



Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725



*Your destination for affordable
healthcare, including Medi-Cal*

{HH_FIRST_NAME} {HH_LAST_NAME}
{HH_MAILING_ADDRESS_LINE1}
{HH_MAILING_ADDRESS_LINE2}
{HH_MAIL_CITY}, {HH_MAIL_STATE} {HH_MAIL_ZIP}

**Your health insurance will end on September 30, 2015
Contact us right away!**

<Date>

Case Number <XXXXXX>

Dear {HH_FIRST_NAME} {HH_LAST_NAME},

Your health insurance will end on **September 30, 2015**, if you don't contact us right away. You received a letter from Covered California in the last 45 days requesting that you send us documents by **August 31, 2015**, for the individuals listed below to show that you or other members of your household are eligible to continue health insurance and/or financial assistance through Covered California.

We need documents from the following individual(s) where a box is checked below:

	Citizenship/ Lawful Presence	Social Security Number
{FIRST_NAME} {LAST_NAME}	<input type="checkbox"/>	<input type="checkbox"/>
{FIRST_NAME} {LAST_NAME}	<input type="checkbox"/>	<input type="checkbox"/>
{FIRST_NAME} {LAST_NAME}	<input type="checkbox"/>	<input type="checkbox"/>

As of today, we still do not have the documents we need from you or there may be a problem processing what you have sent us. Without the correct documents, we cannot check to see if you can continue to qualify to keep your health coverage.

What Happens Next?

The individuals listed above will no longer qualify for health insurance and their current health coverage will end on **September 30, 2015**. Other members in your household will be able to keep their current health plan.

Your health insurance company will send the individuals listed above a letter that their health coverage will end on **September 30, 2015**.

This notice is being sent to you in compliance with the Affordable Care Act:
45 C.F.R. §§ 155.305, 155.315, 155.430.
Cal. Code Regs., tit. 10, §§ 6472, 6478, 6506.

If you received premium tax credits, you may have to repay the Internal Revenue Service (IRS) some or all of the tax credits you received when you file your taxes in 2016. You may also have to pay a tax penalty if you stay uninsured and do not qualify for an exemption.

I Do Not Want to Lose My Coverage. What Are My Options?

Covered California does not want you to lose your coverage if you or members of your household can show that you are eligible for Covered California. If you have already submitted documents or if you are having trouble submitting documents, you have options.

1: Call our Service Center at 1-800-300-1506 to speak with a representative. You can call Monday through Friday 8 a.m. to 6 p.m. and Saturdays 8 a.m. to 5 p.m. The call is free. For TTY, call 1-888-889-4500.

2: File an appeal. If you think we made a mistake or you don't agree with our decision, you can appeal. You have 90 days from the date of the eligibility decision to file an appeal. If you appeal and we agree with you, we may change our decision. If we change our decision, your family members' coverage may also change, even if they do not file their own appeal. Appeal hearings will be conducted by telephone, video conference, or in person. You may choose to represent yourself, or be represented by an attorney or another representative.

You have the right to appeal any of the following decisions:

- 1) You did not qualify for a Covered California health plan or premium assistance.
- 2) You did not qualify for Medi-Cal.
- 3) The amount of premium assistance (federal tax credits to help lower your monthly premium) you qualified for is not correct.
- 4) The level of cost-sharing reductions (help paying your co-payments and deductibles) that you qualify for is not correct.
- 5) You did not get a decision about your application in a timely manner. (More than 10 days after receipt of a complete application if you qualified for Covered California or more than 45 days if you qualified for Medi-Cal).

You may request to stay in your Covered California health plan with your current level of premium assistance while your appeal is pending. This is called "continued enrollment". You must keep paying your share of premium on time to qualify for continued enrollment. If you request continued enrollment, please do not send your appeal by mail. Instead, call 1 (855)795-0634 or use fax or email.

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: SHDACABureau@DSS.CA.gov (please do not email private information such as your Social Security Number).

- Request an appeal in person at your County Welfare Department.
- Call the State Hearings Division and submit your appeal over the phone: 1 (855) 795-0634.
- If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited appeal by calling 1 (855) 795-0634.
- An appeal decision for you or other members of your household may result in a change in your eligibility or the eligibility of other members of your household. The change in eligibility may result in a redetermination of eligibility for all household members.
- For free local assistance with appeals, please call the Health Consumer Alliance: 1 (888) 804-3536.

