LEON HEALTH

Medicare Advantage

ENROLLMENT GUIDE

2024

January 1st - December 31st

Leon Health is an HMO plan with a Medicare Contract.
Enrollment in Leon Health, Inc. depends on contract renewal.

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Table of Content

Welcome to Leon Health, Inc.

About Leon Health

Leon Health is a Medicare Advantage Plan launched by Benjamin León, Jr., a visionary in the health care field, and the Leon family.

If you have Medicare, have both Medicare and Medicaid, or are eligible for Medicare as a senior or due to a disability and live in Miami-Dade County, Leon Health has the right plan to fit your needs.

Leon Health works with Leon Medical Centers and other health providers to provide members comprehensive care and the benefits they need in order to stay healthy.

With many different health care professionals in the network who serve more than 41,700 Medicare recipients, we are redefining the delivery of medical care in the healthcare industry.

Leon Medical Centers offers superior medical care, providing the Medicare population in Miami-Dade County with the dignity, respect, compassion and human kindness that they deserve.

The Leon family has provided health and well-being to its beneficiaries in Miami-Dade County for 55 years, and the Leon family continues to invest in innovation, physician trainings, center expansions and a health plan that has been customized to our Medicare community with the ultimate purpose of improving lives.

Need Help ?

CALL Member Services at **1-844-969-5366** or **305-541-5366.** TTY users call **711.**
Our hours of operation are 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year.

VISIT www.leonhealth.com

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-844-969-5366** or **305-541 -5366 TTY users call 711,** 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year.

UNDERSTANDING THE BENEFITS

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.LeonHealth.com or call 1-844-969-5366 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

UNDERSTANDING IMPORTANT RULES

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. Enrollees that have elected to enroll into Leon MediDual (D-SNP) may not be subject to the Medicare Part B premium. For enrollees that have elected to enroll into Leon MediMore, Leon Health will cover up to $110 of your monthly Part B

premium. You will receive the premium refund amount back on your monthly Social Security check. This process usually takes 90 days to go into effect.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services provided by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Leon MediDual is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Scope of Sales Appointment Form

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Please initial below beside the type of product(s) you want the agent to discuss.

☐ STAND ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that must cover all Part A and Part B healthcare. In most HMOs, you can only go to doctors, specialists or hospitals in the plan's network, except in an emergency.

Medicare Health Maintenance Organization Point of Service (HMO-POS) Plan — A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Preferred Provider Organization (PPO) Plan — A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-For-Service (PFFS) Plan — A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment and terms and conditions.

Medicare Special Needs Plan (SNP) — A special type of Medicare Advantage Plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — A type of health plan. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare covered services will be paid for under the Original Medicare Plan (your Cost Plan pays for emergency services, or urgently needed services).

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Date of Appointment:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in):	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
[Plan use only]	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented at least 48-hours prior to meeting:	

LEON HEALTH

OMB No. 0938-1378 | Expires:7/31/2024

Enrollment Request Form Cover Page

WHO CAN USE THIS FORM?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

WHEN DO I USE THIS FORM?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

WHAT DO I NEED TO COMPLETE THIS FORM?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

REMINDERS

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.

REMINDER (continued)

- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

WHAT HAPPENS NEXT?

Send your completed and signed form to:

Leon Health, Inc.
P.O. Box 668230
Miami, FL 33166

Once they process your request to join, they'll contact you.

HOW DO I GET HELP WITH THIS FORM?

Call Leon Health Plans, Inc. at 1-844-969-5366. TTY users can call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Leon Health, Inc. al 1-844-969-5366 / TTY: 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

INDIVIDUALS EXPERIENCING HOMELESSNESS

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Leon MediExtra - $0 per month ☐ Leon MediDual - $14.90 per month

☐ Leon MediMore - $0 per month

FIRST name: LAST name: Middle Initial:

Birth date: (MM/DD/YYYY)
(_____/_____/_____)

Sex:
☐ Male ☐ Female

Phone number:
( )

Permanent Residence street address (Don't enter a PO Box):

City: County: State: ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Leon Health?

☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage

_____ _____ _____

To enroll in our Special Needs Plans you must qualify for:

☐ *Medicaid - Please provide your Medicaid number:* _____

☐ *Medicare Savings Programs (QMB, SLMB, QI)*

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Leon Health Plans, Inc.
- By joining this Medicare Advantage Plan, I acknowledge that Leon Health Plans, Inc. will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Leon Health Plans, Inc. coverage begins, I must get all of my medical and prescription drug benefits from Leon Health Plans, Inc. Benefits and services provided by Leon Health Plans, Inc. and contained in my Leon Health Plans, Inc. "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Leon Health Plans, Inc. will pay for benefits or services that are not covered.

