
<thead>
<tr>
<th>Booklets and tapes</th>
<th>Ask the plan to send you booklets, workbooks, videos and tapes that you can take home with you to learn.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classes</td>
<td>Join a class where a health expert will show you how to manage your illness and stay healthy.</td>
</tr>
<tr>
<td>One-on-one learning</td>
<td>Talk to a health expert in-person or by telephone to ask questions and solve problems as you learn how to manage your illness and stay healthy.</td>
</tr>
<tr>
<td>Support groups</td>
<td>Join a group of people who are like you. People in the group learn from each other and help each other.</td>
</tr>
</tbody>
</table>

The plans want to offer these programs in ways that will work best to help you learn. To find out the details about how these programs work and how you can sign up, call your health plan. Look at the last page of this guide for phone numbers.
How Medi-Cal plans compare on quality of care for children and adults

This information comes from two sources. The State of California did a survey* to ask people in Medi-Cal about the quality of care and service they were getting from their health plan. Medi-Cal also collected information from each plan to see how many people in the plan got the care and services they needed when they needed them.

<table>
<thead>
<tr>
<th>Children</th>
<th>Care1st Partner Plan, LLC</th>
<th>Community Hlth Gp Partner</th>
<th>Health Net Comm Solutions</th>
<th>Kaiser</th>
<th>Molina Healthcare Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Getting needed care</strong></td>
<td>average</td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Children got the care they needed without problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Getting care quickly</strong></td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Children got appointments and treatment without long waits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How well doctors communicate</strong></td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>higher</td>
<td>higher</td>
</tr>
<tr>
<td>Doctors listened carefully, gave good explanations, and showed respect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shared decision making</strong></td>
<td>average</td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Doctors talked with parents about treatment choices for the child and asked which was best for the child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Plan customer service</strong></td>
<td>average</td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Parents got the help they needed from plan customer service and plan written materials.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccines (shots) for children</strong></td>
<td>higher</td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Children got all of the vaccines (shots) they were supposed to have to prevent illness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Check-ups for teenagers</strong></td>
<td>average</td>
<td>lower</td>
<td>lower</td>
<td>average</td>
<td>average</td>
</tr>
<tr>
<td>Teenagers got all of the check-ups they were supposed to have.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care for children with colds and flu</strong></td>
<td>higher</td>
<td>higher</td>
<td>higher</td>
<td>higher</td>
<td>higher</td>
</tr>
<tr>
<td>Children with colds and flu got the right kinds of treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Data reported in 2011.
This is what the symbols mean:

- **higher** = Scored **higher than the average** for Medi-Cal plans in California.
- **lower** = Scored **lower than the average** for Medi-Cal plans in California.
- **average** = Scored **about the same as the average** for Medi-Cal plans in California.
- **no results** = Too few Medi-Cal plan members to report OR results were not available.

### Adults

<table>
<thead>
<tr>
<th>Adults</th>
<th>Care1st Partner Plan, LLC</th>
<th>Community Hlth Grp Partner</th>
<th>Health Net Comm Solutions</th>
<th>Kaiser</th>
<th>Molina Healthcare Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting needed care</td>
<td>lower</td>
<td>average</td>
<td>lower</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Getting care quickly</td>
<td>average</td>
<td>lower</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>How well doctors communicate</td>
<td>average</td>
<td>average</td>
<td>lower</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>average</td>
<td>average</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Plan customer service</td>
<td>average</td>
<td>average</td>
<td>average</td>
<td>average</td>
<td>average</td>
</tr>
<tr>
<td>Pregnancy care</td>
<td>average</td>
<td>lower</td>
<td>higher</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Testing diabetics' blood sugar level</td>
<td>average</td>
<td>higher</td>
<td>average</td>
<td>higher</td>
<td>average</td>
</tr>
<tr>
<td>Care for adults with bronchitis</td>
<td>average</td>
<td>lower</td>
<td>lower</td>
<td>average</td>
<td>lower</td>
</tr>
</tbody>
</table>

*Data reported in 2011.*
Where to get answers if you have questions

Questions about Medi-Cal

Look in your enrollment booklet, called My Medi-Cal Choice for Healthy Care.

Call 1-844-580-7272 to talk to someone at Health Care Options. It’s a free call.

The TDD/TTY number is 1-800-430-7077. This phone number is for people who have difficulties with hearing or speech. You need special equipment to use it.

Medi-Cal holds meetings all over the state to help people understand the Medi-Cal program and how to sign up. You can come to one of these meetings if you want to hear about your choices and ask questions in person. To find out where and when meetings are held, look in the booklet My Medi-Cal Choice for Healthy Care or call Health Care Options at 1-844-580-7272.

