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

COVERED CALIFORNIA
Your destination for affordable healthcare, including Medi-Cal

{PRIMARY_FIRST_NAME} {PRIMARY_LAST_NAME}
{ADDRESS_LINE1}
{ADDRESS_LINE2}
{CITY}, {STATE_CD (FK)} {ZIPCODE}-{ZIP+4}

Renew your plan for {Next_Benefit_Year}!

{CURRENT_DATE} Case Number: {Case_#}

Dear {PRIMARY_FIRST_NAME} {PRIMARY_LAST_NAME},

It is time to review and update your household information and renew your health and/or dental plans through Covered California for {next_benefit_year}. You can also shop for a new health or dental plan now.

To renew your coverage by {End_Renewal_Date}:

1. Log in to your CoveredCA.com account.
2. Click “Renew” or “Continue.”
3. Click “Edit” to update information that has changed. See the list below for changes you may need to report. Then click “Submit Application.”
4. Shop and choose the best plans for you.

Changes you may need to report:

- Household size
- Other coverage – Do you qualify for Medicare or an employer health plan?
- Address change
- Income – Did you start a new job? Are you getting unemployment benefits?

For a full list, go to: CoveredCA.com/RAC

DO NOT TRANSLATE RED TEXT: The sections below with red brackets { } are dynamic and will only populate if the household meets the triggering conditions listed in the FDD. Any text without {} brackets is static and will appear in every notice.

NOD12a_04

{You may now qualify for tax credits!

Due to changes in the American Rescue Plan, people who were not eligible for the Advance Premium Tax Credit (APTC) before may qualify now. To find out if you qualify, update your application now.

}

NOD12_01
{ⓘ Don't have an online account?
Go to CoveredCA.com/create-account. Enter your information and access code:
{Access_Code}
Then follow the instructions to create an online account.
}
Need help renewing your plan? A Covered California certified enrollment counselor or certified insurance agent can help you.
NOD12_02 **{**Our records show you were helped last year by {Agency Business Name/Entity Business Name}. Contact them: {Agent Phone Number/Entity Phone Number}**}**
NOD12_03**{**Find one near you: CoveredCA.com/find-help.**}**

Or call Covered California at {SERVICE_CENTER_PHONE} (TTY: 1-888-889-4500). You can call Monday through Friday, 8 a.m. to 6 p.m.

Things to think about:

- **Your premium (monthly cost) may be different next year.**

  Your health plan premium may change for your {next benefit year} coverage. Premium rates are based on age, zip code, insurance company and benefit level. Follow the steps on the first page of this letter to see plan choices and prices.

- NOD12a_05**{Your premium tax credit amounts may be different next year.**

  In {current benefit year}, your household qualified for up to ${current benefit year APTC&CAPS} per month in premium tax credits to help pay your health plan. Even if your income and household size stay the same, the amount of premium tax credit may change each year.

  Your premium tax credits are based on the income and family size you report. Our records show your current household income is **${annual income}** per year. If we do not have your current household information, you could get **too much premium tax credit and have to pay it back** when you file taxes next year. Or you may not get enough during the year. To learn more, read the Frequently Asked Questions below in this letter.**}**

- NOD12a_06**{We need your consent (permission) to see if your household qualifies for financial help in {Next_Benefit_year}.**

  If you do not give us permission to check electronic records, we will renew your health insurance without any financial help. If you want financial help to lower the cost of a Covered California health plan, you must follow the steps above to renew your application. Or you can update your consent on our automated phone system at any time. Call 1-800-300-1506 (TTY: 1-888-889-4500).**}**

- NOD12a_07**{A member of your household may soon qualify for Medicare.**

  Most people who qualify for Medicare should cancel their Covered California health plan and/or financial help to avoid tax penalties. You must call Covered California at least 14 days before the date you would like your coverage to end. It will **not** end automatically. To learn more, go to: CoveredCA.com/Medicare.

Note: Covered California does **not** offer Medicare Part A, B or D. Covered California also does **not** offer Medicare Advantage plans (Part C) or Supplemental Insurance (Medigap).**}**

❖ **NOD12a_08{A member of your household may <u>not</u> qualify for a minimum coverage plan in {Next Benefit Year}.**

Our records show that a member of your household is enrolled in a minimum coverage plan and will no longer meet the age requirement in {next benefit year}. This member will need to choose a new plan. They may also need to update their application to ask for financial help. If they do not choose a new plan before the renewal date above, we will enroll them in similar plan.**}**

What happens next?

- **If you do not renew your coverage by {End_Renewal_Date},** Covered California will use the most recent information on your application and from electronic data sources to see if you still qualify. We will re-enroll your household in the same plans you have now if they are available.

  Note: If your current plan is not available or you no longer qualify to enroll in that plan, we will enroll you in a similar plan with the same or another insurance company.

- **Pay your premium (monthly cost) directly to your insurance company.** Do not send your payment to Covered California. If you choose a new plan, your {Next Benefit Year} coverage will not start until you make your first payment.

- **Open enrollment ends January 31, {Next_benefit_year}.** To start your coverage on January 1, you must enroll on or before December 31.

Thank you,

Covered California

This letter is being sent to you in compliance with the Affordable Care Act and its implementing regulations: 45 CFR 155 § 335(c) and Cal. Code Regs., tit. 10, § 6498(e).

Frequently Asked Questions

Q: What is the last day I can make changes to my {Next Benefit Year} health plan?

A: The last day to make changes is **January 31, {Next_benefit_year}.** If you want your changes to start January 1, you need to make them **before** December 31. Otherwise, the changes may start later in the year.

Q: Some of my household members are enrolled in Medi-Cal. When do I renew their coverage?

