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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

<<First Name>><<Last Name>>
<<Address Block 1>>
<<Address Block 2>>
<<City>><<State>><Zip Code>>

Your child(ren) is eligible for the
County Children's Health Initiative Program

<<Date>>

Dear **<<First Name>> <<Last Name>>**,

Thank you for choosing health insurance through Covered California. When Covered California receives new information, they must check to see if you and your family members still qualify for premium assistance. Based on the information received during the 2016 Open Enrollment Period, the following child(ren) qualify for the County Children's Health Initiative Program (C-CHIP) and no longer qualify for premium assistance through Covered California.

- **<<First Name>> <<Last Name>>**

This information has already been sent to the C-CHIP in your county of residence for C-CHIP enrollment and they will be contacting you to enroll your child(ren). Your child(ren)'s enrollment in a Covered California health plan with premium assistance will end on March 31, 2016. If you want to keep your child(ren) enrolled in Covered California without the premium assistance, please let the C-CHIP know that when they contact you or you call Covered California at **1 (800) 300-1506** to request coverage without premium assistance.

The C-CHIP offers comprehensive medical, dental, and vision insurance for uninsured children and teens under 19 years old who:

County Children's Health Initiative Program (C-CHIP)
Medi-Cal Eligibility Division, MS 4607
P.O. Box 997417, Sacramento, CA 95899-7417
Phone: (916) 552-9430
Internet Address: http://www.DHCS.ca.gov

- Reside in one of the following counties: San Mateo, San Francisco, or Santa Clara
- Are not eligible for Medi-Cal or Covered California coverage with premium assistance
- Do not have health care coverage through a parent's employer-sponsored insurance
- Are U.S. citizens, nationals, or lawfully present immigrants, and
- Have a family adjusted gross monthly income above 266% and up to and including 322% of the Federal Poverty Level; *example*: between $5,376 - $6,508 for a family of four (4).

The children listed above qualify for 12 months of continuous C-CHIP coverage and their Covered California coverage with premium assistance will end on March 31, 2016. Family members not listed above who are enrolled in a Covered California plan will continue to be enrolled in their Covered California plan.

The C-CHIP in your county of residence will be contacting you to enroll your child(ren). You do not need to do anything else at this time. If you have questions regarding this letter, or your child(ren)'s eligibility for C-CHIP, or you are not contacted by March 15, 2016, please contact the C-CHIP in your county of residence by phone or in writing at:

San Francisco County:
San Francisco Healthy Kids
P.O. Box 194327
San Francisco, CA 94119

1 (415) 615-5700

In-Person Assistance:
7 Spring Street
San Francisco, CA 94104
Monday-Friday, 8:00 am to 5:30 pm

San Mateo County:
San Mateo County Health Coverage Unit
Children's Health Initiative
801 Gateway Blvd. Suite 100
South San Francisco, CA 94080

1 (650) 616-2002

Santa Clara County: Children's Health Initiative
770 S Bascom Ave.
San Jose, CA 95128

1 (888) 244-5222
1 (408) 808-6180

What To Do Next

If you want to find out what information that was used to make this decision, please log in to your CoveredCA.com account to review the information they have for your family based on the 2016 Open Enrollment Period. You can change the information they have if it needs updating. Be sure that all family members in your tax household are listed on your application for 2016. It is also important that they have your current income, so please double check the Income Section. If you do not have a login or you need help, you can call the Covered California Service Center at **1 (800) 300-1506**.

If the information in your account is correct, it means that your child(ren) no longer qualify for Covered California coverage with premium assistance. You have the option to keep your child(ren) in Covered California coverage in 2016, but you will not get any premium assistance to help you pay for their coverage. This means you will have to pay the full premium for a Covered California plan. If you want to keep your child(ren) enrolled in Covered California without the premium assistance, please let the C-CHIP know that when they contact you or you call Covered California at **1 (800) 300-1506** to request coverage without premium assistance.

If your child(ren) is currently receiving treatment for certain health conditions, talk to their doctor and the new C-CHIP plan in your county of residence to see if their provider is in the network or you may be able to request to continue seeing your child(ren)'s current doctor.

If You Think We Made a Mistake

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. To request continued enrollment, be sure to complete page 6 of the appeal form and fax or email it as described below.

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.
- You may choose to represent yourself, or be represented by an attorney or another representative.
- 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.
- For free local assistance with appeals, please call the Health Consumer Alliance: 1 (888) 804-3536.

Getting Help in Another Language

IMPORTANT: Can you read this letter? You can call **1-(800)-300-0213** 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.

Espanol
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.

Mandarin or Cantonese
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 TRỌNG: 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)-300-0213**에 연락하셔서 번역되어 있거나
인쇄물 등 다른 포맷으로 되어 있는 편지를 요청해보세요. TTY **1-(888)-889-4500**에서도
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
طخب ،د رخأ ةغ يصب وأ ك تغل **(800) 6317**-ب لا صد تالا ك نكمي ؟ب اطخلا اذه ةءارق ك نكمي له :ماه **826**
مختلفة." **(888) 889**-ب ل صد تا ،مك بلاو مصدلل .م ثلا ريب بك **14500**طخلا اذه ب لطو د لإ م ترجم ا ب ا
1ةغ يصب ب اطخلا اذه ب لطت نأ أيض ا ك نكمي ث يح

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
សំ□ន់៖ េ◌ត□េ◌□កអ□ក□ច□នលិខិតេនះ□នែដរឬេទ? េ◌□កអ□ក□ចទូរស័ព□មកេលខ **1-(800)-906-8528** និងេស□□សុំឲ្យេគបកែ្របលិខិតេនះ□□□របស់េ◌□កអ□ក ឬ□ទ្រមង់មួយេផ្សងេទៀតដូច□អក្សរពុម□ធំៗ។ ស្រ□ប់ TTY ទូរស័ព□មកេលខ **1-(888)-889-4500** ដេល□កអ□កក៏□ចេស□□សុំលិខិតេនះ□ទ្រមង់េ◌ផ្សងេទៀត□នផងែដរ។

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
(800) 921-8879 هوامش اب دیـ ناوت یـ م ؟دیـ ناوخب ار هنان ذ یا دیـ ناوت یـ م ایآ :مهم___________"
و ت اضاقت ا نک دیـ هک یا ذ ناهه ب ز ابـ ن امش هجرت دوش ای هب فرم ت دیـ گر یـ مان ذن حرو ف درش ت
وخرد دیـ ناوت یـ م ت سا **(888) 889**-هوامش اب **4500**یـ ارب .دوش لا سرا امش هب YTT **1**دیـ ریـ گب سامت
دوش لا سرا امش هب یـ رگ دیـ ت مرف هب هنان ذ یا هک . "**1**ذ یـ نچمه هوامش ن امه ق یرط زا و دیـ ریـ گب سامت
دیـ نک

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**