How to file a grievance

If you have trouble getting an interpreter when you need one, or getting important written materials translated, you have the right to file a grievance. To file a grievance you may call your health plan or send them a letter.

At the same time that you file a grievance with your health plan, you can ask for a State Hearing. Call 1-800-952-5253 (TDD/TTY: 1-800-952-8349) to ask for a State Hearing or send a letter to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

Questions about the health plans

If you have questions about how to use the plans and the programs or services they offer, you can call these phone numbers:

Care1st Partner Plan, LLC
1-866-852-2731
TDD/TTY: 1-888-757-6034

Community Hlth Grp Partner
1-800-224-7766
TDD/TTY: 1-800-735-2929

Health Net Comm Solutions
1-800-675-6110
TDD/TTY: 1-800-735-2929

Kaiser
1-800-464-4000
TDD/TTY: 1-800-777-1370

Molina Healthcare Partner
1-888-665-4621
TDD/TTY: 1-800-479-3310

Para recibir una copia de esta guía en español, llame al 1-800-430-3003. ¡Llamada gratis! Esta guía se llama Una Guía para Ayudarle a Escoger el Mejor Plan de Salud de Medi-Cal para Usted y su Familia. Tiene información importante sobre la calidad de la atención médica de los planes de salud de Medi-Cal que puede escoger.

Funding for the development of this guide was provided by the California HealthCare Foundation.
Special Services
County Projects

St. Paul’s PACE (Program of All-Inclusive Care for the Elderly) began operations February 1, 2008, as a new Program of All-Inclusive Care for the Elderly (PACE) in San Diego County. PACE is an all-inclusive capitated managed care program that covers all medical and social services for its participants – with the exception of cosmetic and experimental surgeries/drugs. In order to qualify for the PACE program, participants must be 55 years of age or older, live in the plan’s designated service area and be determined by the Department of Health Care Services to be at the nursing home level of care.

Individuals seeking more information regarding services, eligibility and plan’s service area may contact St. Paul’s PACE at (619) 677-3800 or at TTY 1 (800) 735-2922 for the hearing impaired. Individuals may also visit St. Paul’s PACE website at http://www.stpaulspace.org/
Making a Health Plan Choice is EASY!

Call Toll Free
Call toll free 1-844-580-7272 Monday through Friday, 8:00 am to 5:00 pm. For TDD/TTY 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 TDD/TTY 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
# Health Care Options Presentations

Attend an informative session at one of these convenient locations.

California Health Care Options (HCO) Presentation Sites  
San Diego County  
June 2014 Schedule

- In-Person Medi-Cal Managed Care Information
- Appointment Necessary
- Free Help To Complete Forms

<table>
<thead>
<tr>
<th>CITY</th>
<th>LOCATION</th>
<th>ZIP CODE</th>
<th>ENROLLMENT COUNSELOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chula Vista</td>
<td>South Bay 690 Oxford Street</td>
<td>91911</td>
<td>619-409-3296</td>
</tr>
<tr>
<td>El Cajon</td>
<td>El Cajon 220 South First Street</td>
<td>92019</td>
<td>619-401-6184</td>
</tr>
<tr>
<td>Escondido</td>
<td>Escondido 620 East Valley Parkway</td>
<td>92025</td>
<td>760-740-4069</td>
</tr>
<tr>
<td>Lemon Grove</td>
<td>Lemon Grove 7065 Broadway</td>
<td>91945</td>
<td>619-668-3784</td>
</tr>
<tr>
<td>Oceanside</td>
<td>Oceanside 1315 Union Plaza Court</td>
<td>92054</td>
<td>760-754-5860</td>
</tr>
</tbody>
</table>

You can call the HEALTHY SAN DIEGO Information Line at 1-844-580-7272. Please leave a message with your name and telephone number and someone will return your call within 24 hours.
Attend an informative session at one of these convenient locations.