What If I Am Having Trouble Getting My Documents?

We know it can take a long time to get copies of certain documents. Please visit coveredca.com to see a full list of acceptable documents you can submit to us.

What If I Get Renewal Notice From Covered California?

You may get a notice from Covered California about renewing your current health insurance. The individuals listed above will only be able to renew their health insurance for 2016 if they give us the documents we are requesting. Please call the Service Center right away so that the individuals listed above can renew their coverage.

Can I Wait Until Open Enrollment To Sign Up Again?

Yes. The next open enrollment period for Covered California runs from November 1, 2015 through January 31, 2016. Coverage will begin January 1, 2016 if you renew or apply again and select a plan by December 15, 2015.

If your coverage ends on September 30, 2015 and you did not get us your documents, you will have to apply again during open enrollment. You will not be able to qualify for coverage in 2016 unless you give us the documents that we are now asking for. Please call us if you need help getting your documents.

This notice is being sent to you in compliance with the Affordable Care Act:
45 C.F.R. §§ 155.305, 155.315, 155.430.
Cal. Code Regs., tit. 10, §§ 6472, 6478, 6506.

Get Help in a Language Other than English

English: IMPORTANT: Do you need help reading this letter? This letter is about your health insurance application. We need more information from you to see if you qualify for health insurance through Covered California or Medi-Cal. If you do not send us the information we need by the due date, you may not get the health coverage you need. You can call **1-800-300-1506** to speak with someone who speaks your language. You can also ask for this letter to be 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 a different format.

Español: IMPORTANTE: ¿Necesita ayuda para leer esta carta? Esta carta es acerca de su solicitud de seguro de salud. Necesitamos más información sobre usted para ver si califica para el seguro de salud a través de Covered California o Medi-Cal. Si no nos envía la información que necesitamos para la fecha límite, puede ser que no obtenga la cobertura médica que necesita. Puede llamar al **1-800-300-0213** para hablar con alguien que hable en español. También puede pedir que esta carta sea traducida en su idioma o en otro formato, como por ejemplo, letra grande. Para TTY, llame al: 1-(888)-889-4500 donde también puede pedir esta carta en un formato diferente. (Spanish)

中文/繁體字: 重要事項：您需要我們幫助您閱讀此函嗎？此次致函意在告知您有關您的健康保險申請事宜。我們需要您提供更多資訊，以確認您是否有資格透過 Covered California 或 Medi-Cal 獲得健康保險。若您未能於截止日期之前向我們發送所需的資訊，則您可能無法獲得所需的健康保險。您可撥打

1-800-300-1533，向講您的語言的人員諮詢。您亦可要求將此函翻譯為您的語言版本或索取其他格式（如大字版）的信函。文字電話號碼用戶請撥打 **1-(888)-889-4500**，透過撥打此號碼亦可索取不同格式的信函。(Chinese)

Tiếng Việt: QUAN TRỌNG: Quý vị có cần trợ giúp đọc lá thư này? Lá thư này trình bày về đơn đăng ký bảo hiểm y tế của quý vị. Chúng tôi cần thêm thông tin từ quý vị để xem quý vị có đủ điều kiện nhận bảo hiểm y tế thông qua Covered California hay Medi-Cal không. Nếu quý vị không gửi cho chúng tôi những thông tin chúng tôi cần chậm nhất vào ngày hết hạn, quý vị có thể không nhận được khoản bao trả y tế mà quý vị cần. Quý vị có thể gọi số **1-800-652-9528** để trao đổi với những người nói ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu thư này được dịch sang ngôn ngữ của quý vị hoặc ở định dạng khác như bản in cỡ lớn. Đối với TTY, vui lòng gọi số 1-(888)-889-4500 nơi quý vị cũng có thể yêu cầu thư này ở một định dạng khác nhau. (Vietnamese)

한국어: 주요 사항: 이 편지를 읽는 데 도움이 필요하십니까? 이 편지는 귀하의 의료 보험 신청서에 대한 것입니다. 저희는 귀하가 Covered California나 Medi-Cal을 통한 의료 보험 가입 자격이 있으신지를 알기 위해 추가 정보가 필요합니다. 기한 내에 필요한 정보를 보내주시지 않으시면, 필요하신 보험 혜택을 받지 못하실 수 있습니다. 귀하가 사용하시는 언어로 통화하시려면 **1-800-738-9116** 으로 전화해 주십시오. 이 편지를 귀하가 사용하시는 언어로 번역하도록 요청하시거나 큰 활자 인쇄 등의 다른 유형으로 요청하실 수도 있습니다. TTY의 경우, 1-(888)-889-4500로 전화하셔서 이 편지를 다른 유형으로 요청하실 수 있습니다. (Korean)

