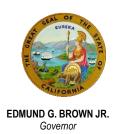


State of California—Health and Human Services Agency Department of Health Care Services



January 7, 2015

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 15-01

ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS

ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

ALL COUNTY HEALTH EXECUTIVES

ALL COUNTY MENTAL HEALTH DIRECTORS

ALL COUNTY MEDS LIAISONS

SUBJECT: Transitioning Covered California cases to Medi-Cal

The Department of Health Care Services (DHCS) is providing guidance to the counties and the Statewide Automated Welfare Systems (SAWS) regarding Covered California (Covered CA) cases that transitioned to the Medi-Cal program on January 1, 2015, as a result of Covered CA's annual redetermination process. DHCS will issue additional guidance in the near future pertaining to Covered CA cases transitioning to the Medi-Cal program as a result of a reported change in circumstance.

Covered CA Annual Redetermination Process

Covered CA redetermined the eligibility of qualified individuals enrolled in a Covered CA Program during the annual redetermination period. The annual redetermination period for Covered CA is not based upon a predetermined number of months. For the 2015 benefit year, Covered CA started processing their enrollee redeterminations in early October 2014. Consumers had 34 days from the date of their annual redetermination notice (NOD12) to actively complete their annual redetermination through the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) online portal. If the consumer did not actively complete their annual redetermination by the 34th day after their redetermination notice date, Covered CA re-enrolled the consumer into their current plan for the 2015 benefit year. If the consumer was unhappy with the plan they selected, or the plan they were automatically enrolled in, they have the ability to change their plan during Open Enrollment. Open Enrollment started November 15, 2014, and ends February 15, 2015.

All County Welfare Directors Letter No.: 15-01

Page 2

January 7, 2015

Covered CA to Medi-Cal Referral Process

Unlike the Medi-Cal program which re-examines eligibility once in a 12-month period if there are no reported changes, Covered CA benefits are tied to the tax year. Meaning, regardless of application month, Covered CA benefits will always end December 31st of the current year and enrollees will need to reestablish eligibility for January 1st of the following year.

During the Covered CA annual redetermination process, the Covered CA enrollee may have been determined potentially eligible for the Medi-Cal program. This occurs when the consumer actively completes the redetermination process or during the ex-parte review conducted by Covered CA. The most common reasons why a Covered CA enrollee would move from the Covered CA program to the Medi-Cal program would be a reported decrease in income, updates to the Federal Poverty Level, and/or an increase in tax dependents. In the event that a Covered CA enrollee is determined potentially eligible for Medi-Cal, the case is referred to the appropriate county of residence for a final confirmation of Medi-Cal eligibility. The case is sent to the county using the CalHEERS e-HIT process. Once the county receives the case, the county must complete a Medi-Cal eligibility determination and provide adequate notice to approve, discontinue or deny Medi-Cal benefits.

While DHCS recognizes there are current system challenges with eligibility determination when these cases are referred to the counties with the individuals' original application date, DHCS also recognizes that there may be Insurance Affordability Programs (IAPs) benefits calculation which could result in dual coverage (i.e. Medi-Cal or Covered CA eligibility) being reported to the Medi-Cal Eligibility Data System (MEDS) from the initial IAPs application date instead of January 1, 2015. For purposes of premium reimbursement and Medi-Cal retroactive coverage, these consumers are not able to request refunds of premiums paid to Covered CA plans in 2014 nor are they entitled to receive retroactive Medi-Cal to pay their medical expenses because they received Covered CA benefits with coverage through December 31, 2014, from a Qualified Health Plan. If consumers disagree with their Medi-Cal determination effective date, they may file an appeal. To ensure the consumer is informed of this transition, this population was mailed a notice from Covered CA notifying them that they no longer qualify for an Advanced Premium Tax Credit under Covered CA and now qualify for Medi-Cal effective January 1, 2015.