California Health Care Options (HCO) Presentation Sites
San Diego County
June 2014 Schedule

- In-Person Medi-Cal Managed Care Information
- Appointment Necessary
- Free Help To Complete Forms

Just ask for the "Health Care Options" Representative

<table>
<thead>
<tr>
<th>CITY</th>
<th>LOCATION</th>
<th>ZIP CODE</th>
<th>ENROLLMENT COUNSELOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre City</td>
<td>1255 Imperial Avenue</td>
<td>92101</td>
<td>619-237-8506</td>
</tr>
<tr>
<td>Kearny Mesa</td>
<td>5055 Ruffin Road</td>
<td>92123</td>
<td>858-573-7341</td>
</tr>
<tr>
<td>northeastern</td>
<td>7290 El Cajon Boulevard</td>
<td>92115</td>
<td>619-337-6240</td>
</tr>
<tr>
<td>Southeast</td>
<td>4588 Market Street</td>
<td>92101</td>
<td>619-266-3963</td>
</tr>
</tbody>
</table>

You can call the HEALTHY SAN DIEGO Information Line at 1-844-580-7272. Please leave a message with your name and telephone number and someone will return your call within 24 hours.
## Medical Staff

100% of Medical Doctors are **Board Certified**.

Medical Staff is supported by a **dedicated** group of on-site professionals: including Pharmacists, Public Health Nurses, Clinic Nurses, Case Managers, Psychologists, a Nutritionist, Dentists, and more.

**On-Site** specialties include Preventive Medicine, Family Practice, Pediatrics, Internal Medicine, Obstetrics, and Podiatry.

Medical Staff primarily **dedicated** to health care for American Indian and Alaska Native populations.

**On-site** Perinatal Program includes free birthing classes.

High attention to childhood immunizations - **over 90% success rate** for past 5 years.

**Transportation provided** for handicapped, disabled, and seniors without transportation to IHC clinics.

Facility hours Monday - Friday 8:00 am - 4:30 pm

All on-site services **free** to American Indians and Alaska Natives.

## Features

IHC is a Federally Qualified Health Center (FQHC).

**Specializing in the health care needs** of American Indians and Alaska Natives.

Board of Directors and Administrator from local Indian community.

Formal relationships with a complete network of local specialists.

50,000 sq. ft. facility under construction to help assure adequate space for a growing community.

**On-site** Pharmacy, X-Ray, Mammography, Lab, Dental, Community Health, Nutrition, Mental Health, Perinatal Services, and WIC.

**Member** of the San Diego Council of Community Clinics.

IHC is a **non-profit** health care corporations.

Two clinics conveniently located on North San Diego County Indian reservations.

## Hospitals

Palomar Hospital*

Pomerado Hospital*

Children’s Hospital*

Fallbrook Hospital*

Sharp Memorial Hospital*

UCSD Medical Center

Mercy Hospital*

Tri-City Hospital*

* denotes formal contract
<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Southern Indian Health Council, Inc.</strong> is committed to providing a</td>
<td>24 hour access to medical care with a choice of primary care providers to</td>
</tr>
<tr>
<td>comprehensive, coordinated, high quality health delivery system that is</td>
<td>provide your basic medical care and a Telephone Nurse Advice Line to assist</td>
</tr>
<tr>
<td>patient friendly, affordable and accessible.</td>
<td>you afterhours with your medical problems.</td>
</tr>
<tr>
<td><strong>100% of our physicians are Board certified.</strong></td>
<td><strong>Free</strong> health education and wellness programs.</td>
</tr>
<tr>
<td>Our dedicated team of healthcare professionals offer <em>personalized care</em></td>
<td>Lab, pharmacy, and x-ray services conveniently located <em>onsite</em>, under one roof.</td>
</tr>
<tr>
<td>with an emphasis on prevention &amp; early intervention.</td>
<td>Family oriented, <em>culturally responsive</em> philosophy of care consistent with</td>
</tr>
<tr>
<td></td>
<td>American Indian values and traditions.</td>
</tr>
<tr>
<td><strong>Extended office hours and same day appointments</strong> to better serve you</td>
<td><strong>Organization wide</strong> continuous quality improvement/quality assurance program.</td>
</tr>
<tr>
<td>and your family members.</td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal healthcare bonus program</strong> available for mothers and babies.</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty and urgent care referrals</strong> through an established provider</td>
<td><strong>A federally qualified health center</strong> which delivers expanded healthcare</td>
</tr>
<tr>
<td>network to meet all your needs. Weekly podiatry clinic provided onsite.</td>
<td>benefits <em>free of charge</em> including medical social services, nutritional</td>
</tr>
<tr>
<td></td>
<td>counseling, preventive health education, screenings, and risk assessments.</td>
</tr>
<tr>
<td><strong>C.H.D.P. examinations</strong> for children to 21 years of age.</td>
<td><strong>15 year history</strong> of serving MediCal beneficiaries and the Indian</td>
</tr>
<tr>
<td></td>
<td>community.</td>
</tr>
<tr>
<td><strong>Interdisciplinary Staged Diabetes Management Program</strong> based on the</td>
<td><strong>East county offices</strong> located on reservation lands and easily accessible</td>
</tr>
<tr>
<td>latest research in diabetic care.</td>
<td>from major freeways/bus routes.</td>
</tr>
<tr>
<td>Hospitals utilized:</td>
<td></td>
</tr>
<tr>
<td>**Sharp Hospitals and Children’s Hospital, Alvarado Hospital Medical</td>
<td>We are a <em>nonprofit corporation</em> which means that any excess revenue</td>
</tr>
<tr>
<td>Center, UCSD Medical Center**</td>
<td>generated is reinvested back into the community to expand and improve</td>
</tr>
<tr>
<td></td>
<td>services.</td>
</tr>
</tbody>
</table>
About Medi-Cal Managed Care Health Plans

