DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
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Age 26-49 Adult Expansion

Eligibility and Enrollment Plan

August 18, 2023

Senate Bill (AB) 184 (Chapter 47, Statutes of 2022)
Welfare and Institutions Code Section 14007.8

Contents

Introduction

Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age and who do not have satisfactory immigration status (SIS) as required by Welfare and Institutions Code section 14011.2, if otherwise eligible. This new coverage is referred to as the Age 26-49 Adult Expansion. SB 184 provides that the Age 26-49 Adult Expansion will not take effect until the Department of Health Care Services (DHCS) confirms that both the State and counties' automated systems are programmed as needed to enroll the new population into coverage. DHCS is planning system readiness and effectuation of the Age 26-49 Adult Expansion no later than January 1, 2024.

The purpose of this Eligibility and Enrollment Plan is to describe the process by which the Age 26-49 Adult Expansion population will receive full scope Medi-Cal. The expansion population includes new Medi-Cal enrollees and current beneficiaries transitioning from restricted scope to full scope Medi-Cal because of this expansion. This plan provides an overview of the Age 26-49 Adult Expansion activities that will occur for individuals to have full scope Medi-Cal beginning January 1, 2024, including:

1. The application process for the new enrollee population (not currently enrolled in Medi-Cal);

2. The transition process for the existing restricted scope Medi-Cal population, including how and when the transition population is identified, when they will receive notices, and when and how their aid code will change; and

3. The managed care health plan enrollment process for both new enrollee and transition populations.

Impacted Populations

There are two populations impacted by the Age 26-49 Adult Expansion:

- New Enrollee Population: The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in Medi-Cal, who apply for Medi-Cal starting January 1, 2024, and who meet all eligibility criteria for full scope Medi-Cal, except for SIS. The new enrollee population can be eligible under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI.

- Transition Population: The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have an SIS or are unable to establish SIS for full scope Medi-Cal. The transition population can be eligible under any eligibility group, including MAGI and Non-MAGI, before January 1, 2024.

Age Policy – New Enrollees and Transition Populations

With the implementation date of January 1, 2024, CalHEERS, CalSAWS, and DHCS will use the following age policy to determine who is eligible for the Age 26-49 Adult Expansion, if otherwise eligible:

- An individual who is 26 through 49 years of age on any day in January 2024 will be eligible for full scope Medi-Cal under any eligibility group, including MAGI and Non-MAGI, for the entire month of January 2024, if they are otherwise eligible.
    - Individuals who turn 26 years of age on January 1, 2024, are considered 26 years of age for the month of January 2024 and are eligible for full scope coverage under the Age 26-49 Adult Expansion.
- Individuals who turn 26 years of age between January 2, 2024, and January 31, 2024, are considered age 25 for the month of January 2024, and remain eligible for full scope coverage under the Young Adult Expansion.

System Readiness

DHCS' goal is to complete and implement all system changes necessary to implement the Age 26-49 Adult Expansion no later than January 1, 2024. DHCS is working with CalSAWS and the counties to ensure that necessary system changes are implemented in CalSAWS, including all necessary Notice of Action (NOA) revisions in all threshold languages, updated Eligibility Determination and Benefits Calculation (EDBC) functionality, County Eligibility Worker (CEW) training and supports, and more.

- Contingency Planning: If the system implementation date is delayed, it will not change the effective date of the policy change. The policy shall be implemented no later than January 1, 2024, even if system implementation is delayed to the month of February 2024. If necessary, DHCS will effectuate full scope eligibility on January 1, 2024.

DHCS is also working with CalHEERS to ensure that necessary CalHEERS system changes are implemented for the Age 26-49 Adult Expansion.

Aid Codes

There are no new aid codes for the Age 26-49 Adult Expansion. Individuals who are eligible under this expansion will be placed into existing full scope MAGI and Non-MAGI Medi-Cal aid codes respectively. For the transition population, DHCS has developed an aid code crosswalk that identifies the appropriate full scope aid code for eligible individuals in restricted scope aid codes to move into once the Age 26-49 Adult Expansion is implemented (see Enclosure 1 – Age 26-49 Adult Expansion Aid Code Crosswalk).

Application Process

Individuals can apply for Medi-Cal online, by mail, by telephone, by fax, or in person. If the applicant qualifies for full scope Medi-Cal under the Age 26-49 Adult Expansion,

they will receive the appropriate NOA notifying them of their eligibility for full scope Medi-Cal effective no sooner than the month of implementation, January 2024.

For applications submitted prior to January 1, 2024, individuals will be granted restricted scope Medi-Cal for the months prior to January 2024.

Scenario 1: An individual 26 through 49 years of age without SIS for full scope Medi-Cal, applies for Medi-Cal in December. The individual will be granted restricted scope Medi-Cal for the December 2023 month of eligibility. The individual will be transitioned to full scope Medi-Cal beginning with the January 2024 month of eligibility.

Scenario 2: An individual 26 through 49 years of age without SIS for full scope Medi-Cal, applies for Medi-Cal in November. The individual will be granted restricted scope Medi-Cal for the November 2023 and December 2023 months of eligibility. The individual will be transitioned to full scope Medi-Cal beginning with the January 2024 month of eligibility.

Retroactive Medi-Cal

Applicants can request retroactive Medi-Cal coverage for up to three months prior to the month of application. However, under the Age 26-49 Adult Expansion, full scope retroactive coverage will be available no sooner than January 2024. Eligible Age 26-49 Adult Expansion individuals, who request retroactive coverage for any month(s) prior to the month of implementation, will be granted restricted scope Medi-Cal based on eligibility policies in effect prior to implementation of the Age 26-49 Adult Expansion. The following scenarios are provided to clarify retroactive Medi-Cal coverage eligibility for individuals without an SIS for federally-funded full scope Medi-Cal.

Scenario 1: An individual, who turns 26 in January 2024, applies for Medi-Cal in January 2024 and requests retroactive Medi-Cal. Because full scope Medi-Cal is available for individuals under age 26, the individual is determined eligible for full scope Medi-Cal during the three months prior to turning 26years old.

- Individual is eligible for full scope retroactive Medi-Cal for October 2023, November 2023, and December 2023, if otherwise eligible.

Scenario 2: An individual, who turns 26 in February 2024, applies for Medi-Cal in February 2024 and requests retroactive Medi-Cal.

- Individual is eligible for full scope retroactive Medi-Cal for November 2023, December 2023, and January 2024, if otherwise eligible, because they were 25 years old and eligible for full scope Medi-Cal under the Young Adult Expansion.

Scenario 3: An individual, who turns 45 in January 2024, applies for Medi-Cal in February 2024 and requests retroactive Medi-Cal.

- Individual is eligible for full scope retroactive Medi-Cal for January 2024, if otherwise eligible, due to their age and the Adult Expansion. Individual is eligible for restricted scope retroactive Medi-Cal for November 2023 and December

2023, if otherwise eligible, due to no full scope eligibility for individuals 26 through 49 without SIS prior to January 1, 2024.

Scenario 4: An individual, who is 30 years old, applies for Medi-Cal in April 2024 and requests retroactive Medi-Cal.

- Individual is eligible for full scope retroactive Medi-Cal for January 2024, February 2024, and March 2024, if otherwise eligible.

Transition Process

As CalHEERS and CalSAWS readies to enroll newly eligible individuals into full scope aid codes, DHCS will implement the transition of current Medi-Cal eligible individuals who fall in the transition period and who the county cannot renew from restricted scope Medi-Cal to full scope Medi-Cal (through CalSAWS). Individuals in restricted scope aid codes will receive advance notice of the transition process in the beginning of November 2023 and no action is required on their part.

If the Medi-Cal annual redetermination falls in the transition period (October 2023 through January 2024) and the county cannot renew their Medi-Cal eligibility using an ex parte review of available information, these individuals will receive an annual renewal packet to renew their Medi-Cal eligibility. Individuals who receive a renewal packet must provide the county with any requested information. All 90-day cure policies applicable to Medi-Cal redeterminations and NOAs apply to redeterminations and NOAs for the Age 26-49 Adult Expansion population.

An individual must have active restricted scope Medi-Cal eligibility effective for the December 2023 month of eligibility and continue to be eligible for Medi-Cal for the January 2024 month of eligibility to be automatically transitioned to full scope coverage for the January 2024 month of eligibility.

Once CalHEERS and CalSAWS systems are determined ready, CalSAWS will:

1. Identify eligible individuals 26 through 49 years of age enrolled in restricted scope MAGI Medi-Cal aid codes and process the transition into full scope aid codes via CalHEERS, based on the Age 26-49 Adult Expansion aid code crosswalk (Enclosure 1).

2. Identify eligible individuals 26 through 49 years of age enrolled in restricted scope, Non-MAGI Medi-Cal aid codes and process the transition to full scope aid codes via CalSAWS based on the Age 26-49 Adult Expansion aid code crosswalk
(Enclosure 1).

3. Use a batch process to identify the MAGI and Non-MAGI Aged 26-49 Adult Expansion transition population and transmit the appropriate aid code change to MEDS.