Tagalog: MAHALAGA: Kailangan mo ba ng tulong sa pagbasa ng sulat na ito? Ang sulat na ito ay tungkol sa iyong aplikasyon sa health insurance. Kailangan namin ng karagdagang impormasyon upang makita kung ikaw ay karapat-dapat para sa health insurance sa pamamagitan ng Covered California o Medi-Cal. Kung hindi ka magpapadala sa amin ng impormasyong kailangan namin sa petsang taning, maaaring hindi mo matatanggap ang health coverage na kailangan mo. Maaari kang tumawag sa **1-800-983-8816** upang makipag-usap sa isang tao na nagsasalita ng iyong wika. Maaari mo ring hilingin na ang sulat na ito ay isalin sa iyong wika o sa ibang pormat tulad ng, malalaking letra. Para sa TTY tumawag sa 1-(888)-889-4500 kung saan maaari mo ring hilingin ang sulat na ito sa naiibang pormat.

Hmoob: TSEEM CEEB: Koj puas xav kom pab nyeem tsab ntawv no rau koj? Tsab ntawv no hais txog koj daim ntawv thov kev pab kas phais pov hwm kev noj qab haus huv. Peb xav tau koj cov ntaub ntawv ntxiv los kuaj xyuas seb koj puas muaj cai tau txais kev pab kas phais pov hwm kev noj qab haus huv los ntawm Covered California lossis Medi-Cal. Yog koj tsis xav cov ntaub ntawv no tuaj rau peb, peb xav tau cov ntaub ntawv no kom tsis pub dhau hnuv tag sijhawm, yog

tag sijhawm lawm, tej zaum koj yuav tsis tau txais pab kas phais pov hwm kev noj qab haus huv raws li qhov koj xav tau. Koj tuaj yeem hu xovtooj rau tus xovtooj **1-800-771-2156** mus tham nrog ib tug neeg uas paub hais koj hom lus. Thiab yog koj xav tau ib tug neeg pab txhais lus lossis xav tau cov ntaub ntauv ua koj hom lus, xav kom muab luam tawm kom nyeem tau zoo, koj kuj tuaj yeem hu rau tus xovtooj saud tau. Rau cov neeg lag ntseg los yog hais lus tsis tau, hu rau tus xovtooj TTY 1-(888)-889-4500 koj tuaj yeem thov kom lawv muab tsab ntauv no sau ua lwm hom ntauv rau koj tau. (Hmong)

Русский: ВАЖНАЯ ИНФОРМАЦИЯ: Вам нужна помощь, чтобы прочитать это письмо? Это письмо касается Вашего заявления на медицинское страхование. Нам нужно получить больше информации от Вас, чтобы определить, соответствуете ли Вы требованиям для получения медицинского страхования через Covered California или Medi-Cal. Если Вы не отправите нам необходимую информацию до установленной даты, Вы можете не получить необходимое Вам страховое покрытие медицинского обслуживания. Вы можете позвонить по номеру **1-800-778-7695**, чтобы поговорить с лицом, владеющим Вашим языком. Вы также можете обратиться с запросом на перевод этого письма на Ваш язык или на предоставление этого письма в другом формате, например, крупным шрифтом. Лица с нарушениями слуха могут позвонить по номеру 1-(888)-889-4500, по которому Вы также можете обратиться с запросом на предоставление этого письма в другом формате. (Russian)

հայերեն: ԿԱՐԵՎՈՐ է: Ձեզ այս նամակի հետ կապված օգնություն անհրաժեշտ է: Այս նամակը վերաբերում է Ձեր առողջության ապահովագրություն դիմումին: Մեզ հարկավոր է Ձեզանից լրացուցիչ տեղեկություններ ստանալ՝ պարզելու համար, թե արդյոք Դուք համապատասխանում եք «Covered California»-ի կամ «Medi-Cal»-ի միջոցով ապահովագրություն ստանալու պահանջներին: Եթե Դուք մինչև պահանջված օրը մեզ չուղարկեք այդ տեղեկությունները, հնարավոր է, որ չստանաք առողջության Ձեզ անհրաժեշտ ապահովագրությունը: Դուք կարող եք զանգահարել **1-800-996-1009** և խոսել Ձեր լեզվով խոսող որևէ աշխատակցի հետ: Կարող եք նաև խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրամադրվի որևէ այլ ձևաչափով, օրինակ՝ խոշորատառ տպագրությամբ: TTY-ի համար զանգահարեք 1-(888)-889-4500, որտեղ կարող եք նաև մեկ այլ ձևաչափով խնդրել այս նամակը: (Armenian)