For Covered CA enrollees that appear to be eligible for Medi-Cal, the counties will receive, via e-HIT, one of three e-HIT eligibility determination results from CalHEERS: Eligible, Conditionally Eligible, or Pending Eligible which are further described below.

Reminder: Because these are Covered CA renewal cases, case information sent by CalHEERS to the counties will reflect the initial application date from the last open or special enrollment period.

All County Welfare Directors Letter No.: 15-01 Page 3

January 7, 2015

• Eligible

In the event that CalHEERS can electronically verify that the Covered CA enrollee now meets Medi-Cal eligibility criteria, the case will be referred to the county of residence for the county to confirm that the information is correct. The county eligibility worker shall not request any additional information from the client unless the worker has reason to believe that the information used to determine Medi-Cal eligibility is not correct. If the determination appears to be correct, the eligibility worker shall approve the case per existing SAWS procedures. If the determination appears to be incorrect, the eligibility worker should work the case as prescribed below under "Pending Eligible".

Conditionally Eligible

An individual will be determined "conditionally eligible" if CalHEERS can electronically verify Medi-Cal eligibility and the individual attests to having satisfactory citizenship/immigration status or a Social Security Number (SSN) but the status cannot be verified. If the determination appears to be correct, the eligibility worker shall approve the transaction per existing SAWS procedures. If the determination appears to be incorrect, the eligibility worker should work the case as prescribed below under "Pending Eligible".

If approved, the individual has 90 days to provide verification of their citizenship/immigration status. Counties shall follow pre-established Medi-Cal policies and procedures in the event that citizenship or immigration status should be verified. If, after 90 days, the individual has not provided satisfactory proof of citizenship/immigration status, the individual shall be moved to restricted scope services according to pre-established Medi-Cal policies and procedures.

Similarly, an individual will be determined "conditionally eligible" if CalHEERS can electronically verify Medi-Cal eligibility but the individual's SSN cannot be electronically verified.

If approved, the individual has 60 days to provide verification of their SSN status. Counties should follow the pre-established Medi-Cal policies and procedures for SSN verification for approval or discontinuance.

Pending Eligible

In the event that CalHEERS cannot electronically verify that the Covered CA enrollee now meets Medi-Cal eligibility criteria, but the attested income is within the Medi-Cal limit, the case will be referred to the county of residence in a pending status. A

All County Welfare Directors Letter No.: 15-01 Page 4

January 7, 2015

pending status means the county must verify program eligibility for whatever data element(s) could not be electronically verified by CalHEERS.

Since the Covered CA enrollee is not an existing Medi-Cal beneficiary, the Covered CA referral is treated as a new application for Medi-Cal purposes. This means that the county has 45 days from the date when the referral is sent to work the cases and all information shall be requested in conformity with the two contact requirement established in All County Welfare Directors Letter No.: 08-07, using 10-day request(s) for information and/or verification.

Once the applicant provides the needed information or the verification issue is otherwise resolved and is entered into SAWS, the CalHEERS Business Rules Engine will determine Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility.

- If MAGI Eligible If the applicant is determined eligible for MAGI Medi-Cal, the applicant shall be sent a Notice of Action (NOA) and shall have his/her eligibility established for a new 12-month period. For those who transition from Covered CA to Medi-Cal, a beneficiary's current Covered CA health plan doctor may or may not be in his or her new Medi-Cal health plan. If required, the beneficiary will need to select a new plan and plan selection information will be provided separately. The beneficiary may be able to keep their current plan and continue seeing his or her current physician if treatment is being provided for certain health conditions or if this is a plan offered by Medi-Cal. To determine if this is available, please refer the beneficiary to their doctor, the Health Care Options Representative at 1-800-430-4263, or if applicable, their new Medi-Cal health plan.
- If Covered CA Eligible If the applicant is determined eligible for Covered CA coverage, the county shall accept the Covered CA eligibility determination and assist the applicant with plan selection/enrollment to the greatest extent possible. Refer consumers with plan selection/enrollment questions that the county is unable to resolve to Covered CA Customer Services Representatives.
- If Not Enough Information to Determine Eligibility If the county makes the necessary two-contacts and the applicant does not respond, the case shall be denied. If the applicant does provide additional information, but it is not enough information to determine ongoing eligibility, the county shall continue to work with the client to collect the necessary information, as per current policy. The county shall attempt to work with the client in the client's preferred method of contact and language, to the extent possible. If the county feels that the client is not making a good faith effort to provide the requested information, and the 45-days to provide the information has passed, the county shall deny the case for failure to provide.