4. After the batch processes begins at the end of November 2023, generate and send the NOA to inform transitioned beneficiaries that their level of benefits will increase from restricted scope to full scope Medi-Cal coverage.

When an Age 26-49 Adult Expansion eligible individual transitions from restricted scope Medi-Cal to full scope Medi-Cal upon implementation of the program, the Medi-Cal annual redetermination date will not be reset. The Age 26-49 Adult Expansion is an increase in the level of benefits for the individual and is not considered a change in circumstance; therefore, a change to the redetermination date is not required and the date should remain unchanged (See ACWDL 14-22).

Quality Assurance and Reporting Requirements

To ensure Age 26-49 Adult Expansion individuals smoothly transition to full scope Medi-Cal, DHCS is developing the following data tracking reports from MEDS:

- In November 2023, DHCS will compile county level data identifying eligible Age 26-49 Adult Expansion individuals that are 26 through 49 years of age who are in restricted scope aid codes in MEDS.
- After CalSAWS completes its batch process to provide full scope eligibility to the transition population effective January 1, 2024, DHCS will compile data identifying eligible Age 26-49 Adult Expansion individuals who were transitioned into full scope aid codes in MEDS.
- In December 2023, DHCS will reconcile these data reports to identify Age 26-49 Adult Expansion individuals who were properly transitioned into full scope Medi-Cal and those who were not. DHCS will create a batch process to place individuals who did not properly transition into a full scope aid code.
- Beginning February 2024, DHCS will provide monthly reports at the county level to the counties and work with the counties to ensure individuals who were batched into full scope by DHCS are transitioned into the appropriate full scope Medi-Cal aid code. Counties are responsible for correcting cases with transition exceptions.to ensure individuals are placed in the appropriate full scope aid code. DHCS will continue this process until all eligible individuals are properly transitioned into the appropriate full scope Medi-Cal aid code.

On a quarterly basis, DHCS will post ongoing monthly counts of the Adult Expansion population on the DHCS Open Data Portal.

Notices to New Enrollees and Transition Populations

DHCS has developed three notices that will be translated into all Medi-Cal threshold languages and will be sent to beneficiaries in the written threshold language indicated on their MEDS record. The following assumes a January 1, 2024, implementation.

First Notice (General Information Notice) – Transition Population

All individuals in the Age 26-49 Adult Expansion transition population will receive the First Notice (see Enclosure 2 – First Notice (General Information Notice) approximately 60 days prior to January 1, 2024, implementation. The First Notice includes general

information about the Age 26-49 Adult Expansion, including Frequently Asked Questions (FAQs) that provides information about full scope Medi-Cal, Medi-Cal managed care plans, benefits, and how to get more information or help.

In October 2023, DHCS will identify all active restricted scope individuals who are 26 to 49 years of age, who do not have verified citizenship or SIS in MEDS. These individuals make up the expected transition population and will be sent the First Notice. For individuals who meet the Age 26-49 Adult Expansion eligibility criteria and who apply for Medi-Cal from October 1, 2023, to the implementation date, counties are required to include the First Notice and FAQs in the materials provided at application.

Second Notice (Notice of Action) – New Enrollees and Transition Populations

DHCS has developed NOA snippets for the Age 26-49 Adult Expansion (see Enclosure 3 – Second Notice (Notice of Action Letter Snippets). These NOA snippets will be translated into all Medi-Cal threshold languages and must be sent to beneficiaries in their indicated threshold language.

- New Enrollee Population: When an individual is determined to be newly eligible for Medi-Cal under the Age 26-49 Adult Expansion, CalSAWS will generate a NOA with the appropriate translated snippet included.

- Transition Population: When an individual is transitioned from restricted scope Medi-Cal to full scope Medi-Cal, CalSAWS will generate a NOA with the appropriate translated snippet included to notify the individual of their benefit increase.

Third Notice (Enrollment Notice) – Transition Population

DHCS will mail out the Medi-Cal Managed Care Plan Enrollment Notice at least 30 days prior to January 1, 2024. This notice provides information for transitioned beneficiaries who are required to enroll in a Medi-Cal managed care plan.

- **County Organized Health Systems (COHS) Counties and Single Plan Counties:** The enrollment notice will explain what a Medi-Cal managed care plan is, the name of the Medi-Cal managed care plan that the individual will be enrolled into (each COHS county only has one plan and each Single Plan county has a Local Initiative plan and Kaiser as plan options[1]), the date of enrollment, January 1, 2024 effective date, and the Medi-Cal managed care plan contact information.

- **Non-County Organized Health Systems (non-COHS)/non-Single Plan Counties**: The enrollment notice will explain what a Medi-Cal managed care plan is and inform the individual of their Medi-Cal managed care plan options and that they should have received their Choice Packet. Individuals who do not make a plan selection by the date listed in the *My Medi-Cal* Choice Packet will be enrolled into the Medi-Cal managed care plan listed in the notice effective

[1] Beneficiaries will be enrolled in the Local Initiative Plan in Single Plan counties. Beneficiaries must meet special eligibility requirements to enroll in Kaiser.

February 1, 2024. DHCS will assign all beneficiaries in a family to the same plan unless beneficiaries in the household affirmatively choose otherwise.

Managed care dental coverage is available in Sacramento, Los Angeles, and San Mateo counties. The remaining counties have dental coverage through the fee-for-service delivery system. Information about dental services is included in the enrollment notices.

New Enrollee – Managed Care Enrollment Process

The existing Medi-Cal managed care enrollment process applies to individuals who first apply for Medi-Cal and receive full scope Medi-Cal after the Age 26-49 Adult Expansion implementation.

Transition Population – Managed Care Enrollment Process

DHCS will implement a managed care enrollment process for the Age 26-49 Adult Expansion transition population, as explained below:

COHS and Single Plan Counties

- DHCS will send the Third Notice (Medi-Cal Managed Care Enrollment Notice) which includes a link to the FAQs to individuals at least 30 days prior to January 1, 2024. The FAQ will be posted on the DHCS website in all required threshold languages. The Third Notice will include instructions for any member who requests to receive the FAQ in a print copy by mail or an alternative format.
- Beginning January 1, 2024, individuals will be enrolled into the COHS plan in their county or into the Local Initiative plan in their Single Plan county. The COHS plan or the Local Initiative plan will mail a welcome packet to individuals within a week of enrollment.

Non-COHS/non-Single Plan Counties

- DHCS will send the Third Notice (Medi-Cal Managed Care Enrollment Notice) which includes a link to the FAQs to individuals at least 30 days prior to January 1, 2024. The FAQ will be posted on the DHCS website in all required threshold languages. The Third Notice will include instructions for any member who requests to receive the FAQ in a print copy by mail or an alternative format.
- DHCS will send Medi-Cal Choice Packets to individuals starting in December 2023.
- Individuals can enroll in a Medi-Cal Managed Care plan as early as January 1, 2024. Beneficiaries who do not enroll in a Medi-Cal Managed Care plan listed by the date in the *My Medi-Cal* Choice Packet will be enrolled into the Medi-Cal managed care plan listed in the notice effective February 1, 2024.

Medi-Cal Choice Packets – New Enrollees and Transition Populations

Individuals in non-COHS/non-Single Plan counties will receive a Medi-Cal Choice Packet in their threshold language. The packets include all of the following:

- An Enrollment Choice Form;
- A self-addressed stamped envelope to return the completed form;
- A Medi-Cal managed care plan enrollment choice booklet that provides health plan information;
- Guidance on how to enroll in a Medi-Cal managed care plan or change plans;
- The Health Care Options presentation schedule;
- A summary list of Medi-Cal managed care plan benefits;
- Instructions and forms for the Medical Exemption Request/Waiver, and;
- A Medi-Cal managed care plan provider directory for their county, if applicable.

Medi-Cal Choice Packets will be mailed starting in December 2023 for the non-COHS/non-Single Plan transition population. New enrollees will receive the packets after applying and being determined eligible for full scope Medi-Cal.

Health Care Options has posted Choice Packet documents on its website at https://www.healthcareoptions.dhcs.ca.gov/download-forms. Listing the individual's social security number (SSN) is not required on any Health Care Options form. Contact information for Health Care Options is available at https://www.healthcareoptions.dhcs.ca.gov/contact-us. Health Care Options can be reached toll-free at 1-800-430-4263 (TTY 1-800-430-7077).

Provider and Medi-Cal Managed Care Plan Updates

DHCS will post a provider bulletin on the Medi-Cal Provider website approximately 45 days prior to the transition date. This bulletin will remind providers of the implementation of the Age 26-49 Adult Expansion and will include contact information for provider questions. The posted bulletin will be available to FFS providers and shared with Medi-Cal managed care plans. DHCS will continue to update the Medi-Cal managed care plans through weekly conference calls and webinars.

Outreach

DHCS is developing a global outreach toolkit. The goal of the outreach language is to inform beneficiaries and prospective applicants of upcoming changes to Medi-Cal which will expand eligibility for full scope Medi-Cal to all individuals who are 26 to 49 years of age and who meet all Medi-Cal eligibility criteria without regard to immigration status. The outreach materials will include messaging that, beginning January 1, 2024, all individuals, regardless of immigration status, who meet all other Medi-Cal eligibility criteria will be eligible for full scope Medi-Cal.