• Medi-Cal wants you and your family to be healthy and satisfied with your health care.

• Medi-Cal Managed Care Health Plans have their own doctors, specialists, clinics, pharmacies, and hospitals.

• You can choose the doctor or clinic for all your health care needs. Medi-Cal Managed Care Health Plans offer special care (physicals, routine tests for adults, and shots for children and babies) that can help you before you get sick.

• You can go to your primary care doctor first, unless it is an emergency or a family planning visit.

• The health plan has a Member Services Department or an after hours number that you can call.

Eligibility for CalWORKs, Medi-Cal, and Food Stamps
If you change your health plan or keep the one you have, it does not change your eligibility for other programs.

Medi-Cal Benefits Identification Card or BIC
The plastic card you use for your Medi-Cal benefits stays the same. You will use the plastic card to get services your health plan does not provide.

Direct Access to Women’s Health Services
A woman can go directly to any network provider for women’s health care without a referral from another doctor.

Medical Second Opinions
You can request that another doctor or specialist see you before you make decisions about your doctor’s plan for your care or surgery.

You do not have to ask managed care doctors if they take Medi-Cal patients.
Health Plan Benefits

Medi-Cal Managed Care Health Plan
NO cost to you, NO co-payment

- **Choose a Doctor and Clinic**
  You choose a primary care doctor or clinic from a list that belongs to the health plan. You must go to that doctor or clinic first for your health care. The doctor or clinic you go to now may be part of the health plan.

- **Specialty Care**
  Your primary care doctor will send you to specialty doctors who are part of your health plan, when necessary.

- **Pharmacy and Other Providers**
  Each health plan has pharmacies and other providers as part of the health plan. Your primary care doctor will send you to other providers, when necessary.

- **Medical Advice**
  Medi-Cal Managed Care Health Plans have a 24-hour toll free number you can call with questions about your care.

- **Health Education**
  All health plans offer special classes to keep you healthy.

- **Change Your Doctor or Clinic**
  If you are not happy with your primary care doctor or clinic, you can call the health plan Member Services Department and choose a different primary care doctor or clinic.

- **Change Your Health Plan**
  If you want to choose another health plan for any reason, you may leave the health plan and join a different health plan.

- **Family Planning**
  You can get family planning from doctors or clinics in your health plan or from family planning providers who accept Medi-Cal outside your health plan. You do not need to ask your health plan first. Family planning services do not include the services you need after you become pregnant.

- **Health Plan Information**
  The health plan you choose will send you information about their services and a member identification card.
How To Choose A Health Plan

Think about what is important to you when you get health care. Talk to your family, friends, and doctor. Look at the Health Plan Comparison Chart(s) to help you decide which health plan you want. Look at the provider directories to help you decide which doctor you want.

**Here are some things to think about before you make your choice:**

**Doctor**

- Am I happy with the doctor I have right now?
- Does my doctor belong to a health plan?
- Which health plan?
- Do I have to wait long to get an appointment?
- Are they open when I can go?
- Does the doctor have experience with my child's or my medical problem?

**Language**

- Does the doctor speak my language or provide interpreters who do?

**Location**

- Is the doctor's office or clinic near by?
- Is it easy to get to?
- Does the health plan or doctor provide transportation?
Join or Change
A Health Plan

Join a Health Plan

• You must be eligible for Medi-Cal to join a health plan.

• You can use your Medi-Cal Benefits Identification Card (BIC) for services through Regular Medi-Cal (Fee-For-Service) until you are a health plan member.

• Health Care Options will send you a letter within 15 to 45 days telling you that the health plan change has taken place.

• Your health plan will send you information about its services and a health plan member card.

• Take your health plan member card and BIC card with you when you get all medical services, including pharmacy, x-rays, and office visits.