IMPORTANT: Read and sign below:

- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
Agent Signature:	**Received date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in a language other than English.

- ☐ Spanish

Select one if you want us to send you information in an accessible format.

- ☐ Braille
- ☐ Large print
- ☐ Audio CD

Please contact Leon Health Plans, Inc. at 1-844-969-5366 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year. TTY users can call 711.

Section 2 – All fields on this page are optional

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

Are you an existing member of this PCP? ☐ Yes ☐ No

Provider ID #

I want to get the following materials via email. Select one or more:

- ☐ Provider and Pharmacy Directory
- ☐ Comprehensive Formulary
- ☐ Summary of Benefits
- ☐ Evidence of Coverage (EOC)
- ☐ Dental Schedule of Benefits
- ☐ Over the Counter Catalog (OTC)

Email address: _____

Paying your plan premiums

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail, or through our payment portal each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

☐ Get a Bill or
Automatic deduction from: ☐ SSA ☐ RRB

If you have to pay a Part D Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Leon Health, Inc. the Part D-IRMAA.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____ _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____._____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Leon Health Plans, Inc. at 1-844-969-5366 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year.

Form CMS-1696 Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, "not applicable".

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at 42 CFR 405.910.

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: https://www.hhs.gov/sites/default/files/OMHA-118.pdf

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Instructions for completing the Member Authorization Form

01 Print your last name, first name and middle initials

02 Leon Health Plans policy ID number

03 Write your date of birth in this format: mm/dd/yyyy

04 Write your full street address

05 Write your full, city, state, and ZIP code

06 Write your daytime phone number (including area code)

07 Write the full name of the person or entity that you want us to give your information to

08 Write the full street address of your authorized representative

09 Write the city, state, zip code of your authorized representative

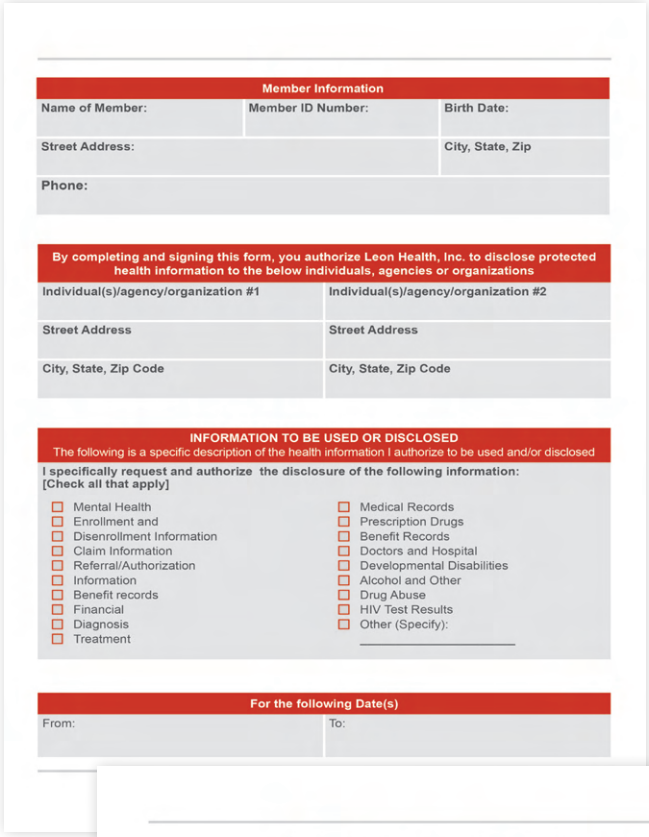
10 This section tells us what information you would like us to release

11 Note the effective date of when this form will be valid. (MM/DD/YYYY)

12 Note the effective date of when this form will expire. (MM/DD/YYYY)

13 14 Sign your name and put the date on the form. Your name and signature must match the information in Member Information.

01 This section should only be filled out if you're signing as a personal representative, who has a legal representation, like a Power of Attorney. (Otherwise this section must be left blank.)