The global outreach toolkit will include messaging that can be used in various forms of outreach including social media posts, call scripts, and county website content. While counties are not required to utilize this language, DHCS highly recommends counties utilize this messaging and integrate it into their outreach and social media campaigns. Counties may modify the global outreach language to meet any business need in utilizing the language; however, the intent of the language must remain the same to retain consistency in messaging.

DHCS is sharing the global outreach toolkit broadly for use by Medi-Cal Managed Care Plans, other State departments, Medi-Cal providers, and other community partners for use in their outreach activities.

Stakeholder Engagement

DHCS is using existing stakeholder engagement forums to discuss and provide updates on Age 26-49 Adult Expansion implementation, including but not limited to:

- Age 26-49 Adult Expansion Stakeholder Workgroup;
- The Consumer-Focused Stakeholder Workgroup;
- County Welfare Directors Association of California (CWDA) meetings;
- Managed Care Operations Plan conference calls; and
- Medi-Cal Dental Advisory Committee meetings.

Ongoing DHCS stakeholder discussion topics include:

- The Eligibility and Enrollment Plan;
- Key milestones and timeline;
- The restricted scope transition populations;
- The Age 26-49 Adult Expansion Aid Code Crosswalk;
- FAQs for DHCS' website;
- Notices for the expansion population;
- Outreach efforts to reach expansion eligible individuals who are not yet enrolled in Medi-Cal;
- DHCS guidance on the Age 26-49 Adult Expansion implementation; and
- Enrollment report by counties.

Key Milestones

The key milestones are based on January 2024 implementation of the Age 26-49 Adult Expansion. DHCS will provide updates through established stakeholder meetings and will share revisions to the milestones and implementation efforts as applicable.

- *April 2023* – Readability/translation of all MAGI and Non-MAGI Medi-Cal notice snippets into all threshold languages. Completed.
- *June – July 2023* – Share initial drafts of the Eligibility and Enrollment Plan through existing stakeholder forums. Completed.
- *June – August 2023* – User testing and readability/translation of First Notice (General Information Notice) and FAQs materials in all threshold languages. In process.
- *September – October 2023* – Data pull of individuals 26 to 49 years of age who do not have satisfactory immigration status but have restricted scope Medi-Cal in MEDS in preparation for the First Notice (General Information Notice) mailing. In process.
- *October 2023* – Present Webinar #1 to counties. Webinar will provide an overview of the proposed implementation efforts and next steps. In process.

- *October 2023* – Present Webinar #1 to advocate community to provide an update on implementation efforts. In process.
- *November 2023* – Post a provider bulletin on the Medi-Cal Provider website with an implementation update and contact information for provider questions. In process.
- *November – December 2023* – Complete system changes and notify Department of Finance and all stakeholders with confirmation of the implementation date. In process.
- *November 2023* – Release of the First Notice (General Information Notice) to the transitioning population. This notice explains their upcoming change in benefits, their mandatory enrollment into a Medi-Cal Managed Care Plan, and FAQs and contact information for assistance. In process.
- *(Late) November – (Early) December 2023* – CalSAWS/Counties to send the appropriate Notice of Action to the transitioning population. This notice explains their change in benefits from restricted to full scope Medi-Cal coverage along with their Hearing Rights. In process.
- *(Late) November – (Early) December 2023* – Begin processing new applicants and the transition population for full scope Medi-Cal eligibility effective January 1, 2024. In process.
- *October – November 2023* – Send the Third Notice (Enrollment Notice) to the population transitioning into a Medi-Cal Managed Care Plan. The Health Care Options Medi-Cal Choice Packets will also be sent in December 2023. In process.
- *December 2023* – Present Webinar #2 to counties. Webinar will provide an overview of the proposed implementation efforts and next steps. In process.
- *December 2023* – Present Webinar #2 to advocate community to provide an update on implementation efforts. In process.
- *January 1, 2024* – Effective implementation date for the Age 26-49 Adult Expansion. In process.
- *June 2024* – Submit first semi-annual report to the Legislature.

Other Age 26-49 Adult Expansion Resources

The DHCS webpage provides Age 26- 49 Adult Expansion publications and information, including FAQs:

https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx

Please submit questions and/or feedback regarding the Age 26-49 Adult Expansion to the following email: AdultExpansion@dhcs.ca.gov.

Enclosure 1 – Age 26-49 Adult Expansion Aid Code Crosswalk

The chart below shows the full scope aid codes that will be used for the implementation of the Age 26-49 Adult Expansion. CalHEERS, CalSAWS, and MEDS will use these charts to ensure the proper full scope aid code is programed into their eligibility systems.

Aid Code Crosswalk for the Transition of Individuals 26-49 Years of Age

The left side of the chart shows restricted scope aid codes. The right side of the chart shows full scope aid codes that beneficiaries 26 through 49 must be transitioned into for the Age 26-49 Adult Expansion.

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
0U	Breast and Cervical Cancer Treatment Program (BCCTP) for individuals Age 65 or younger without SIS – At or below 200% FPL - Limited to breast and/or cervical cancer treatment, LTC and emergency services. During pregnancy and for 365 days post, the full breadth of medically needy services. (No SOC)	**0P**	Breast and Cervical Cancer Treatment Program (BCCTP) - Age 65 or younger – Citizen/with SIS – At or below 200% FPL (No SOC)
58	Omnibus Budget Reconciliation Act (OBRA) Individuals Covers eligible aliens who do not have satisfactory immigration status. Women who are pregnant, who would qualify as categorically needy, except for income.	**Varies**	The county must redetermine the individual and place them in the appropriate full scope aid code.
3T	Transitional Medi-Cal (TMC) - Initial 6 Months for individuals without SIS - Discontinuance of 1931(b) (No SOC)	**39**	Transitional Medi-Cal (TMC) - Initial 6 Months - Discontinuance of 1931(b)(No SOC)
5J	SB 87 Pending Disability Program (No SOC)	**6J**	SB 87 Pending Disability Program - Age 21 up to 65 who have lost their non-disability linkage to M/C and are claiming disability (No SOC)
5R	SB 87 Pending Disability Determination (SOC)	**6R**	SB 87 Pending Disability Determination – Age 21 up to

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
			65 who have lost their non-disability linkage to M/C and are claiming disability (SOC)
5T	Continuing Transitional Medi-Cal (TMC) – Provides an additional 6 months for individuals without SIS who received 6 months of initial TMC coverage under aid code 3T (No SOC)	**59**	Continuing Transitional Medi-Cal (TMC) – Provides an additional 6 months of TMC for beneficiaries who had 6 months of initial TMC coverage under aid code 39 (No SOC)
5W	Four Month Continuing (FMC) – Emergency Services and, during pregnancy and for 365 days post, the full breadth of medically necessary services. For individuals without SIS who are no longer eligible for Section 1931(b) (No SOC)	**54**	Four Month Continuing (FMC) – Covers individuals discontinued from CalWORKs or Section 1931(b) (No SOC)
6U	Restricted - Disabled – Covers the disabled in the Aged & Disabled (A&D) FPL Program without SIS (No SOC)	**6H**	Disabled – Covers the disabled in the Aged & Disabled (A&D) FPL Program (No SOC)
6U	Restricted - Blind – Covers blind individuals in the Aged & Disabled (A&D) FPL Program without SIS (No SOC)	**2H**	Blind – Federal Poverty Level – Covers blind individuals in the Aged & Disabled (A&D) FPL Program (No SOC)
C3	OBRA Aliens and Unverified Citizens or who do not have SIS - Blind - Medically Needy (MN) (No SOC)	**24**	Blind - Medically Needy (MN) (No SOC)
C4	OBRA Aliens and Unverified Citizens or who do not have SIS - Blind - Medically Needy (MN) (SOC)	**27**	Blind - Medically Needy (MN) (SOC)
C5	OBRA Aliens and Unverified Citizens or who do not have SIS - Aid to Families with Dependent Children (AFDC) - Medically Needy (MN) (No SOC)	**34**	Aid to Families with Dependent Children (AFDC) - Medically Needy (MN) (No SOC)
C6	OBRA Aliens and Unverified Citizens or who do not have SIS - Aid to Families with	**37**	Aid to Families with Dependent Children (AFDC) - Medically Needy (MN) (SOC)