Change a Health Plan

• If you are not happy with your health plan, you can choose another health plan, if available.

• Call Health Care Options at 1-844-580-7272 and ask for a Medi-Cal Choice Form.

• Mail the completed choice form.

• Health Care Options will send you a letter within 15 to 45 days telling you that the health plan change has taken place.

• You must see your present doctor until you get the letter from Health Care Options.
Emergencies

If you or a family member are very sick and think it might be an emergency:

- Call 911 or go to the nearest emergency room in an emergency.

- An emergency is when someone reasonably believes that she or he needs immediate medical attention. Examples are:
  - Bleeding heavily
  - Trouble breathing
  - In a lot of pain
  - Looks like the person might die or be disabled

- If you go to any emergency room for an emergency, your health plan will authorize services.

- If you go to an emergency room and it is not for an emergency, the emergency room staff will send you to your health plan’s doctor or clinic.

If you are not sure it is an emergency:

- Call your doctor or your health plan’s after hours phone number.

- The health plan will see that you get to the emergency room if you need to. Or, they will schedule an appointment for you with your doctor or clinic.

Family Planning

You can get family planning services from:

- The doctors, nurse practitioners, nurse midwives, physician assistants, and clinics in your health plan.

- Any family planning practitioner or clinic outside of your health plan that takes Medi-Cal. You do not need to ask your health plan first.

(Family planning services do not include the services you need after you become pregnant.)
Working With Your Health Plan

It is very important for you to know how to use your health plan as soon as you become a member. Read all the information your health plan sends you. Call your health plan’s Member Services Department and ask any questions you have about your health plan. Member services staff will be glad to help you.

What if:

• I am no longer happy with the doctor I am going to?
• I disagree with my doctor about what is best for my family or me?
• My doctor denies or delays my request to see a specialist, to have more visits, or to get certain medicines?
• My doctor or health plan denies or limits medical services?
• My health plan reduces or stops a service that I was getting before I changed plans?
• I received a “Notice of Action” that denied, delayed, modified, or reduced my treatment request, or terminated treatment I’ve been receiving?

You have a right to do any or all of these:

Change Your Health Plan

• Call Health Care Options at 1-844-580-7272 and ask for an informing packet.

• Complete the choice form and follow the mailing instructions.

File A Complaint Or Grievance With Your Health Plan

• Call the health plan’s Member Services Department. A member services worker may be able to help you with your complaint.

• If member services staff cannot assist you with your complaint, ask them to mail a grievance form to you at your home address. Your doctor will also have grievance forms or you can send a letter to your health plan.

• Complete the grievance form and mail the original to the health plan’s Member Services Department (keep a copy for your records).

• Your health plan will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 3 days.

Report The Problem To The California Department Of Health Services’ State Ombudsman

• Call 1-888-452-8609, Monday through Friday, from 8:00 a.m. to 5:00 p.m.
Report The Problem To The California Department Of Managed Health Care’s Office Of Patient Advocacy

• Call 1-888-466-2219, 24 hours a day, seven days a week.

Ask For A State Fair Hearing With An Administrative Law Judge

• If you want a State Fair Hearing, you must ask for it within 90 days from the date of the “Notice of Action” or “Grievance Resolution” letter that you receive from your health plan, or from the date of the order or action you are complaining of.

• If the “Notice of Action” letter states that your requested treatment is terminated or reduced and you want to keep your treatment going, you must ask for a State Fair Hearing within 10 days from the date the letter was postmarked or personally delivered to you, or before the effective date of the action you’re disputing, whichever is earlier.

• Complete the “Form To File A State Fair Hearing” that is included with your “Notice of Action” letter.

• You can also send a personal letter to ask for a State Fair Hearing. Be sure to include your name, address, phone number, Social Security Number, and the reason you want a State Fair Hearing. If someone is helping you ask for a State Fair Hearing, add his/her name, address, and phone number to the letter.

• If you want to keep your treatment going during the hearing process, be sure to state that in the “Form To File A State Fair Hearing” or in your personal letter.

• If you need a free interpreter, state that in the “Form To File A State Fair Hearing” or in your personal letter. Include the language that you speak.

• It takes up to 90 days after you ask for a hearing to get an answer. If you think waiting that long will threaten your health, ask your doctor or health plan for a letter. Make sure the letter explains how waiting will threaten your health. Then, ask for an expedited hearing and include the letter with the “Form To File A State Fair Hearing” or with your own personal letter.