All County Welfare Directors Letter No.: 15-01 Page 5 January 7, 2015

In accordance with due process requirements, counties shall send the applicant a timely and adequate denial NOA explaining the basis for denial.

2014 Covered CA to Medi-Cal Batch Run

Primary Process

DHCS has coordinated with Covered CA, CalHEERS and SAWS to identify the population by Client Identification Number (CIN) and SSN for individuals and family cases who are transitioning from Covered CA to Medi-Cal. These cases were processed through Accelerated Enrollment (AE), pending a final Medi-Cal determination, on December 29, 2014 through December 31, 2014, with an effective date of January 1, 2015, using the existing Express Lane aid codes 7W (individuals under 19 years old) and 7S (individuals 19 years old and over). Assignment of the aid codes was based on the age of the Covered CA enrollee at the time of the batch run. These beneficiaries are identified in MEDS with a unique file name "ACA/Renewal/Rush".

The cases discontinued from Covered CA as of December 31, 2014, and identified as "eligible", "pending eligible" or "conditionally eligible" for Medi-Cal, were activated in MEDS with temporary full-scope Medi-Cal coverage effective January 1, 2015. DHCS' Information Technology Systems Division worked with CalHEERS, to activate these cases in MEDS to minimize the need for manual intervention by the counties for purposes of granting temporary Medi-Cal eligibility effective January 1, 2015. This measure was taken in order to avoid a gap in coverage. These new Medi-Cal cases will be assigned the same health plan as they had under Covered CA, to the extent it is possible. If it is not possible, they will be assigned to a new health plan under the Medi-Cal program and be notified as such. These cases will still need to be processed by the counties, as described above, in order to establish on-going eligibility into the correct aid codes and properly established in SAWS.

As with any AE process and using the Presumptive Eligibility rules, the temporary coverage provided is only until a final eligibility determination is made by the county. If the final determination results in eligibility for Medi-Cal, the beneficiary will be appropriately assigned a permanent aid code. These applications are to be treated as any other pending application for purposes of noticing the applicant of the final determination for health coverage whether it is Medi-Cal, Covered CA, or an application denial.

Exception Processes

During the course of running the above batch process, it was determined that approximately 4,500 individual and/or family cases were incorrectly terminated from Covered CA based on the income reported on the Covered CA online application in the entry field titled "last date paid". Covered CA has already reinstated these cases in their system. However, since the

All County Welfare Directors Letter No.: 15-01

Page 6

January 7, 2015

Determinations of Eligibility and Response (DERs) were already sent to the counties to work, DHCS is in the process of having these DERs systemically canceled so these cases will not require any county intervention. These individuals were not included in the batch process and were returned to Covered CA for coverage. Since the counties were previously made aware of these cases in prior efforts, DHCS will work with the counties and SAWS to provide a list of all 4,500 individuals identified in the Exception Process to reduce any duplication of effort.

DHCS has also identified approximately 1,700 individuals statewide that did not receive AE and were rejected in MEDS during the batch run due to data issues such as incorrect SSN, multiple CINs assigned and/or incorrect dates of birth. These transactions were rejected in MEDS and may not have Medi-Cal coverage as of January 1, 2015. To the extent possible, DHCS is reviewing these cases to identify the reasons for the rejects and to determine if any files can be processed at the state level to expedite coverage. Any rejected transactions that can be processed at the state level will be excluded from any files that may need to be sent to the counties for processing. DHCS, in discussions with the Counties Welfare Director's Association, are examining next steps and will provide further instructions regarding the remaining rejected transactions. DHCS and counties will need to coordinate expedited processing of rejected transactions that may require counties to manually work these transactions. In the interim, if one of these individuals come to the county's attention and needs immediate medical care, the county may utilize MEDS to provide immediate coverage while the case is in process.