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
	Dependent Children (AFDC) - Medically Needy (MN) (SOC)		
C7	OBRA Aliens and Unverified Citizens or who do not have SIS - Disabled - Medically Needy (MN) (No SOC)	**64**	Disabled - Medically Needy (MN) (No SOC)
C8	OBRA Aliens and Unverified Citizens or who do not have SIS - Disabled - Medically Needy (MN) (SOC)	**67**	Disabled - Medically Needy (MN) (SOC)
D4	OBRA Aliens - Not PRUCOL and Unverified Citizens - Blind - Long Term Care (LTC) - (No SOC)	**23**	Blind - Long Term Care (LTC) (SOC/No SOC)
D5	OBRA Aliens - Not PRUCOL and Unverified Citizens - Blind - Long Term Care (LTC) - (SOC)	**23**	Blind - Long Term Care (LTC) (SOC/No SOC)
D6	OBRA Aliens – Not PRUCOL and Unverified Citizens - Disabled - Long Term Care (LTC) (No SOC)	**63**	Disabled - Long Term Care (LTC) (SOC/No SOC)
D7	OBRA Aliens – Not PRUCOL and Unverified Citizens - Disabled - Long Term Care (LTC) (SOC)	**63**	Disabled - Long Term Care (LTC) (SOC/No SOC)
D8	OBRA Unverified Pregnant Women - Medically Indigent (MI) Confirmed Pregnancy – Age 21 or older without SIS who meet the eligibility requirements of MI (No SOC)	**86**	Medically Indigent (MI) Confirmed Pregnancy - Age 21 or older who meet the eligibility requirements of MI (No SOC)
D9	OBRA Unverified Pregnant Women - Medically Indigent (MI) Confirmed Pregnancy - Age 21 or older without SIS who meet the eligibility requirements of MI but are not eligible for 185%/200% or the Medically Needy (MN) programs (SOC)	**87**	Medically Indigent (MI) Confirmed Pregnancy - Age 21 or older who meet the eligibility requirements of MI but are not eligible for 185%/200% or the Medically Needy (MN) programs (SOC)
F2	Inmate – Adult State Inmate Program (ASIP) – Individuals without SIS - Limited to all	**F1**	Inmate – Adult State Inmate Program (ASIP) – Title XIX, Limited to covered inpatient

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
	M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)		hospital, inpatient mental health, and inpatient pregnancy-related services only (No SOC)
F4	Inmate - Adult County Inmate Program (ACIP) – Individuals without SIS- Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)	**F3**	Inmate – Adult County Inmate Program (ACIP) – Limited to covered inpatient hospital and inpatient mental health services only (No SOC)
G4	Inmate - Adult County Inmate Program (ACIP) – Individuals without SIS- Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (SOC)	**G3**	Inmate – Adult County Inmate Program (ACIP) – Limited to covered inpatient hospital and inpatient mental health services only (SOC)
G9	Inmate - State Medical Parole Program (MPP) – Title XIX, Individual without SIS – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)	**G0**	Inmate - State Medical Parole Program (MPP) – Title XIX, entitled to all Medi-Cal covered services because they are not considered to be incarcerated (No SOC)
J3	Inmate - County Compassionate Release/Medical Probation (CCRP/CMPP) –Individuals without SIS – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)	**J1**	Inmate - County Compassionate Release/Medical Probation (CCRPCMPP) – Entitled to all M/C covered services because they are not considered to be incarcerated (No SOC)

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
J4	Inmate - County Compassionate Release/Medical Probation (CCRP/CMPP) - Individuals without SIS – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (SOC)	**J2**	Inmate - County Compassionate Release/Medical Probation (CCRP/CMPP) - Entitled to all M/C covered services because they are not considered to be incarcerated (SOC)
J6	Inmate – County Compassionate Release/Medical Probation County Inmates who reside in LTC facilities– Without SIS – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services. Covers all Medi-Cal covered LTC services. (No SOC/SOC)	**J5**	Inmate – County Compassionate Release/Medical Probation County Inmates who reside in LTC facilities – Title XIX, entitled to all Medi-Cal covered LTC services because they are not considered to be incarcerated. (No SOC/SOC)
J8	Inmate - County Compassionate Release/Medical Probation (CCRP/CMPP) - LTC - Disabled individuals without SIS who resides in a LTC facility – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services. Covers all Medi-Cal covered LTC services. (SOC/No SOC)	**J7**	Inmate - County Compassionate Release/Medical Probation (CCRP/CMPP) – LTC – Disabled (not on SSI) who resides in a LTC facility – Title XIX, entitled to all Medi-Cal covered LTC services because they are not considered to be incarcerated (SOC/No SOC)
K3	Inmate – State Medical Parole Program (MPP) - Newly eligible – Without SIS – age 19 up to 65 – with (MAGI) income 0% to 138% FPL, including disabled/blind with	**K2**	Inmate - State Medical Parole Program (MPP) – Newly eligible, Citizen/with SIS aged 19 up to 65 – with (MAGI) income 0% to 138% FPL, including disabled/blind

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
	income 128% to 138% FPL – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)		individuals with income 128% to 138% FPL – Covers all M/C covered services, including mental health services (No SOC)
K5	Inmate – State Medical Parole Program (MPP) – Not newly eligible – Without SIS – age 19 up to 65, including disabled/blind (MAGI) 0% to 128% FPL – Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)	**K4**	Inmate – State Medical Parole Program (MPP) – Not newly eligible – Citizen/with SIS – age 19 up to 65, including disabled/blind (MAGI) 0% to 128% FPL – Limited to all covered emergency, mental health emergency, and pregnancy-related services (No SOC)
K7	Inmate – County Compassionate Release/Medical Probation (CCRP/CMPP) – Newly eligible – Without SIS aged 19 up to 65, including disabled/blind through (MAGI) 0% to 138% FPL – Covers all M/C covered services, including mental health services (No SOC)	**K6**	Inmate – County Compassionate Release/Medical Probation (CCRP/CMPP) – Newly eligible Citizen/with SIS aged 19 up to 65, including disabled/blind through (MAGI) 0% to 138% FPL – Covers all M/C covered services, including mental health services (No SOC)
K9	Inmate – County Compassionate Release/Medical Probation (CCRP/CMPP) – Not newly eligible – Without SIS – age 19 up to 65, including disabled/blind (not on SSI) – (MAGI) 0% to 128% FPL - Limited to all M/C covered emergency, including mental health emergency, during pregnancy and for 365 post, the full breadth of medically necessary services (No SOC)	**K8**	Inmate – County Compassionate Release/Medical Probation (CCRP/CMPP) – Not newly eligible – Citizen/ with SIS – age 19 up to 65, including disabled/blind (not on SSI) – (MAGI) 0% to 128% FPL - Limited to all M/C covered emergency, including mental health, and all pregnancy-related services (No SOC)

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
L7	Disabled/Blind – Adults ages 19 through age 64 – Without SIS – 0% to 128% FPL	**L6**	Disabled/Blind – Adults ages 19 through age 64 – Citizens/with SIS– 0% to 128% FPL
M0	Title XIX. Pregnancy. Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, and emergency services to pregnant individuals without satisfactory immigration status with income above 138 up to and including 213 percent of the FPL.	**M9**	Pregnant Citizen/Lawfully Present Women – (MAGI) 139% up to and including 213% FPL –Limited to family planning pregnancy- related, postpartum and emergency services (No SOC)
M2	Title XIX. Adults Eligible recipients age 19 through 65 years old. ‹‹Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, emergency services and LTC services to adults without SIS with income at or below 138 percent of the FPL.	**M1**	Adults age 19 through 64 – Citizens/with SIS– (MAGI) at or below 138% FPL
M4	Title XIX. Parents/caretaker relatives. Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, emergency services and LTC services to undocumented parents/caretaker relatives with income at or below 109 percent of the FPL.	**M3**	Parents and Caretaker Relative – Citizens/Lawfully Present - (MAGI) at or below 109% FPL (No SOC)
M8	Pregnant Women - Without SIS – (MAGI) Up to and including 138% FPL (No SOC) - Provides family planning and full breadth of services during pregnancy, and for 365 days following the	**M7**	Pregnant Citizen/Lawfully Present Women - (MAGI) up to and including 138% FPL (No SOC)

Restricted Scope Aid Code	Description	Full Scope Aid Code	Description
	end of pregnancy, and emergency services		
N6	Inmate – Adult State Inmate Program (ASIP) – Citizen/without SIS – age 19 up to 65 – (MAGI) 0% to 138% FPL (No SOC) – Limited to inpatient hospital emergency services only (No SOC)	**N5**	Inmate – Adult State Inmate Program (ASIP) – Citizen/with SIS – age 19 up to 65 – (MAGI) 0% to 138% FPL (No SOC)
N8	Inmate - Adult County Inmate Program (ACIP) – Without SIS – age 19 up to 65 - (MAGI) 0% to 138% FPL – Limited to inpatient hospital emergency, inpatient mental health emergency, and inpatient pregnancy-related services only (No SOC)	**N7**	Inmate - Adult County Inmate Program (ACIP) – Citizen/with SIS – age 19 up to 65 - (MAGI) 0% to 138% FPL – Limited to all covered inpatient hospital and inpatient mental health services only (No SOC)

Enclosure 2 – First Notice (General Information Notice)

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

Medi-Cal

[insert MMYYYY]

Important news about your health coverage

Dear Medi-Cal Member,

Good news! You may get more Medi-Cal benefits soon. Starting **January 1, 2024**, full Medi-Cal will be available to adults ages 26 through 49 who qualify for Medi-Cal. **Full** Medi-Cal is different from the **restricted** Medi-Cal you have now. Restricted Medi-Cal only covers emergency services. It does not cover things like medicine and primary care.

Things to consider in the upcoming months:

- Your immigration status will not be considered as part of the eligibility process.
- **In December 2023, you will get a letter in the mail telling you if and when you will get full Medi-Cal.**
- **You will** get **more health care services with full Medi-Cal.**
- Medi-Cal has free or low-cost health care for people who live in California.