State Fair Hearing

Write to:
California Department of Social Services
State Fair Hearing Division
PO Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

Call: 1-800-952-5253
TDD/TTY: 1-800-952-8349
How To Get An Exemption/Waiver

You or a member of your family must choose a health plan if:

- You receive CalWorks benefits (cash aid, food stamps)
- You receive Medi-Cal only and you do not have a share of cost

You or a member of your family cannot choose a health plan if:

- You are a member of a commercial health plan through private insurance
- You receive share of cost Medi-Cal

You or a member of your family may not have to choose a health plan if:

- You receive health services from an Indian Health Provider
- You are being treated for a complex medical condition, such as:
  - Pregnancy
  - Cancer
  - Organ transplant (or are scheduled for one)
  - Renal disease and have dialysis at least two times a week
  - A disease that affects more than one organ system (such as diabetes)
  - You are HIV positive
  - Other conditions may qualify

How To Get An Exemption/Waiver

- You and your doctor must complete and sign the Medical or Non-Medical Exemption Form in this packet. Your doctor may not authorize your medical exemption, if he or she is part of a Medi-Cal Managed Care Health Plan in your area.
- You must return the form no later than 30 days after you receive this packet.
- If you do not return the form within 30 days, the State will choose a health plan for you.
- The State will review your request to change you to Regular Medi-Cal (Fee-For-Service).
- The State will send you a letter to let you know if your request has been approved or denied.
- If denied, you can call the State’s Ombudsman at 1-888-452-8609. The call is free.
# REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Each area of the Request For Exemption From Plan Enrollment form must be completed. If not, the medical exemption will be denied – **Please Print or Type (Ink Only)**

## To Be Completed and Signed By Beneficiary

### Part I

1. **Name:** (Please Print)
   - Last Name
   - First Name
   - M.I.

2. **Benefits Identification Card Number:**

3. **Date of Birth:**
   - Month / Day / Year

4. **Check One:**
   - Female
   - Male

5. **Medi-Cal ID Number:**

6a. **Are you a member of a health Plan?**
   - Yes
   - No (go to box 6b)

6b. **Plan Name:**

6c. **Plan Membership Number:**

7a. **Is someone other than the beneficiary completing this section?**
   - Yes (go to box 7b)
   - No (go to box 8)

7b. **If yes, please provide the following information:**
   - **Print Name**
   - **Relationship**
   - **Phone Number**

8. **I am requesting that Dr. send in a request for a Medi-Cal Managed Care medical exemption for me.**

   **Name of Doctor**

9. **Beneficiary’s Signature:**
   - Signature of beneficiary or Parent of beneficiary if a minor child

10. **Date Signed:**
    - Month / Day / Year

---

## Physician’s Certification For Medical Exemption

**Part II**

*The beneficiary’s rendering physician MUST fill out AND SIGN this section.*

11. **Date you started treating beneficiary for one of the conditions listed below in box 13:**
    - Month / Day / Year

12. **Estimated date of completion of treatment or therapy for condition requiring exemption:**
    - Month / Day / Year

13. **Please check the following as appropriate (ICD-9-CM code must be included in column 14 at right, or the exemption will be considered incomplete and returned.)**

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- **P**
  - A. Pregnant and currently under your care for the pregnancy. Due Date ______________

- **F**
  - B. HIV+ or has been diagnosed with AIDS

- **D**
  - C. Receiving chronic renal dialysis treatment under your supervision

- **E**
  - D. Undergoing one of three transplant classifications (see item 13-D on page 4)
    - Classification: __________________________
    - Medi-Cal designated transplant center: __________________________

14. **ICD-9 Codes**

   1. __________________________
   2. __________________________

---

HCO 7101 (12/00)
INSTRUCTIONS FOR COMPLETING REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

PART I – To Be Completed and Signed By Beneficiary

Dear Medi-Cal Beneficiary: You and/or your family is now or may soon be required to receive your health care through a Medi-Cal Managed Care health plan. You may be seeing a doctor who is not part of a health plan. If you want to keep seeing this doctor, you may qualify for what is called a medical exemption. To receive a medical exemption, you must be seeing your doctor for something serious, and your doctor must NOT be a part of a health plan in the county where you live.

If you want to ask for a medical exemption, you must fill out Part I of this form. Please sign it and give it to your doctor. Your doctor will fill out and sign Part II of this form. If your request for a medical exemption is approved, you will NOT have to join a Medi-Cal Managed Care health plan for the time being. You can remain on regular Medi-Cal (non-managed care) and keep seeing your current doctor for up to 12 months. (In some cases, the exemption will be for fewer months. Your doctor will decide this). If you need another medical exemption after your exemption period is over, you and your doctor must fill out and sign a new exemption form.