Managed Care Process

It is the intent of DHCS for all transitioning individuals to be eligible for Medi-Cal to the extent possible and enrolled in a health plan by January 1, 2015.

DHCS transferred beneficiaries to a health plan using one of two methods.

- Beneficiaries with a health plan in Covered CA that is also a Medi-Cal health plan in the county. DHCS assigned the members to the same health plan.
- Beneficiaries with a health plan in Covered CA that does not match to a Medi-Cal health plan. DHCS assigned the members to a new health plan.

If the new Medi-Cal beneficiary does not agree with the assignment of the health and/or dental plan, they will be able to change health plans by contacting a Health Care Options Representative. Additionally, beneficiaries residing in counties with more than one plan can change their Medi-Cal Managed Care Plan at any time. For any questions regarding their health and/or dental plan(s), they can contact a Health Care Options Representative at 1-800-430-4263.

All County Welfare Directors Letter No.: 15-01 Page 7
January 7, 2015

DHCS will also mail a notice to the beneficiaries informing them of the plan they are enrolled in, the effective date and information on contacting Health Care Options to change their plan. Additionally, all new Medi-Cal beneficiaries will receive a Welcome to Medi-Cal packet the first week of January2015.

Beneficiaries will also receive a Medi-Cal Benefit Identification Card (BIC). For beneficiaries who already have a BIC and are going through this process, their old card will be deactivated and a new BIC issued. Should the beneficiary contact the county with inquiries regarding the new card, the county should be prepared to provide clarification.

Attached are reference documents county staff can review and use to respond to consumer questions on the transition and referral process from Covered CA to Med-Cal:

- Talking Points: Transitioning from Covered California Coverage to Medi-Cal Process When Eligibility Changes.
- Sample Medi-Cal Program Consumer Correspondence: Medi-Cal Health Plan Enrollment Confirmation Letter.
- Sample Covered California to Medi-Cal Transition Notice

For further information or additional questions, you may contact Michelle Marean-Williams at (916) 341-3968 or by email at michelle.marean-williams@dhcs.ca.gov and Deborah Palmer at (916) 440-7855 or by email at deborah.palmer@dhcs.ca.gov.

Alice Mak, Acting Chief Medi-Cal Eligibility Division

Attachments





December 30, 2014

Transitioning from Covered California Coverage to Medi-Cal: Process When Eligibility Changes

The Department of Health Care Services (DHCS) has coordinated with Covered California, the California Healthcare Eligibility and Enrollment Retention System (CalHEERS), the County Welfare Directors Association, and the Statewide Automated Welfare System (SAWS) to prepare for individuals and family cases currently enrolled in Covered California health plans who, due to changes in their family income, will be transitioned to Medi-Cal for health care coverage.

To provide a seamless transition of these Covered California enrollees and prevent any gaps in their health coverage, DHCS will ensure all cases have Medi-Cal coverage and are enrolled in a health plan effective January 1, 2015. There are two populations that will transition:

- 1. Those individuals who have not had their Medi-Cal coverage activated as of yet. DHCS will administratively process those cases that have not had a final Medi-Cal determination to begin temporary Medi-Cal coverage in the Medi-Cal Eligibility Data System (MEDS) effective January 1, 2015. These individuals will have accelerated enrollment into Medi-Cal and be placed into one of two aid codes: 7W for individuals under 19 years of age and 7S for individuals 19 years old or older. The assignment to these two aid codes will be based on the age of the beneficiary at the time of the batch run. These individuals will stay under temporary Medi-Cal coverage with full-scope benefits until the counties complete their final Medi-Cal eligibility determination and send appropriate notices.
- 2. Those individuals who have their Medi-Cal coverage active for January 1, 2015. This population will need no action from DHCS.