Member Information

Name of Member:	Member ID Number:	Birth Date:
Street Address:		City, State, Zip
Phone:		

By completing and signing this form, you authorize Leon Health, Inc. to disclose protected health information to the below individuals, agencies or organizations

Individual(s)/agency/organization #1	Individual(s)/agency/organization #2
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code

INFORMATION TO BE USED OR DISCLOSED

The following is a specific description of the health information I authorize to be used and/or disclosed

I specifically request and authorize the disclosure of the following information: [Check all that apply]

- ☐ Mental Health
- ☐ Enrollment and
- ☐ Disenrollment Information
- ☐ Claim Information
- ☐ Referral/Authorization
- ☐ Information
- ☐ Benefit records
- ☐ Financial
- ☐ Diagnosis
- ☐ Treatment
- ☐ Medical Records
- ☐ Prescription Drugs
- ☐ Benefit Records
- ☐ Doctors and Hospital
- ☐ Developmental Disabilities
- ☐ Alcohol and Other
- ☐ Drug Abuse
- ☐ HIV Test Results
- ☐ Other (Specify): _____

For the following Date(s)

From:	To:

Your rights with respect to this Authorization

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I may request a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Leon Health, Inc. may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the plan's Member Services Department. I am aware that my withdrawal will not be effective until received by Leon Health, Inc. and will not be effective regarding the uses and/or disclosures of my health information that Leon Health, Inc. has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Member Services.

Redisclosure Notice: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Expiration Date: This authorization is good until the end date noted on the previous page, or if none noted, it is valid indefinitely unless I withdraw the authorization in writing.

By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Member/Legal Rep:	Date:

If you are the authorized representative, you **must** provide the following information:

☐ Check here if you are signing as a personal representative and complete below. **Please attach the appropriate documentation (for example, Power of Attorney).** This only applies if someone other than the Leon Health member signed above.

Personal Representative's Information

Name	Relationship to Member		Telephone Number
Street Address	City	State	Zip-Code

Authorization for Use & Disclosure of Health Information

Member Information		
Name of Member:	**Member ID Number:**	**Birth Date:**
Street Address:		**City, State, Zip**
Phone:		

By completing and signing this form, you authorize Leon Health, Inc. to disclose protected health information to the below individuals, agencies or organizations	
Individual(s)/agency/organization #1	**Individual(s)/agency/organization #2**
Street Address	**Street Address**
City, State, Zip Code	**City, State, Zip Code**

INFORMATION TO BE USED OR DISCLOSED

The following is a specific description of the health information I authorize to be used and/or disclosed

I specifically request and authorize the disclosure of the following information: [Check all that apply]

- ☐ Mental Health
- ☐ Enrollment and
- ☐ Disenrollment Information
- ☐ Claim Information
- ☐ Referral/Authorization
- ☐ Information
- ☐ Benefit records
- ☐ Financial
- ☐ Diagnosis
- ☐ Treatment
- ☐ Medical Records
- ☐ Prescription Drugs
- ☐ Benefit Records
- ☐ Doctors and Hospital
- ☐ Developmental Disabilities
- ☐ Alcohol and Other
- ☐ Drug Abuse
- ☐ HIV Test Results
- ☐ Other (Specify): _____

For the following Date(s)	
From:	To:

Your rights with respect to this Authorization

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I may request a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Leon Health, Inc. may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the plan's Member Services Department. I am aware that my withdrawal will not be effective until received by Leon Health, Inc. and will not be effective regarding the uses and/or disclosures of my health information that Leon Health, Inc. has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Member Services.

Redisclosure Notice: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Expiration Date: This authorization is good until the end date noted on the previous page, or if none noted, it is valid indefinitely unless I withdraw the authorization in writing.

By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Member/Legal Rep:	**Date:**

If you are the authorized representative, you **must** provide the following information:

☐ Check here if you are signing as a personal representative and complete below. **Please attach the appropriate documentation (for example, Power of Attorney).** This only applies if someone other than the Leon Health member signed above.

Personal Representative's Information

Name	**Relationship to Member**		**Telephone Number**
Street Address	**City**	**State**	**Zip-Code**

Multi-Language Insert

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-969-5366. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-969-5366. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-969-5366。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-969-5366。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-969-5366. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-969-5366. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-969-5366 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-969-5366. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-969-5366 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-969-5366. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-969-5366 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-969-5366 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-969-5366. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-969-5366. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-969-5366. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-969-5366. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには 1-844-969-5366 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Use this envelope to return your Enrollment Forms once completed.
No postage necessary.

LEON HEALTH

Your Plan

PLAN NAME: _____

Effective Date: _____

Premium: _____

Deductible: _____

Electronic Enrollment Confirmation #: _____