All information in this medical exemption form will be kept confidential. This information will only be used by the Medi-Cal program, its employees, and contractors.

If you have any questions regarding this form, please call Health Care Options at 1-844-580-7272.

INSTRUCCIONES PARA COMPLETAR LA CERTIFICACION DE EXENCION DE ATENCION MEDICA DE LOS PLANES ADMINISTRADOS DE MEDI-CAL

Primera Parte - Para Ser Completado y Firmado Por el Beneficiario.

Estimado Beneficiario de Medi-Cal: Usted o su familia están ahora o pueden requerirse que pronto reciban su cuidado de salud a través de un plan de Medi-Cal por Managed Care. Usted puede estar viendo a un doctor que no es parte de un plan de salud. Si usted quiere seguir viendo a este doctor, usted puede calificar para lo que se llama una exención médica. Al recibir una exención médica, usted debe estar viendo a su doctor para algo serio, y su doctor no debe de participar en uno de los planes de Managed Care en el condado donde usted vive.

Si usted quiere pedir una exención médica, usted debe completar la primera parte de esta forma. Por favor, firmelo y díselo a su doctor. Su doctor completará la segunda parte de esta forma. Si su petición para una exención médica es aprobada, usted no tendrá que afiliarse en un plan de Medi-Cal Managed Care por el momento. Usted puede permanecer en Medi-Cal regular (sin plan de salud) y seguir viendo a su actual doctor hasta por 12 meses. (En algunos casos, la exención será por menos meses. Su doctor decidirá esto.) Si usted necesita otra exención médica después de que su período de la exención haya terminado, usted y su doctor deben completar y firmar una nueva forma de exención.

Nos gustaría informarle que toda la información en esta forma de la exención médica se mantendrá confidencial. Esta información sólo será usada por el programa de Medi-Cal, sus empleados, y contratistas.

Para mas información por favor llame a Health Care Options al 1-844-580-7272 esta llamada es completamente gratis.

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### Part II Continued

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<tr>
<td>□ E. Undergoing one of two cancer classifications (see item 13-F on the reverse side).</td>
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<tr>
<td>Classification:</td>
<td></td>
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<tr>
<td>Type of Therapy:</td>
<td></td>
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<td>□ F. Has been approved for and is awaiting a major surgical procedure (see item 13-F on the reverse side).</td>
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<td>CPT code(s) for pending procedure(s):</td>
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<tr>
<td>□ G. Has a complex neurological disorder, such as multiple sclerosis</td>
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<td>□ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease</td>
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<td>□ I. Has other complex and/or progressive disorder not covered above which requires ongoing medical supervision (See item 13-I on the reverse side).</td>
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<tr>
<td>Describe treatment:</td>
<td></td>
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Please note that chronic disorders, such as asthma and diabetes, do not generally constitute grounds for approval as a medical exemption. Providers who believe that the severity of such a condition, or any other condition or combination of conditions, is/are sufficient to require a medical exemption should attach to this form additional medical documentation to establish the necessity for an exemption. Please include the beneficiary’s Medi-Cal identification number and Benefits Identification Card Number on each page of medical documentation submitted.

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<td>15. Beneficiary’s Benefits Identification Card Number</td>
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<td>16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary’s county of residence?</td>
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<tr>
<td>□ Yes</td>
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<tr>
<td>□ No</td>
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<td>Print the name of health plan</td>
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<td>17. Physician National Provider Identification Number used to bill the Medi-Cal Program for this beneficiary:</td>
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<tr>
<td>18. Medi-Cal Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
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<tr>
<td>City:</td>
<td>State:</td>
<td>Zip:</td>
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<tr>
<td>Phone:</td>
<td>FAX:</td>
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<td>19. Medi-Cal Billing Information: (If different from box 18 above.)</td>
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<td>Name:</td>
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<td>Address:</td>
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<td>City:</td>
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<td>Zip:</td>
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<tr>
<td>Phone:</td>
<td>FAX:</td>
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I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Care Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary’s listed medical condition constitutes grounds for a medical exemption.