Each year, Covered California is required to verify that its enrollees still qualify for federal premium assistance. This determination is based upon income and family size. Covered California is now sending out notices to enrollees who no longer qualify for federal subsidies to help pay the cost of their premiums.

This document is intended to assist County Welfare Departments, Covered California Service Centers, the DHCS' Office of Public Affairs, and legislative staff in responding to questions from the public or press about the transition.

- Medi-Cal Coverage Begins on January 1, 2015. Certain enrollees' current Covered California coverage with premium assistance will end on December 31, 2014, and new coverage with Medi-Cal begins on January 1, 2015. No action is required by the enrollee to obtain Medi-Cal. If additional information is needed to maintain Medi-Cal coverage, the beneficiary's <u>County Human Services Agency</u> will contact them.
- DHCS to Ensure a Seamless Transition. DHCS has coordinated with Covered California, CalHEERS and SAWS to identify the individuals and family cases transitioning from Covered California to Medi-Cal. To provide a seamless transition and ensure there is no gap in health care coverage, the cases will be processed through accelerated enrollment, effective January 1, 2015.
- Enrollment Process. The goal is to enroll each beneficiary into a managed care health plan, effective January 1, 2015. For those who transition to Medi-Cal and their current Qualified Health Plan (QHP) is also a Medi-Cal managed care plan, they will transition to the matching managed care plan with no lapse in coverage. For those who are enrolled in a QHP that does not match a Medi-Cal managed care health plan, they will be automatically enrolled into a managed care plan in their county.
- Enrollees Can Keep Their Covered California Plan in 2015 and Not Enroll in Medi-Cal. All enrollees have the option of keeping their Covered California health plan, but will have to pay the full premium out of pocket for the Covered California plan. No premium assistance will be provided. To keep coverage with their Covered California health plan, enrollees can call their Covered California health plan directly.
- Continuity of Care. For those who transition to Medi-Cal, a beneficiary's current
 Covered California health plan or health plan doctor may or may not be in their new
 Medi-Cal health plan. The beneficiary may be able to keep seeing his or her current
 physician if treatment is being provided for certain health conditions. To find out if this
 applies, the beneficiary should talk to his or her doctor and new Medi-Cal health plan.

Beneficiaries have the right to request Continuity of Care when they are in the course of treatment. They should contact their Medi-Cal health plan's member services to begin the process. For a list of health plan member services visit http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

For more information and additional resources on Continuity of Care in the Medi-Cal managed care plan please visit http://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx

- Emergency Services. In Medi-Cal all enrollees have access to Emergency Room (ER) care in any ER. There is no cost to Medi-Cal enrollees for services provided on an emergency basis. In addition, the ER does not need to be contracted with the Medi-Cal health plan to provide emergency services.
- **Mailed Notices.** Covered California will begin to send notices to individuals transitioning from Covered California to Medi-Cal beginning in the week of December

29, 2014. The notices explain that their coverage with Covered California will end on December 31, 2014, and that they may be eligible for Medi-Cal.

On January 2, 2014, DHCS will send a letter to individuals confirming their Medi-Cal health plan enrollment, effective January 1, 2015. The letter will also notify individuals that they may contact Health Care Options (1-800-430-4263) at any time to change their Medi-Cal health plan if there are multiple plan choices in his or her county.

- Benefit Identification Card (BIC). Those individuals determined eligible for Medi-Cal
 will receive a BIC during the first week in January and a "Welcome to Medi-Cal" packet
 from their health plan within the first ten days of enrollment.
- Premium Payments. Former Covered California consumers who have Medi-Cal
 coverage in 2015 should end any automatic premium payments or check payments to
 their Covered California health plan. Consumers who sent premium payments for
 2015 coverage can request refunds from the health plan for these payments only.
 Consumers may contact their health plan for questions about refunds in this situation.
- Consumers Returning to Covered California Health Plan Coverage.
 If a consumer is determined ineligible for Medi-Cal and eligible for Advance Premium Tax Credit (APTC), the county will transfer the record to Covered California for ongoing case management.