Full Medi-Cal covers these services and more:

- Medical care
- Medicine your doctor orders
- Specialty care
- Mental health care
- Family planning and maternity care
- Emergency care
- Tests your doctor orders
- Medical supplies
- Alcohol and drug use treatment
- Dental care
- Transportation to doctor and dental visits and to get prescriptions
- In-home care and supports to help avoid nursing home care

California Department of Health Care Services
Director's Office
1500 Capitol Avenue | Sacramento, CA | 95899-7413
MS 0000 | Phone (916) 440-7400 | dhcs.ca.gov

State of California
Gavin Newsom, Governor
California Health and Human Services Agency

- Vision care (eyeglasses)
- Hearing aids
- Foot care

If you have pregnancy-related Medi-Cal now, you have all the medically necessary services that Medi-Cal covers.

You can learn more about Medi-Cal in the Frequently Asked Questions (FAQ) for members that came with this letter.

Below you will find important information that will inform you about the next steps:

You do not need to fill out a new Medi-Cal application.
You already have restricted Medi-Cal, so you do not need to fill out a new application for full Medi-Cal. **If you qualify for full or SOC Medi-Cal, you will automatically be enrolled.**

If you get a packet in the mail to renew your Medi-Cal, fill it out and return it. You can call your county office for help.

How you will get health care services.
Most people with full Medi-Cal will get health care services through a Medi-Cal Managed Care Plan. A Medi-Cal Managed Care Plan is a health plan that works with doctors, hospitals, and other health care providers in your service area to give you the Medi-Cal services you need.

When you join a Medi-Cal Managed Care Plan, you may still get some services through Fee-For-Service (regular) Medi-Cal instead of through your Medi-Cal Managed Care Plan. In most counties, these include certain home and community-based services, most Medi-Cal pharmacy services, substance use disorder treatment services, and dental services.

Your Medi-Cal Managed Care Plan choices depend on the county you live in. Some counties have one plan. Some counties have more than one plan to choose from. We will mail you a letter and a *My Medi-Cal Choice* packet with your plan choices.

How you will get health care services if you have Medi-Cal with a Share of Cost (SOC).
If you have a SOC, you may get your health care services through Fee-For-Service (regular) Medi-Cal or through a Medi-Cal Managed Care Plan. You may not need to choose a Medi-Cal Managed Care Plan. In Fee-For-Service (regular) Medi-Cal, you can see any doctor who accepts Fee-For-Service (regular) Medi-Cal.

You should keep your Medi-Cal Benefits Identification Card (BIC).
Your BIC is a plastic card with orange poppy flowers or a blue and white design. You will need it when you get full or SOC Medi-Cal. Call your county office if you need a new BIC.

Always take your BIC to your doctor and other medical and dental visits. When you are in a Medi-Cal Managed Care Plan, you will get a card from your new plan. You will need to show both cards when you visit your doctor, dentist, pharmacy, and other medical providers.

Resources for you and your family as navigate your Medi-Cal services:

You need help in a different language.

If you need help in a language other than English, read the list of phone numbers for free language assistance services that came with this letter. Contact the language assistance services to get an interpreter to help you read this letter.

You can get materials in a different format.
You can ask to get all written information about your Medi-Cal benefits in a different format. The format can be Braille, large print, an audio or data CD, or some other format to help you understand and read letters or fill out your packet. To ask for this, you can:

- Go to afs.dhcs.ca.gov. Follow the instructions to choose a different format.
- Call **1-833-284-0040** (California Relay 711). The call is free.
- Contact your local county office. You can find your local county office information at dhcs.ca.gov/COL.

For in-person assistance, you can contact a Health Enrollment Navigator in your community. Visit GetMedi-CalCoverage.dhcs.ca.gov and select "Find Local Help."

To learn about Medi-Cal Managed Care Plans, call Health Care Options at 1-800-430-4263 (TDD/TYY users call 1-800-430-7077) the call is free. Or go to the Health Care Options website at healthcareoptions.dhcs.ca.gov/.

You can learn more about the Adult Full Medi-Cal Expansion on the DHCS website at bit.ly/AdultExpansion.

For questions about immigration and the Medi-Cal program:
For immigration information and resources, go to California's Immigrant Guide at immigrantguide.ca.gov/.

The U.S. Department of Homeland Security and U.S. Citizenship and Immigration Services do NOT consider health, food, and housing services as part of the public charge determination. Therefore, using Medi-Cal benefits (except for nursing home or mental health institution care) will NOT hurt an individual's immigration status. When someone applies for state-funded benefits, their information is only used to determine if they qualify. State laws protect the privacy of their information.

To learn about public charge go to the California Health and Human Services Agency Public Charge Guide at chhs.ca.gov/public-charge-guide.

The California Department of Social Services (CDSS) funds qualified nonprofit organizations to give services to immigrants who live in California. There is a list of these organizations at bit.ly/immigration-service-contractors.

Thank you,

Department of Health Care Services

Enclosure 3 – Second Notice (Notice of Action Letter Snippets)

Notice Type	English Text MAGI Snippets
Restricted Scope Retro Approval	You asked us to check if Medi-Cal could cover your bills for any of the 3 months before you applied. You qualified for **restricted** scope Medi-Cal in <month year>. You did not qualify for **full** scope Medi-Cal coverage before January 1, 2024 because: • You are 26 through 49 years old, **and** • You did not send us proof of U.S. citizenship or satisfactory immigration status Restricted scope Medi-Cal only covers emergency services; pregnancy-related services such as prenatal care, labor, delivery, and postpartum care, and long-term care services. If you are not sure if restricted scope Medi-Cal covers a service, ask your medical provider. **This letter is to tell you that you got restricted scope Medi-Cal for <month year>.** You may get, or already got, other notices about your eligibility for other time periods. If you have proof of your citizenship or immigration status to give us or want to tell us you can't get your proof, call your county Medi-Cal office at the number on this letter. Your retroactive (past) benefits may change from restricted scope to full scope when you give us your proof. Full scope benefits cover doctor visits for all your medical needs. **We counted your household size and income to make our decision.** For Medi-Cal, your household size is <household size>. Your monthly household income is <modified adjusted gross income>. The monthly Medi-Cal income limit for your household size is <MAGI limit>. Your income is below this limit. So, you qualify for Medi-Cal. You got restricted scope Medi-Cal because you did not provide proof of your U.S. citizenship or satisfactory immigration status. The regulation or law we used to decide is Welfare and Institutions Code Section 14007.8. **If you think we made a mistake, you can appeal.** To learn how to appeal, read "Your Hearing Rights" on the last page of this letter. You have **90** days to ask for a hearing. The 90 days started the day after the date on this letter.
Restricted Scope to Full Scope	Good news! Your Medi-Cal changed to full scope on <month dd, year>. Your Medi-Cal changed from restricted scope to full scope because of a new law that starts January 1, 2024. To learn more about full scope Medi-Cal benefits, go to:

	https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx. You will keep your full scope Medi-Cal coverage unless you are found to no longer qualify. This could happen when your eligibility is renewed or when your situation changes. **You may qualify for full scope Medi-Cal for past months.** If you paid for medical care while you had restricted Medi-Cal benefits, you may be able to get your money back. If you have questions about getting your money back, call the Department of Health Care Services Beneficiary Services at **1-916-403-2007**. The regulation or law we used to decide is Welfare and Institutions Code Section 14007.8. **If you think we made a mistake, you can appeal.** To learn how to appeal, read "Your Hearing Rights" on the last page of this letter. You have **90** days to ask for a hearing. The 90 days started the day after the date on this notice.
Notice Type	**English Text Non-MAGI Snippets**
Restricted Retro Approval (Specific to Non-MAGI Programs)	You asked us to check if Medi-Cal could cover your bills for any of the 3 months before you applied. You qualified for **restricted** scope Medi-Cal in <month year>. You did not qualify for **full** scope Medi-Cal before January 1, 2024 because: • You are 26 through 49 years old, **and** • You did not send us proof of your U.S. citizenship or satisfactory immigration status Restricted scope Medi-Cal only covers emergency services and pregnancy-related services such as prenatal care, labor, delivery, and postpartum care, and long-term care services. If you are not sure if restricted scope Medi-Cal covers a service, ask your medical provider. **This letter is to tell you that you got restricted scope Medi-Cal coverage for <month year>.** You may get, or already got, other letters about your eligibility for other time periods. If you have proof of your citizenship or immigration status to give us or want to tell us you can't get your proof, call your county Medi-Cal office at the number on this letter. Your retroactive (past) benefits may change from restricted scope to full scope when you give us your proof. Full scope benefits cover doctor visits for all your medical needs. The regulation or law we used to decide is Welfare and Institutions Code Section 14007.8. **If you think we made a mistake, you can appeal.** To learn how to appeal, read "Your Hearing Rights" on the last page of this letter. You have **90** days to ask for a hearing. The 90 days started the day after the date on this letter.