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<tr>
<td>20. Rendering Physician’s Medical License Number:</td>
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<td>21. If you are NOT affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary’s county of residence, you MUST complete this box. If you are affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary’s county of residence, please make sure boxes 18 and 19 are complete.</td>
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<tr>
<td>Rendering Physician’s Phone number:</td>
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<td>FAX:</td>
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<td>22. Signature: (No Stamp)</td>
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<td>(Authorized Rendering Medical Physician)</td>
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<td>23. Date Signed:</td>
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<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
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MAIL COMPLETED FORM to: Health Care Options or FAX this form to: P.O. Box 989009 (916) 364-0287 West Sacramento, CA 95798-9850

HCO 7101 (12/00) - 3 -
PART II – To Be Completed and Signed By Beneficiary’s Rendering Physician

Dear Medi-Cal Physician: If you are currently providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual. The beneficiary must request a medical exemption, and you and the beneficiary must fill out this form, sign it, and mail or fax it (Part I and Part II) to the Health Care Options office (see mailing address and fax number at the bottom of Part II). Please refer to Title 22, California Code of Regulations, Sections 53887 or 53923.5, for additional information concerning requirements for medical exemptions.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved. An exemption can be requested for a maximum of 12 months. An extension may be requested at the end of 12 months by submitting a new exemption form.

Instructions for completing Boxes 13-D through 13-I (and 14):

Item 13-D
Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD-9 code for organ transplanted/to be transplanted and any codes for complications in box 14. (Please note: this exemption does not apply to beneficiaries who are medically stable on post-transplant therapy.)

Transplant classifications:
- Beneficiary is under active evaluation for the need for an organ transplant
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed.

Item 13-E
The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. Beneficiaries in long-term remission without signs of disease or who are classified as “cured” are not eligible for medical exemption.

Cancer classifications:
- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

Item 13-F
Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, including surgery for cancer.

List both ICD-9 (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If beneficiary is immediately post-operative, estimate duration of time necessary for recovery under your supervision in box 12.

Item 13-I (and all box 14 ICD codes)

The ICD-9 code must be listed in box 14, and the treatment must be stated on the line provided. Please check this item if beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:
- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted.
Medi-Cal Managed Care
Non-Medical Exemption
Excepción Por Razones No Médicas
Para Atención Médica Administrada de Medi-Cal

Request for Non-Medical Exemption from Plan Enrollment
American Indians and Beneficiaries with HIV/AIDS

Each area of this non-medical exemption form must be completed or the form will be returned unprocessed.

Please Print or Type (Ink Only)

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.

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 used to bill the Medi-Cal Program for this beneficiary
   ___ ___ ___ ___ ___ ___ ___ ___ ___

5. Telephone number of Medical Provider
   (___ ___ ___) ___ ___ ___—___ ___ ___ ___

6. Fax number of Medical Provider
   (___ ___ ___) ___ ___ ___—___ ___ ___ ___

9. Telephone number of Medical Physician
   (___ ___ ___) ___ ___ ___—___ ___ ___ ___

10. Fax number of Medical Physician
    (___ ___ ___) ___ ___ ___—___ ___ ___ ___

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you or a family member is 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 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.

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

Spanish
Translation Here
A List of Useful Words

• **Benefits Identification Card or BIC**
  The plastic card sent to everyone who is eligible for Medi-Cal. All Medi-Cal providers use the BIC to check eligibility. Also called “Medi-Cal Card”.

• **Emergency**
  Immediate need for medical attention for an injury or illness that is life-threatening or disabling.

• **Grievance**
  Your written or verbal feelings of your dissatisfaction with your health plan provider, or medical care service.

• **Health Care Options**
  The company that works for the Medi-Cal Program to help you choose or change health plans.

• **Medi-Cal**
  The California government program that pays providers who give health care services to eligible beneficiaries.

• **Medi-Cal Choice Form**
  The form you fill out to choose or change health plans.

• **Medi-Cal Managed Care Health Plan**
  Organizations with doctors, specialists, clinics, pharmacies, and hospitals that provide health care services to their members.

• **Member Services Department**
  The office in a Medi-Cal Managed Care Health Plan that can answer your questions and help you use your health plan’s services.

• **Primary Care Provider**
  The doctor, nurse practitioner, nurse midwife, or physician’s assistant who provides your health care.

• **Provider Directory**
  A list of doctors, clinics, pharmacies, and hospitals you can choose from when you join a health plan.

• **Specialist or Specialty Care Doctor**
  A doctor who only treats certain kinds of health problems like broken bones, asthma, or heart problems. To get this special care, your primary care provider must send you to the specialist or specialty care doctor. OB/GYN (Obstetrics and Gynecology) services may be contacted directly.
Making a Health Plan Choice is EASY!

Call Toll Free
Call toll free 1-844-580-7272 Monday through Friday, 8:00 am to 5:00 pm. For TDD/TTY 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 TDD/TTY 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