The coverage start date for consumers returning to Covered California for plan enrollment should immediately follow the last date of Medi-Cal coverage. For example, if Medi-Cal coverage ended on January 31, the new Covered California plan should start on February 1. In the case of a late processed enrollment, a March 1 enrollment is also acceptable, at the consumer's request.

Responses to Individual Inquiries:

- Compliance with County Requests. You may receive a request from a county
 eligibility worker for additional information to confirm your Medi-Cal eligibility. Please
 be sure to respond in a timely manner to ensure you do not lose your coverage.
 Examples of information that may be requested include income verification
 documentation or additional information about family members.
- Enrollees Can Appeal. If an enrollee does not agree with this decision, there are a
 number of ways he or she can appeal. You may file an appeal by downloading and
 filling out the Request for a State Fair Hearing to Appeal a Covered California Eligibility
 Determination form. You may also file a complaint with Covered California by
 downloading and filling out this Covered California complaint form.
- Additional Information. Consumers may contact the Covered California Service Center at 1-800-300-1506 or the beneficiary's <u>County Human Services Agency</u>. Legislative Offices may contact <u>ExternalAffairs@Covered.CA.Gov</u>.





{FIRST_NAME} {LAST_NAME}
{ADDRESS_LINE1}
{ADDRESS_LINE2}
{CITY}, {STATE_CD (FK)} {ZIPCODE}

You or your family members may now qualify for Medi-Cal

{Month} {##}, {YEAR}

Case Number: {####}

Dear {FIRST_NAME} {LAST_NAME},

Thank you for choosing health insurance through Covered California in 2014. Each year Covered California must check to see if you and your family members still qualify for premium assistance. We used federal data and information you gave us about your income and family size to see which programs you qualify for in 2015. Based on this information, the family members below no longer qualify for premium assistance through Covered California and now qualify for Medi-Cal. This notice is to advise you that Medi-Cal coverage for these family members will begin on January 1, 2015 and that their enrollment in Covered California with premium assistance will end on December 31, 2014. As noted below, these members have the option of keeping their Covered California health plan but they will no longer be eligible for premium assistance.

- {INDIVIDUAL DETERMINED ELIGIBLE FOR MEDI-CAL}
- {INDIVIDUAL DETERMINED ELIGIBLE FOR MEDI-CAL}

What To Do Next

You do not need to do anything else at this time. Your information has already been sent to the Medi-Cal program. Your local county Human Services agency may contact you if additional information is needed to keep this coverage.

You have the option to keep your Covered California health plan in 2015, but if you want to keep your plan, you will not get any premium assistance. This means you will have to pay the full premium for a Covered California plan. If you want to keep your coverage with your Covered California health plan, call your Covered California health plan directly.

With eligibility under Medi-Cal, your current doctor may not be in your new Medi-Cal plan. You may be able to ask to keep seeing your current doctor if you are getting treatment for certain health conditions. If you want to know if this applies to you, talk to your doctor and your new Medi-Cal plan.

You Can Appeal

If you don't agree with our decision, you can appeal. If you appeal and we agree with you, we may change our decision. If we change our decision, your family members' eligibility may also change, even if they do not file their own appeal.

You can request an appeal in any of the following ways:

- Go to www.CoveredCA.com to download and print a "Request for a State Fair Hearing to Appeal a Covered California Eligibility Determination" form.
- Fax your appeal to the State Hearings Division at: (916) 651-2789
- Mail your appeal to:

CA Department of Social Services

Attn: ACA Bureau P.O. Box 944243 Mail Station 9-17-37

Sacramento, California 94244-2430

- Email your appeal to: <u>SHDACABureau@DSS.CA.gov</u> (please do not email private information such as your Social Security Number)
- Request an appeal by contacting your County Social Services Department
- Call the State Hearings Division and submit your appeal over the phone: 1(855) 795-0634.