Restricted Scope to Full Scope (Specific to Non-MAGI Programs)	Good news! Your Medi-Cal changed to full scope on <month dd, year>. Your Medi-Cal changed from restricted scope to full scope because of a new law that starts January 1, 2024. To learn more about full scope Medi-Cal benefits, go to: https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx. You will keep your full scope Medi-Cal unless you are found to no longer qualify. This could happen when your eligibility is renewed or when your situation changes. **You may qualify for full scope Medi-Cal for past months.** If you paid for medical care while you had restricted Medi-Cal benefits, you may be able to get your money back. If you have questions about getting your money back, call the Department of Health Care Services Beneficiary Services at **1-916-403-2007**. The regulation or law we used to decide is Welfare and Institutions Code Section 14007.8. **If you think we made a mistake, you can appeal.** To learn how to appeal, read "Your Hearing Rights" on the last page of this letter. You have **90** days to ask for a hearing. The 90 days started the day after the date on this notice.

Enclosure 4 – Third Notice (Managed Care Enrollment Notice COHS/Single Plan Counties)

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

MICHELLE BAASS
Director

GAVIN NEWSOM
Governor

1234567AB-A8B-XX/XX/XXXX
XXX123456789_ABCD0-00-0-000000

XX/XX/XXXX

JOHN SAMPLE
1234 SAMPLE STREET
Line 2
ANYTOWN CA 90000

Important news about your Medi-Cal coverage

Dear [Member Name],

In November, we sent you a letter. It told you about changes to your Medi-Cal health coverage. You have **restricted scope** Medi-Cal services now. Your coverage will change to **full scope** Medi-Cal starting **January 1, 2024**. You will have access to more services. You will get your Medi-Cal services through a Medi-Cal Managed Care Plan.

You will be enrolled in this Medi-Cal Managed Care Plan and Dental Plan:

Health Plan	Dental Plan	Start Date
<Insert MCP>	<Insert Dental Program>	01/01/2024

About Medi-Cal Managed Care Plans
A Medi-Cal Managed Care Plan is a health plan. It works with doctors, hospitals, pharmacies, and other health care providers to give you the medically necessary Medi-Cal health services you need. Your plan will:

- Help manage your Medi-Cal benefits and services
- Help you find doctors and specialists in the plan network (group)
- Have a 24-hour nurse advice line you can call
- Have a free member services telephone number to answer your questions
- Help you with rides to and from your providers such as specialists or hospitals
- Help you get services you may need that your plan does not cover
- Give you language services you need such as interpreter services; documents in your language; or documents in Braille, large print, or audio or data CD

How to contact your Medi-Cal Managed Care Plan

Plan name: < Insert COHS/Single Plan Name >

Member services: <Insert Member Services number here and TTY>

Website: <Insert web address>

Your Medi-Cal Managed Care Plan will send you a welcome packet. It will tell you how to choose a doctor. It will also tell you about the benefits the plan offers.

Questions?

- Call the Medi-Cal Helpline Monday – Friday, 8 a.m. to 5 p.m. at **1-800-541-5555**. The call is free.
- Call the Medi-Cal Ombudsman Office Monday – Friday, 8 a.m. to 5 p.m. at **1-888-452-8609** (TTY: 711 for California State Relay). The call is free. Or, email them at **MMCDOmbudsmanOffice@dhcs.ca.gov**. The Medi-Cal Ombudsman Office helps people with Medi-Cal use their benefits and know their rights and responsibilities.
- Read the Frequently Asked Questions (FAQ) on the Medi-Cal website at: **www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx**. If you want a written copy of the FAQ mailed to you, call HCO, Monday – Friday, 8 a.m. to 6 p.m. at **1-800-430-4263** (TTY: 1-800-430-7077). If you want this notice in another language or different format, like large print, audio, or Braille, please call HCO Monday – Friday, 8 a.m. to 6 p.m. at **1-800-430-4263** (TTY: 1-800-430-7077).

Thank you,

Medi-Cal

Department of Health Care Services

Enclosure 4 – Third Notice (Managed Care Enrollment Notice Non-COHS)

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

MICHELLE BAASS
Director

GAVIN NEWSOM
Governor

1234567AB-A8B-XX/XX/XXXX
XXX123456789_ABCD0-00-0-000000

XX/XX/XXXX

JOHN SAMPLE
1234 SAMPLE STREET
Line 2
ANYTOWN CA 90000

Important news about your Medi-Cal coverage

Dear [Member Name],

In November, we sent you a letter. It told you about changes to your Medi-Cal health coverage. You have **restricted scope** Medi-Cal services now. Your Medi-Cal health coverage will change to **full scope** Medi-Cal starting **January 1, 2024**. You will have access to more services. You will get your Medi-Cal services through a Medi-Cal Managed Care Plan.

The *My Medi-Cal Choice* packet you received tells you how to choose a Medi-Cal Managed Care Plan.

If you do not choose a plan by the date listed on your *My Medi-Cal Choice* packet, you will be enrolled in this Medi-Cal Managed Care Plan and Dental Plan:

Health Plan	Dental Plan	Start Date
<Insert MCP>	<Insert Dental Program>	XX/XX/2024

About Medi-Cal Managed Care Plans
A Medi-Cal Managed Care Plan is a health plan. It works with doctors, hospitals, pharmacies, and other health care providers to give you the medically necessary Medi-Cal health services you need. Your plan will:

- Help manage your Medi-Cal benefits and services
- Help you find doctors and specialists in the plan network (group)
- Have a 24-hour nurse advice line you can call
- Have a free member services telephone number to answer your questions
- Help you with rides to and from your providers such as specialists or hospitals

- Help you get services you may need that your plan does not cover
- Give you language services you need such as interpreter services; documents in your language; or documents in Braille, large print, or audio or data CD

How to choose a Medi-Cal Managed Care Plan
Your Medi-Cal Managed Care Plan choices depend on the county you live in. Health Care Options (HCO) sent you a *My Medi-Cal Choice* packet. It tells you about Medi-Cal Managed Care plans in your area and how to enroll.

To learn more about your health plan and provider choices, call HCO Monday – Friday 8 a.m. to 6 p.m. at **1-800-430-4263** (TTY: 1-800-430-7077). This call is free. Or, go to **www.healthcareoptions.dhcs.ca.gov**.

Exemptions from joining a Medi-Cal Managed Care Plan
You may not have to join a Medi-Cal Managed Care Plan if you:

- Are an American Indian/Alaska Native,
- Are a beneficiary who gets assistance under Foster Care, the Adoption Assistance Program, or Child Protective Services,
- Live in a California veteran's home,
- Already have an approved medical exemption from the requirement to join a Medi-Cal Managed Care Plan, or
- Get a medical exemption from the requirement to join a Medi-Cal Managed Care Plan

Medical exemption from joining a Medi-Cal Managed Care Plan
If you have a complex medical condition, including pregnancy, and your Medi-Cal doctor or clinic is a Fee-for-Service (FFS) (regular) Medi-Cal provider who is not in a Medi-Cal Managed Care Plan network in your county, you might be able to get a medical exemption to keep your provider for up to 12 months.

If you want to stay in FFS Medi-Cal, ask for a medical exemption as soon as you can. In most cases, you cannot qualify for an exemption from enrolling in managed care after you have been in a Medi-Cal Managed Care Plan for 90 days.

There are three ways to ask for a medical exemption:

- **Phone:** Call HCO Monday – Friday, 8 a.m. to 6 p.m. at **1-800-430-4263** (TTY: 1-800-430-7077).
- **Mail:** Fill out and mail in the Medical Exemption Request form in your *My Medi-Cal Choice* packet. Your doctor, clinic, or an advocate can help you fill out the form. Your doctor will also need to fill out part of the form. Return the completed form to HCO.
- **Online:** Go to the HCO website at **www.healthcareoptions.dhcs.ca.gov**.

If your exemption is approved, you can stay in FFS Medi-Cal and keep your doctor until the medical exemption ends.

If you have certain health conditions and want to keep your Medi-Cal provider for more than 12 months, you may be able to ask for a medical exemption extension. You must wait until at least 11 months from the start date of your existing medical exemption. HCO will tell you when it is 45 days before your medical exemption ends. They will tell you how to ask for an extension.

What to do now

- If you want to stay in the Medi-Cal Managed Care Plan listed above, you do not have to do anything.
- If you want to keep your same Medi-Cal doctor or clinic, ask them if they work with a Medi-Cal Managed Care Plan in your county. If they do, then choose that plan.
- If you want to choose another Medi-Cal Managed Care Plan, contact HCO:
  - **Phone:** Call HCO Monday – Friday, 8 a.m. to 6 p.m. at **1-800-430-4263** (TTY: 1-800-430-7077).
  - **Mail:** Fill out and mail the choice form in your *My Medi-Cal Choic*e packet.
  - **Online:** Enroll at **www.healthcareoptions.dhcs.ca.gov**.

Your Medi-Cal Managed Care Plan will send you a welcome packet. It will tell you how to choose a doctor. It will also tell you about the benefits the plan offers.

Questions?

