Cal MediConnect: How to Choose a Plan

Jenna MacRae
Attorney, Registered HICAP Counselor
Elder Law & Advocacy

Health Insurance Counseling and Advocacy Program (HICAP) a program of Elder Law & Advocacy

Some of Our Services Include:

- Medicare and related health insurance counseling for residents of San Diego and Imperial counties.
- Long- Term Care Insurance Counseling
- Low-Income application assistance for Part D prescription drug plans and Medicare Premiums
- Legal Assistance for Medicare appeals and billing issues
- ALL SERVICES ARE FREE
- ALL SERVICES ARE CONFIDENTIAL

- Call: 1800-434-0222

State of California

Health and Human Services

DHCS

CalMediConnect
Your choice for complete care
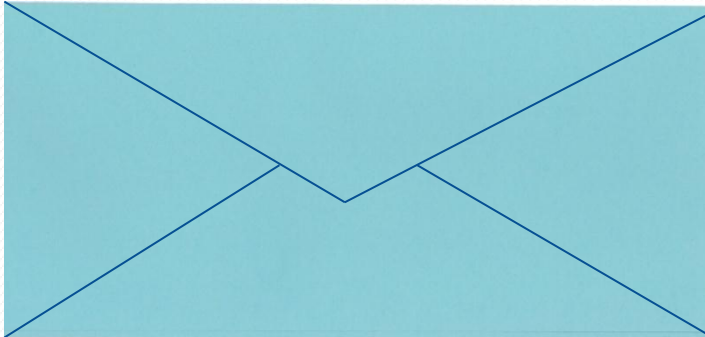
60-Day Notice

Time to take action and make a choice!

What are my choices?

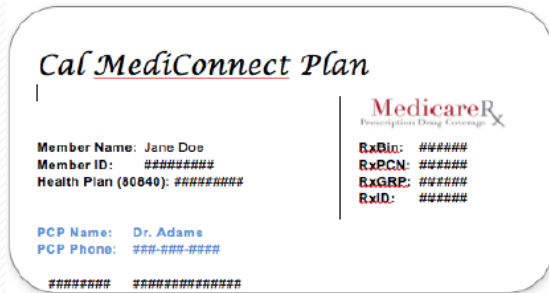| 1	Choose a Cal MediConnect Plan
2	Elect to not participate in Cal MediConnect: Pick only a Medi-Cal Plan for LTSS
3	Elect to not participate in Cal MediConnect: Enroll in PACE

What are my choices?

1 Choose a Cal MediConnect Plan

- Care 1st
- Community Health Group (Communicare Advantage)
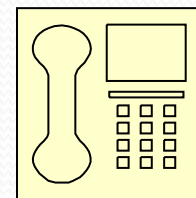- Health Net
- Molina (Molina Dual Options)

Consideration #1:

- Is staying with your doctor, hospital or other provider important to you?
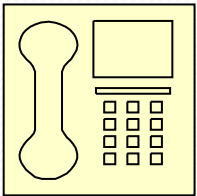
If yes:
Is the Provider on the list of Providers for any of the Plans?

Consideration #2:

Are your medications covered by the new plan?

- Name of Medication
- Dosage of Medication
- Frequency you take Medication

➢Call the plans.
➢Call 1800-Medicare

➢Plan finder online

Medicare.gov
The Official U.S. Government Site for Medicare

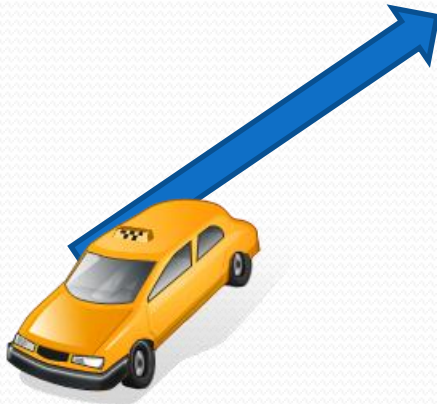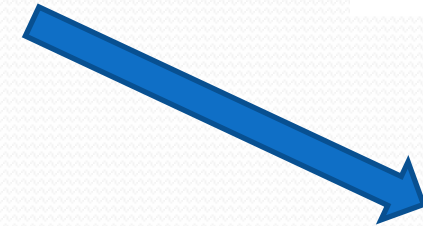Find health & drug plans

Consideration #3:

Are the Care Coordination, Vision and Transportation benefits useful?

CalMediConnect
Your choice for complete care

- Care 1st

- Community Health Group

- Health Net

- Molina

Health Plan Choice Form

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

CCIPA

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

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

JOHN SAMPLE
❶ First Name, Last Name

M- -99999999A-C

1234 SAMPLE STREET SAMPLE CITY
Address, City

Zip Code: 9 9 9 9 9

Date of Birth: 1 2 - 1 4 - 1 1

(___ ___ ___) ___ ___ ___-___ ___ ___ ___   Sex: ○ Male ○ Female   ❷ If pregnant, due date ___ ___ - ___ ___ - ___ ___
(Area Code) Phone Number   Month   Day   Year

❸ **Cal MediConnect Plans**
These plans cover both Medicare & Medi-Cal.
Pick a health plan from the list below:

- ○ 803 Care1st
- ○ 804 CommuniCare Advantage
- ○ 805 Health Net
- ○ 806 Molina Dual Options

❺ **Medi-Cal Plans**
The following plan(s) cover only Medi-Cal.