Getting Help in Another Language

IMPORTANT: Can you read this letter? You can call 1 (800) 300-1506 and ask for this letter translated to your language or in another format such as large print. For TTY call 1 (888) 889-4500 where you can also request this letter in alternate format.

Español (Spanish)

IMPORTANTE: ¿Puede leer esta carta? Usted puede llamar al 1(800) 300-0213 y pedir esta carta traducida en su idioma o en otro formato, como en letras grandes. Si usa TTY, llame al 1-(888) 889-4500, donde también puede pedir esta carta en algún formato alterno.

Chinese

重要事项:您能否阅读此信件?您可以致电 **1(800) 300-1533**, **要求将此信件翻**译为您的母语或者索要其他格式(如,大字版本)的信件。如需 **TTY 服**务或者索要其他格式的信件,请致电 **1(888) 889-4500**。

Vietnamese

QUAN TRONG: Quý vị có thể đọc được bức thư này không? Quý vị có thể gọi điện đến số 1 (800) 652-9528 và yêu cầu được dịch bức thư này sang ngôn ngữ của quý vị hoặc chuyển sang định dạng khác như bản in khổ lớn. Người dùng TTY, hãy gọi số 1(888) 889-4500 quý vị cũng có thể yêu cầu định dạng thay thế khác cho bức thư này.

Korean

중요: 이 편지를 읽을 수 있나요? 1 (800) 738-9116 에 연락하셔서 번역되어 있거나인쇄물 등 다른 포맷으로 되어 있는 편지를 요청해보세요. TTY 1 (888) 889-4500에서도 이 편지의 다른 포맷을 요청할 수도 있습니다.

Tagalog

MAHALAGA: Makakabasa ka ba sa sulat na ito? Maaari kang tumawag sa 1 (800) 983-8816 at humiling na isalin ang sulat na ito sa iyong wika o sa iba pang format katulad ng malalaking titik. Para sa TTY, tumawag sa 1 (888) 889-4500 kung saan maaari kang humiling ng alternatibong format ng sulat na ito.

Arabic

هام: هل يمكنك قراءة هذا الخطاب؟ يمكنك الاتصال بـ 6317-826 (800) 1 وطلب هذا الخطاب مترجماً إلى لغتك أو بصيغة أخرى، بخط كبير مثلاً. للصم والبكم، اتصل بـ 889-4500 (888) 1 حيث يمكنك أيضاً أن تطلب هذا الخطاب بصيغة مختلفة.

Armenian

ԿԱՐԵՎՈՐ Է: Դուք կարո՞ղ եք կարդալ այս նամակը: Դուք կարող եք զանգահարել 1 (800) 996-1009 և խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրվի մեկ այլ ձևաչափով, օրինակ` խոշորատառ։ TTY-ի համար զանգահարեք 1 (888) 889-4500, որտեղ կարող եք նաև այլընտրանքային ձևաչափով խնդրել այս նամակը։

Khmer

សំខាន់៖ តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខត 1-(800)-906-8528 និងស្នើសុំ**ត្យ**គេបកប្រែលិខិតនេះជាភាសារបស់**សា**កអ្នក ឬជាទម្រង់ត មួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ សម្រាប់ TTY ទូរស័ព្ទមកលេខ 1 (888) 889-4500 ដែលលោកត អ្នកក៍អាចស្នើសុំ**តំ**ខិតនេះជាទម្រង់ផ្សេងទៀតបានផងដែរ។ត

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Вы можете прочитать это письмо? Вы можете позвонить по телефону 1 (800) 778-7695 и запросить получение этого письма, переведенного на Ваш родной язык, или распечатанного крупным шрифтом. Лица со сниженным слухом могут позвонить по телефону 1 (888) 889-4500, чтобы запросить это письмо в ином формате.