- Call the Medi-Cal Helpline Monday – Friday, 8 a.m. to 5 p.m. at **1-800-541-5555**. The call is free.
- Call the Medi-Cal Ombudsman Office Monday – Friday, 8 a.m. to 5 p.m. at **1-888-452-8609** (TTY: 711 for California State Relay). The call is free. Or, email them at **MMCDOmbudsmanOffice@dhcs.ca.gov**. The Medi-Cal Ombudsman Office helps people with Medi-Cal use their benefits and know their rights and responsibilities.
- Read the Frequently Asked Questions (FAQ) on the Medi-Cal website at: **www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx**. If you want a written copy of the FAQ mailed to you, call HCO, Monday – Friday, 8 a.m. to 6 p.m. at **1-800-430-4263** (TTY: 1-800-430-7077). If you want this notice in another language or different format, like large print, audio, or Braille, please call HCO Monday – Friday, 8 a.m. to 6 p.m. at **1-800-430-4263**
  (TTY: 1-800-430-7077).

Thank you,

Medi-Cal

Department of Health Care Services

Enclosure 5 – FAQs

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

Medi-Cal

Frequently Asked Questions (FAQ)
About your health care benefits expanding in Medi-Cal

1. **Am I still covered by Medi-Cal?**
   Yes. You still have Medi-Cal. Starting in **January 2024**, you will soon get more health care benefits with your Medi-Cal coverage. You will have these benefits as long as you continue to qualify for Medi-Cal.

2. **Why am I getting more Medi-Cal benefits?**
   Starting **January 1, 2024**, a new law in California will give full Medi-Cal to people 26 through 49 years old who qualify for Medi-Cal. Unlike before, immigration status does not matter. This new law means that all California residents who qualify for Medi-Cal are eligible for full Medi-Cal benefits.

3. **Do I need to take any action right now?**
   No. If you are eligible, you will automatically be given full Medi-Cal benefits on **January 1, 2024**. You do not need to do anything to get more benefits. If you get a packet in the mail to renew your Medi-Cal, you must fill it out and return it by mail, telephone, in person, or online. You can call your county office for help.

4. **What services can I get with full Medi-Cal?**
   You can get:

   Preventive care services
   These include medical, dental, vision, hearing, mental health, and substance use disorder screenings. All preventive care and screening services are free.
   To learn more, contact your Medi-Cal Managed Care Plan member services or Fee-for-Service (regular) Medi-Cal provider.

   Dental services
   You can get dental services through Medi-Cal. Your dental benefits do not change when you enroll in a Medi-Cal Managed Care Plan.

- For **most counties**, you get Medi-Cal dental services through the **Medi-Cal Fee-for-Service (regular) Program**. You need to go to a dental provider who takes Medi-Cal. To find an enrolled dental provider, call the Medi-Cal Dental Member Telephone Service Center at **1-800-322-6384** (TTY: 1-800-735-2922). The call is free.

  You can also find a dental provider and more about Medi-Cal dental services on the "Smile, California" website at smilecalifornia.org/.

- If you live in **Los Angeles County**, you can get services through the **Medi-Cal Dental Program** with Fee-For-Service (regular) dental **or** a **Medi-Cal Dental Managed Care Plan**. To learn more about joining a plan, call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077). To choose a Medi-Cal Dental Managed Care Plan, fill out the dental choice form you got in your *My Medi-Cal Choice* Packet or call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077). If you do not choose a Medi-Cal Dental Managed Care Plan, you will be enrolled in Medi-Cal Dental Fee-for-Service (regular).

- If you live in **San Mateo County**, you will get dental services through Health Plan San Mateo. This is a Medi-Cal Managed Care Plan. To learn more about dental services through Health Plan San Mateo, call the plan at **1-800-750-4776** or **650-616-2133** (TTY: 1-800-735-2929 or 711).

Mental health services
If you need mental health services, talk to your new Medi-Cal Managed Care Plan member services or your primary care provider. You may get some mental health services through your new Medi-Cal Managed Care Plan network. You may also qualify for specialty mental health services. Your county mental health plan provides specialty services. Your Medi-Cal Managed Care Plan must help you with your mental health care needs and help you find the right provider. The County Mental Health Plan Contact List for specialty mental health services is at bit.ly/mhp-contact-list.

Alcohol and drug treatment services
If you need help with alcohol or other substance use disorder treatment services, you can get an assessment from your Medi-Cal Managed Care Plan. You can also call your county Drug Medi-Cal Program for substance use disorder treatment services. Or call your Medi-Cal Managed Care Plan member services at bit.ly/mhp-contact-list.

Family planning and contraception services
You can get family planning services from any Medi-Cal provider, even if they are not in your Medi-Cal Managed Care Plan network. You do not need a referral or prior authorization (pre-approval). There is no co-payment. To learn more, contact your Medi-Cal Managed Care Plan member services or Fee-for-Service (regular) Medi-Cal provider. Covered services include:

- Patient visits for the purpose of family planning
- Family planning counseling services given during a regular patient visit
- Contraceptive procedures, insertions or devices

- Tubal ligations
- Vasectomies
- Contraceptive drugs or devices
- Abortions
- Treatment for complications resulting from previous family planning procedures
- Laboratory procedures, radiology, and drugs associated with family planning procedures

Pharmacy services
Medi-Cal Rx covers prescription drugs that your provider prescribes for you to get from a pharmacy. Your Medi-Cal Managed Care Plan and Fee-for-Service (regular) Medi-Cal cover the drugs your provider gives you in person, such as at the doctor's office or clinic.

To learn more about Medi-Cal Rx prescription drug coverage and pharmacies that take Medi-Cal, go to medi-calrx.dhcs.ca.gov. Or call the Medi-Cal Rx Customer Service Center at 1-800-977-2273 (TTY: State Relay at 711). Have your Medi-Cal Benefits Identification Card (BIC) number ready when you call.

If you have questions after you are enrolled in your new Medi-Cal Managed Care Plan, call your plan's member services phone number.

Transportation
If you do not have a way to get to a covered Medi-Cal service or to pick up a medicine at the pharmacy, you may get free Non-Medical Transportation services. You may get a free ride by car, taxi, bus, or other public or private vehicle. You do not need a prescription from your doctor or provider for Non-Medical Transportation services.

If you cannot use a car, bus, taxi, or other public or private vehicle to your appointments due to your health conditions, you may qualify for free Non-Emergency Medical Transportation. This is by ambulance, wheelchair van, or litter van. It is for people who cannot use public or private transportation.

You will need a prescription from a licensed provider to ask for Non-Emergency Medical Transportation. Your primary care provider, dentist, podiatrist, mental health or substance use disorder provider can prescribe Non-Emergency Medical Transportation. Non-Emergency Medical Transportation is available for appointments covered by your health plan as well as pharmacy services.

If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will not cover the medical transportation but can help you schedule your transportation with Medi-Cal. If you get Medi-Cal through a Medi-Cal Managed Care Plan, call member services to ask for a ride. If you get Medi-Cal through Fee-for-Service (regular) Medi-Cal, you can contact DHCS for assistance. Medi-Cal Members or their designees may email DHCSNMT@dhcs.ca.gov requesting assistance if their provider is not able to arrange Non-Emergency Transportation.

Home and community-based services (HCBS)
These include:

- In-Home Supportive Services (IHSS) attendant care to keep you in your home
- Home and Community-Based Alternatives Waiver services such as in-home nursing, home modification, and personal care services
- Community-Based Adult Services at a center
- Other benefits

To learn more about these services, go to bit.ly/IHSSProgram.

5. **What if I have pregnancy-related Medi-Cal now?**
   If you currently have pregnancy-related Medi-Cal, you have all the medically necessary services that Medi-Cal covers. To learn more about full Medi-Cal benefits, go to bit.ly/medi-cal-ehb-benefits.

6. **Will I pay co-payments?**
   No. There are no co-payments for medical care. The Medi-Cal Managed Care Plan covers all medical costs that are medically necessary.

7. **Will I have a Share of Cost (SOC)?**
   Some people with Medi-Cal have a share of cost (SOC). A SOC is an amount you are responsible for paying before your Medi-Cal coverage starts that month. If you have Medi-Cal with a SOC and meet your SOC for a month, Medi-Cal pays for the rest of your health care costs for that month. You only need to pay your SOC one time in the month that you need to use Medi-Cal.

8. **How will I use my new full Medi-Cal?**
   If you do not have a SOC, you will need to enroll in a Medi-Cal Managed Care Plan once you have full Medi-Cal. You can then go to doctors who work with the plan in the plan's service area. You can get checkups, go to a specialist, get care for a chronic condition like diabetes, or have surgery. Your Medi-Cal Managed Care Plan will cover any medically necessary service covered under Medi-Cal.

   If you live in a county that provides Medi-Cal through a County Organized Health System (COHS) or a Single Plan, you will be enrolled in the COHS Plan, Single Plan, or Kaiser Permanente. You do not need to take any action. If your county has more than one Medi-Cal Managed Care Plan, you will get information on how to choose a plan.

   To find out if you live in a COHS or Single Plan county, go to bit.ly/county-info.

   If you have a SOC and live in a Long-term Care Facility, you may have to enroll in a Medi-Cal Managed Plan.