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

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

___ ___ - ___ ___ ___ ___ - ___ ___ ___

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

❼ If you pick a PACE Plan below, you must also pick a health plan from ❸ or ❺ above:

- ○ 057 St. Paul's PACE

STOP! Read the important information on the back before you sign this form.
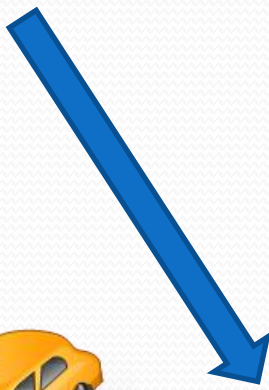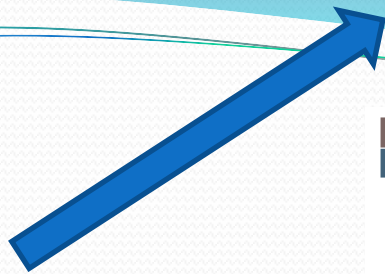
I understand that by filling out and signing this form, I am choosing how to get my health care.

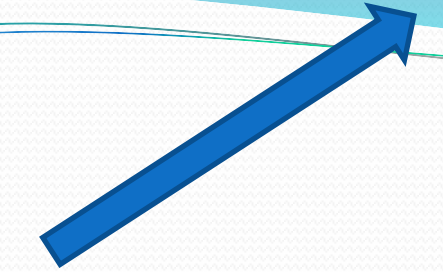Beneficiary's signature   Date   OR   Authorized Representative Signature *(if any)*   Date

- Care 1st

- Community Health Group
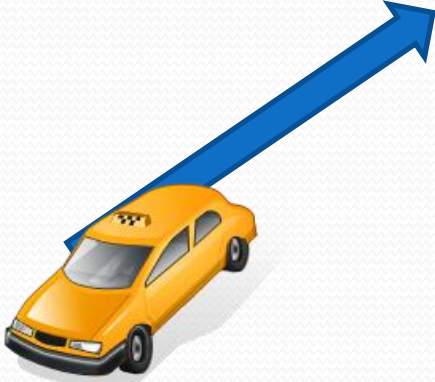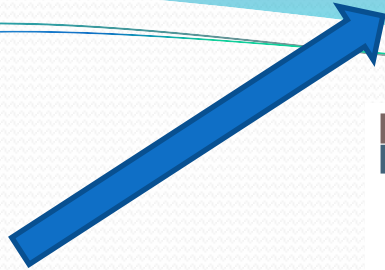
- Health Net

- Molina

Continuity of Care

- Care 1st

- Community Health Group

- Health Net

- Molina

- Care 1st
- Community Health Group
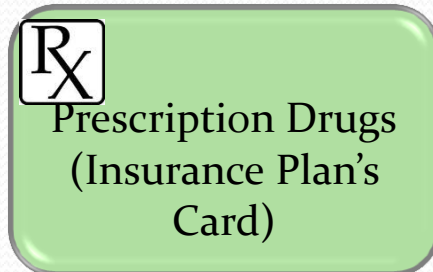- Health Net
- Molina

What are my choices?

2 — Elect to not participate in Cal MediConnect

Medicare **+** Medi-Cal + LTSS

Prescription Drugs (Insurance Plan's Card)

- Care 1st
- Community Health Group
- Health Net
- Molina
- Kaiser

Health Plan Choice Form

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W. Sacramento, CA 95798-9850

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JOHN SAMPLE
❶ First Name, Last Name

M- -99999999A-C

1234 SAMPLE STREET SAMPLE CITY
Address, City

| 9 | 9 | 9 | 9 | 9 |
Zip Code

| 1 | 2 - 1 | 4 - 1 | 1 |
Date of Birth

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___   Sex: ○ Male ○ Female   ❷ If pregnant, due date
(Area Code) Phone Number

___ - ___ ___ - ___ ___
Month   Day   Year

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

What are my choices?

3 Elect to not participate in
Cal MediConnect: Enroll in PACE

PACE

PACE Requirements:

• Are 55 or older

• Live in your home or community setting safely

• Need a high level of care for a disability or chronic condition

• Live in a ZIP code served by a PACE health plan

See all providers at PACE Center

Health Plan Choice Form

CCIPA

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❶ First Name, Last Name

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1234 SAMPLE STREET SAMPLE CITY | 9 9 9 9 9 | 1 2 - 1 4 - 1 1
Address, City | Zip Code | Date of Birth

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Sex: ○ Male ○ Female ❷ If pregnant, due date ___ ___ - ___ ___ - ___ ___
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Beneficiary's signature _____ Date ____ OR Authorized Representative Signature *(if any)* ____ Date

4

Do nothing / Be passively enrolled into a Cal MediConnect Plan

- Care 1st
- Community Health Group
- Health Net
- Molina

- Is staying with your doctor, hospital or other provider important to you?

- Which plan offers you the best coverage for you prescription medications?

- Which plans additional benefits fit best with your needs?

Unsure about what to choose? Still Confused?

Ask for help!

HICAP: 1800-434-0222