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ می توانید با شماره 8879-921 (800) 1 تماس بگیرید و تقاضا کنید که این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند با شماره 4500-889 (888) 1 تماس بگیرید و از طریق همان شماره TTYحروف درشت به شما ارسال شود. برای همچنین می توانید درخواست کنید که این نامه به فرمت دیگری به شما ارسال شود.

Hmong

TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Koj hu tau rau 1 (800) 771-2156 nug daim ntawv txais ua yog koj cov lus los yog lwm hom xws lis tus ntawv loj. Hu tau TTY ntawm 1 (800) 889-4500 ua koj thov hloov tau lwm hom.

State of California-Health and Human Services Agency

Department of Health Care Services □



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

January 01, 9999□

221C2114-000001-01-1





JOHN SAMPLE 123 SAMPLE STREET SAMPLE CITY CA 99999

Congratulations! You and the following member(s) of your family are now enrolled in the Medi-Cal Managed Care health and/or dental plan(s) listed below:

Name Effective Date Health Plan Dental Plan

JOHN SAMPLE Month 00, 0000 SAMPLE HEALTH PLAN

Next to each person's name is the *effective date* of enrollment. Their health and/or dental plan(s) will start on this date. After that day, you and anyone in your family listed above who has Medi-Cal will all get health and/or dental service(s) from the health and/or dental plan(s) listed above.

The health and/or dental plan(s) will soon send you an information packet. This packet will include information about the health and/or dental plan's services, identification cards and a list of their locations.

Call your Member Services Department at your health and/or dental plan(s) if you have questions about getting health or dental care. If you need health and/or dental care before you get the health and/or dental plan(s)' information packet, please take this letter and your enrollment form with you to the health and/or dental plan provider(s).

If you have questions about your enrollment in the health and/or dental plan(s), contact a Health Care Options Representative at **1-800-430-4263**.

If you want to change your health and/or dental plan(s), ask the Health Care Options Representative for a Medi-Cal Choice Form. Fill out the "I wish to JOIN or change my plan to:" bubble on the form. Please tell us why you want to change your plan by filling in the "plan change reason code:" box from the list of codes at the bottom of the choice form. It can take up to 30 days to change health and/or dental plan(s). Call a Health Care Options Representative for more information at 1-800-430-4263.

THE STATE OMBUDSMAN CAN HELP YOU: The State of California has people who can help you. You can call the State's Ombudsman at 1-888-452-8609 (toll-free), Monday through Friday from 8:00 AM to 5:00 PM if:



- You are having problems with your health or dental plan(s), doctor/clinic or dentist and cannot get help when you call the Member Services Department of your Medi-Cal health plan.
- * You are having a problem with changing your Medi-Cal health or dental plan and cannot get help when you call a Health Care Options Representative at 1-800-430-4263.
- * You think a doctor/clinic, dentist, health plan or dental plan representative has told you something about joining a health or dental plan that is not true. For instance, you were told by a doctor/clinic, dentist, health plan or dental plan that you had to join their health or dental plan or you would lose your Medi-Cal.
- * You think a doctor/clinic, dentist, health plan or dental plan signed you up for their plan without your permission.

The State of California must seek repayment of Medi-Cal benefits from the estate of a deceased Medi-Cal beneficiary for services received on or after the beneficiary's 55th birthday. For Medi-Cal beneficiaries enrolled (either voluntarily or mandatorily) in a managed care organization, the State must seek recovery of the total premium/capitation payments for the period of time they were enrolled in the managed care organization. Additionally, any other payments made for services provided by non-managed care providers will also be recovered from the estate. For further information regarding the Estate Recovery program **only**, call (916) 650-0490, or seek legal advice.

PLEASE DO NOT CALL YOUR ELIGIBILITY WORKER. He or she does not have this information, so they cannot help you.

Questions? Call a Health Care Options Representative at **1-800-430-4263**. Please call weekdays 8:00 AM - 5:00 PM. The call is free!