9. **What is a Medi-Cal Managed Care Plan?**
   A Medi-Cal Managed Care Plan is a health plan that:

- Works with doctors, hospitals, and other health care providers in your service area to give you health care services
- Gives you the medically necessary Medi-Cal services you need
- Works with you and your provider to coordinate and manage your care

When you are in a Medi-Cal Managed Care Plan, you may still get some services through Fee-for-Service (regular) Medi-Cal instead of through your Medi-Cal Managed Care Plan. In most counties, these include:

- Certain home and community-based services
- Most Medi-Cal pharmacy services
- Substance use disorder (SUD) treatment services
- Dental services

If you get In-Home Supportive Services (IHSS), you will keep getting those services through Fee-For-Service (regular) Medi-Cal the way you do now.

To learn more about benefits available through Medi-Cal Managed Care Plans, go to healthcareoptions.dhcs.ca.gov.

10. How do I choose a Medi-Cal Managed Care Plan?

Your Medi-Cal Managed Care Plan choices depend on the county you live in.

To find out if you live in a COHS or Single Plan county, go to bit.ly/county-info.

If you live in a county that **does not have** a County Organized Health System (COHS) or a Single Plan, Health Care Options will send you a *My Medi-Cal Choice* packet. It will list Medi-Cal Managed Care Plans in your county. It tells you how to sign up.

If you have a doctor or clinic now, ask them if they work with a Medi-Cal Managed Care Plan in your county. If you want to stay with that doctor or clinic, you can choose any Medi-Cal Managed Care Plan your doctor or clinic accepts.

If you have a doctor or clinic that does **not** work with a Medi-Cal Managed Care Plan in your county, you might be able to keep your Fee-for-Service (regular) Medi-Cal. People with complex medical conditions like HIV/AIDS, pregnancy in the third trimester, ongoing cancer treatment, dialysis treatments, and more may qualify to keep Fee-for-Service (regular) Medi-Cal. If you think this applies to you, fill out and send the "Medical Exemption Request" form that comes with the *My Medi-Cal Choice* packet.

If you do not choose a Medi-Cal Managed Care Plan, Medi-Cal will choose a Medi-Cal Managed Care Plan in your county for you. You have the right to ask to change your Medi-Cal Managed Care Plan at any time. Call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077) or go to healthcareoptions.dhcs.ca.gov.

If you change your Medi-Cal Managed Care Plan, you must enroll in another Medi-Cal Managed Care Plan in the same county. You cannot go back to Fee-For-Service (regular) Medi-Cal if you have been enrolled in a Medi-Cal Managed Care Plan for more than 90 days.

11. What is Health Care Options?

Health Care Options is a Medi-Cal service that helps members learn about Medi-Cal Managed Care Plans. Health Care Options can help members make the right choices about your Medi-Cal.

The Health Care Options website is healthcareoptions.dhcs.ca.gov. To learn more, call Health Care Options at 1-800-430-4263 (TTY: 1-800-430-7077).

Health Care Options has information for non-COHS and Single Plan counties. If you live in a COHS county or a Single Plan county, contact your county social service agency to learn more.

12. Who will be my primary care doctor if I am in a Medi-Cal Managed Care Plan?

Once you join a Medi-Cal Managed Care Plan, you need to choose a primary care doctor who works with your Medi-Cal Managed Care Plan. If you do not choose a doctor within **30 days** of the date you enroll in your Medi-Cal Managed Care Plan, the Medi-Cal Managed Care Plan will choose one for you.

If you want to **keep** your doctor:

- Ask your doctor if they work with a Medi-Cal Managed Care Plan in your county.
- Choose a Medi-Cal Managed Care Plan your doctor works with.

If you want to find a **new** doctor:

- Read the online list of doctors your Medi-Cal Managed Care Plan has to choose from. Or ask them to mail you a list of doctors.
- Ask to change to a doctor who works with your Medi-Cal Managed Care Plan network. You can ask to change your doctor at any time.
- For help finding a doctor or to change your doctor, call your Medi-Cal Managed Care Plan's member services phone number after you join.

13. Can I keep my Medi-Cal doctor if they don't work with a Medi-Cal Managed Care Plan?

Continuity of care means that you may be able to continue seeing your current doctor or therapist for up to 12 months, or more in some cases, after you have been enrolled in a Medi-Cal Managed Care Plan. This includes your Medi-Cal doctors, specialists, and therapists. The types of therapists you may be able to continue seeing include a physical therapist, occupational therapist, respiratory therapist, speech therapist, and behavioral health treatment provider. The provider has to agree to work with the Medi-Cal Managed Care Plan.

If you want continuity of care, call your Medi-Cal Managed Care Plan's member services phone number once you join the plan. If you have more questions about continuity of care, go to bit.ly/DHCSCOC.

14. Who does not have to join a Medi-Cal Managed Care Plan?

If you live in a non-COHS or Non-Single Plan county, you may not have to join a Medi-Cal Managed Care Plan if you:

- Are an American Indian/Alaska Native
- Are an individual who gets assistance under Foster Care, the Adoption Assistance Program, or Child Protective Services
- Live in a California Veteran's home
- Already have an approved medical exemption from the requirement to join a Medi-Cal Managed Care Plan; or
- Get a medical exemption from the requirement to join a Medi-Cal Managed Care Plan

If you are a member who gets assistance under foster care, the Adoption Assistance Program, or Child Protective Services, and you live in a Single Plan county, you have the choice to enroll in a Medi-Cal health plan or FFS Medi-Cal.

To learn more about exemptions from joining a Medi-Cal Managed Care Plan, call Health Care Options at 1-800-430-4263 (TTY: 1-800-430-7077).

To find out if you live in a COHS, Single Plan or non-COHS, non-Single Plan county, go to bit.ly/county-info.

15. Can I get a medical exemption from joining a Medi-Cal Managed Care Plan?

If you have a complex medical condition and your Medi-Cal doctor or clinic is a Fee-for-Service (regular) Medi-Cal provider who is not in a Medi-Cal Managed Care Plan network in your county, you might be able to get a medical exemption to keep your provider for **up to 12 months**.

If you live in a county that does **not** have a County Organized Health System (COHS) or a Single Plan County and want to ask for a temporary medical exemption, use the "Medical Exemption Request" form. This can be found in the *My Medi-Cal Choice* Packet you got. If you want to stay in Fee-for-Service (regular) Medi-Cal, ask for a medical exemption as soon as you can. In most cases, you cannot qualify for an exemption from managed care enrollment after you have been in a Medi-Cal Managed Care Plan for **90 days**. Your doctor, clinic, or an advocate can help you fill out the form. Your doctor will also need to fill out part of the form. Return the completed form to Health Care Options.

There are two ways you can ask for a medical exemption:

- Call Health Care Options at 1-800-430-4263 (TTY: 1-800-430-7077)
- Go to Health Care Options website at healthcareoptions.dhcs.ca.gov.

If your exemption is approved, you can stay in Fee-for-Service (regular) Medi-Cal and keep your doctor until the medical exemption ends.

If you have certain health conditions and want to keep your Medi-Cal provider for **more than 12 months**, you may be able to ask for a medical exemption extension. If you want to ask for an extension, you must wait until at least **11 months** from your existing medical exemption's start date. Health Care Options will tell you when it is 45 days before your medical exemption ends. They will tell you how to ask for an extension.

If your exemption is denied, you might be able to keep your doctor if you ask your Medi-Cal Managed Care Plan for "continuity of care." Read more about continuity of care in Question 11. If you live in a COHS county or Single Plan county, you may **not** be able to ask for a medical exemption.

To learn more about exemptions and how to ask for one, go to the Health Care Options website at healthcareoptions.dhcs.ca.gov.

16. What if I have questions about Medi-Cal and my immigration status?

The U.S. Department of Homeland Security and U.S. Citizenship and Immigration Services does NOT consider health, food, and housing services as part of the public charge determination. Therefore, using Medi-Cal benefits (except for nursing home or mental health institution care) will NOT hurt your immigration status. The Age 26 through 49 Adult Expansion is a state-funded program. When you apply for state-funded benefits, your information is only used to see if you can get Medi-Cal. State laws protect the privacy of your information.

DHCS and county social services agencies cannot answer questions related to immigration or public charge. If you have questions about your immigration status and Medi-Cal benefits, talk to a qualified immigration lawyer.

The California Department of Social Services funds qualified nonprofit organizations to give services to immigrants who live in California. There is a list of organizations at bit.ly/immigration-service-contractors.

For immigration information and resources, go to California's Immigrant Guide at immigrantguide.ca.gov/.

To learn about public charge, go to the California Health and Human Services Agency Public Charge Guide at chhs.ca.gov/public-charge-guide/.

17. Where can I learn more or get help?

- Call the DHCS Medi-Cal Helpline at **1-800-541-5555**. The call is free.
- Call the DHCS Ombudsman Office at **1-888-452-8609.** The call is free. Or email them at MMCDOmudsmanOffice@dhcs.ca.gov. The Ombudsman Office helps people with Medi-Cal use their benefits and understand their rights and responsibilities.

- Learn more about Medi-Cal on the DHCS website at bit.ly/MyMedi-Cal.
- Learn more on the DHCS Adult Expansion website at bit.ly/AdultExpansion.
- Email AdultExpansion@dhcs.ca.gov