A: Medi-Cal renewals happen throughout the year. If a member of your household has Medi-Cal, your local county office may contact you for more information when it is time for them to renew. Members of your household who qualify for Covered California should follow the steps on the first page of this letter to renew their health plan.

Q: How do I report my income if it changes month to month?

A: If your income changes a lot each month, estimate what you will earn by the end of the year. If you are earning more or less than your yearly estimate, tell Covered California right away. It is important to report changes to your income within 30 days. That way we can give you the right amount of financial help.

Q: How much financial help will I qualify for next year?

A: To learn how much financial help you will qualify for, follow the steps on the first page of this letter. Even if your income and household size stay the same, your financial help may change. If you did not ask for financial help before but want to now, update your application.

Q: How does taking financial help in advance (during the year) impact my taxes?

A: Financial help is based on your estimated income, family size and ZIP code on your application. When you file your federal and state taxes at the end of the year, the Internal Revenue Service (IRS) and Franchise Tax Board (FTB) will use the final income and family size that you report on your tax returns to figure out the amount of your premium tax credit and California premium subsidy.

If you got too much premium tax credit or California premium subsidy during the year, you may have to pay some or all of it back to the IRS or FTB as taxes owed. Or, if you qualify for more than what you got during the year, you may get the rest as a tax refund. If you owe other taxes, your unused credit or subsidy may lower the amount you owe.

Q: A member of my household needs coverage next year. What should I do?

A: Log in to your CoveredCA.com account and update your application. Open enrollment starts November 1, {Current_benefit_year} and ends on January 31, {Next_benefit_year}. If you want their coverage to start on January 1, you must apply before December 31.

Section 1557 of the Patient Protection and Affordable Care Act (ACA)

Covered California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Covered California does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Covered California provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and other formats). Covered California also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at 1-916-228-8764 or by email at CivilRights@covered.ca.gov.

If you believe that Covered California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with the Civil Rights Coordinator.

You can file a grievance in the following ways:

Mail: Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: 1-916-228-8764

Fax: 1-916-228-8909

Email: CivilRights@covered.ca.gov

You can also file a civil rights complaint with the Office for Civil Rights at the U.S. Department of Health and Human Services.

Mail: U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Building
Washington, DC 20201

Phone: 1-800-368-1019 or TTY: 1-800-537-7697

Online: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available on the U.S. Department of Health and Human Services Office for Civil Rights website.

Thank you,

Covered California

Getting Help in a Language Other than English

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

Español 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. Para TTY, llame al **1-888-889-4500**, donde también puede pedir esta carta en algún formato diferente. **(Spanish)**

中文/繁體字 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。(Chinese)**

Tiếng Việt 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. **(Vietnamese)**

한국어 중요: 이 편지를 읽을 수 있나요? **1-800-738-9116** 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. **(Korean)**

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.

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

հայերեն 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: **(Armenian)**

ភាសាខ្មែរ សំខាន់ៈ តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ **1-800-906-8528** និងស្នើសុំឲ្យគេបកប្រែលិខិតនេះជាភាសារបស់លោកអ្នក ឬជាទម្រង់មួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ។ សម្រាប់ TTY ទូរស័ព្ទមកលេខ **1-888-889-4500** ដែលលោកអ្នកក៏អាចស្នើសុំលិខិតនេះជាទម្រង់ផ្សេងទៀតបានផងដែរ។ **(Khmer)**

Русский 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. **(Russian)**

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

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

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? इस पत्र को अपनी भाषा में अनुवाद करने के लिए या बड़े प्रिंट की तरह किसी अन्य प्रारूप में प्राप्त करने के लिए **1-800-300-1506** पर कॉल करके अनुरोध कर सकते हैं। TTY के लिए **1-888-889-4500** पर कॉल करें जहाँ आप इस पत्र को किसी अन्य प्रारूप में प्राप्त करने का अनुरोध कर सकते हैं। (**Hindi)**

重要：この文書を読むことができますか？希望の言語に翻訳された文書、または大きな文字など別の形式の文書をご希望の場合、**1-800-300-1506**までお電話ください。TTY の場合、**1-888-889-4500** にお電話いただければ、その他の形式の文書をリクエストすることもできます。**(Japanese)**

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ ਸਕਦੇ ਹੋ ਤੁਸੀਂ **1-800-300-1506** 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਇਸ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਜਾਂ ਕਿਸੇ ਹੋਰ ਸਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪਰਿੰਟ ਲਈ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਵਾਇ ਲਈ **1-888-889-4500** 'ਤੇ ਕਲ ਕਰੋ ਜਿੱਥੇ ਕਿ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਵਿਕਲਪਕ ਰੂਪ ਵਿਚ ਸਰੂਪ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ। **(Punjabi)**

สำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่? ถ้าคุณมีข้อสงสัย คุณสามารถติดต่อได้ที่เบอร์ **1-800-300-1506** เพื่อทำการพูดคุยกับเจ้าหน้าที่ที่ใช้ภาษาของคุณ นอกจากนี้คุณยังสามารถร้องขอให้แปลจดหมายฉบับนี้เป็นภาษาที่คุณต้อง การได้หรือเปลี่ยนแปลงรูปแบบตัวอักษรให้เป็นรูปแบบอื่น เช่น ตัวอักษรพิมพ์ใหญ่หรือทำให้มีขนาดใหญ่ขึ้น สำหรับระบบ TTY คุณสามารถติดต่อได้ที่เบอร์ **1-888-889-4500** ซึ่งคุณสามารถขอจดหมายฉบับนี้ในรูปแบบอื่นๆได้ตามที่คุณต้องการ **(Thai)**