فارسی

مهم: آیا برای خواندن این نامه نیاز به کمک دارید؟ این نامه در ارتباط با تقاضانامه بیمه بهداشتی شما ارسال می شود. برای دانستن اینکه آیا از طریق Covered California یا Medi-Cal صلاحیت دریافت بیمه بهداشتی دارید، نیاز به اطلاعات بیشتری از سوی شما داریم. اگر اطلاعات مورد نیاز ما را تا تاریخ مقرر به ما ارسال نکنید، ممکن است بیمه بهداشتی مورد نیاز خود را دریافت نکنید. می توانید با شماره تلفن **1-800-921-8879** تماس بگیرید و با شخصی که به زبان شما صحبت می کند گفتگو کنید. همچنین می توانید درخواست کنید تا این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند چاپ درشت به شما ارسال شود. برای TTY با شماره **1-(888)-889-4500** تماس بگیرید و در آنجا می توانید تقاضا کنید که این نامه به فرمت متفاوتی به شما ارسال شود. (israF)

ភាសាខ្មែរ: ចំណុចសំខាន់៖ តើអ្នកត្រូវការជំនួយក្នុងការអានលិខិតនេះដែរឬទេ? លិខិតនេះគឺទាក់ទងនឹងការដាក់ពាក្យសុំប័ណ្ណធានារ៉ាប់រងសុខភាពរបស់អ្នក។ យើងខ្ញុំត្រូវការព័ត៌មានបន្ថែមពីអ្នកដើម្បីឲ្យដឹងថាអ្នកមានលក្ខណៈសម្បត្តិគ្រប់គ្រាន់ទទួលបានប័ណ្ណធានារ៉ាប់រងសុខភាពតាមរយៈកម្មវិធី Covered California ឬ Medi-Cal ដែរឬទេ។ ប្រសិនបើអ្នកមិនធ្វើព័ត៌មានដែលយើងខ្ញុំត្រូវការ ឲ្យទាន់តាមកាលបរិច្ឆេទកំណត់ទេនោះ អ្នកអាចនឹងមិនទទួលបានការធានារ៉ាប់រងសុខភាពដែលអ្នកត្រូវការឡើយ។ អ្នកអាចទូរសព្ទទៅលេខ **1-800-906-8528** ដើម្បីនិយាយទៅកាន់នរណាម្នាក់ដែលនិយាយភាសារបស់អ្នក។ អ្នកក៏អាចស្នើសុំឲ្យគេបកប្រែលិខិតនេះជាភាសារបស់អ្នក ឬស្នើសុំលិខិតនេះជាទម្រង់ផ្សេងទៀត ដូចជាឯកសារបោះពុម្ពជាអក្សរធំជាដើម។ សម្រាប់ TTY សូមទូរសព្ទទៅលេខ **1-(888)-889-4500** ដើម្បីអាចស្នើសុំលិខិតនេះជាទម្រង់ផ្សេងទៀត។ (Khmer)

عربي

هام: هل تحتاج إلى مساعدة في قراءة هذا الخطاب؟ يتعلق هذا الخطاب بطلب التأمين الصحي الخاص بك. نحتاج إلى مزيد من المعلومات منك لنرى ما إذا كنت مؤهلاً لتلقي التأمين الصحي من خلال Covered California أو Medi-Cal. إذا لم ترسل إلينا المعلومات التي نحتاج إليها في التاريخ المحدد، فقد لا تحصل على التغطية الصحية التي تحتاج إليها. يمكنك الاتصال على الرقم **1-800-826-6317** للتحدث مع شخص يتحدث بلغتك. يمكنك أيضاً طلب ترجمة هذا الخطاب إلى لغتك أو الحصول عليه بتنسيق آخر مثل نسخة بحجم كبير. للحصول على خدمة الهاتف النصي، اتصل على الرقم **1-(888)-889-4500** حيث يمكنك أيضاً طلب هذا الخطاب بتنسيق مختلف. (cibarA)