How do I apply?

of the documents or evidence listed in numbers 1 through 8 above.

However, you do not have to give evidence if:

1. You are applying for Minor Consent services, or
2. You are the child of a parent who has also applied for Medi-Cal and given evidence of California residence, or
3. Your wife or husband has applied for Medi-Cal and given evidence of California residence, if she or he lives at your same address.

7. Where to Apply for Medi-Cal

Call your county social services office to have a Medi-Cal application sent to your home. If you want to apply in person, ask your county social services office where you can apply. Medi-Cal county eligibility workers also are located at some health clinics and hospitals.

If you get an SSI/SSP grant, Medi-Cal eligibility is automatically set up by your Social Security district office (see Section 2). For more information you can call your local Social Security Administration (SSA) office, or their toll free number, 1-800-772-1213. You can also visit their website at www.ssa.gov.

8. How to Apply for Medi-Cal

The usual application procedure is:

1. **Call or go to your county social services office to get a Medi-Cal application.** If you have an immediate need for health care services (such as severe illness or pregnancy), complete the Medi-Cal application and take it to your closest county social services office. Tell the county social services office that you have an immediate need for medical or dental care. The county social services office will process your application as fast as possible.
2. **Fill out the application form(s)** as completely as you can. Section 9 called "Required Documents to Apply for Medi-Cal" tells you what proof to give the county social services office when you apply for Medi-Cal. You can speed up the process by providing the necessary information and paperwork quickly.
3. **Request Medi-Cal "retroactive coverage"** if you have unpaid bills for covered medical/dental services in any of the three months before the month you apply for Medi-Cal and need help from Medi-Cal to pay the bills. To receive this coverage, you must be eligible for Medi-Cal in the month the Medi-Cal covered medical/dental services were provided. To request retroactive coverage, contact the county social services office within one year of the month in which the covered services were provided to you. For example, if you received medical/dental services any time in October 2010, you should contact the county social services office by October 31, 2011 to have a timely request.

   If you have *already paid* for the covered medical/dental bills provided during the three months of the retroactive period, Medi-Cal may also help you get reimbursed. You must submit your claim within one year of receipt of the services or within 90 days after issuance of the Medi-Cal card, which ever is longer.

   For more information or to file a claim, you MUST call or write to the following:

   For Medical, Mental Health, Drug and Alcohol, and In-Home Support Services Claims:

   Department of Health Care Services
   Beneficiary Services
   P.O. Box 138008
   Sacramento, CA 95813-8008
   (916) 403-2007 (916) 635-6491 TDD

   For Dental Claims:

   Denti-Cal
   Beneficiary Services
   P.O. Box 526026
   Sacramento, CA 95852-6026
   (916) 403-2007 (916) 635-6491 TDD
4. **When you apply for Medi-Cal, you will get a list of your rights and responsibilities.** For example,

REVISED VERSION

How Do I Apply?

You can apply for Medi-Cal at any time of the year by mail, phone, fax, or email. You can also apply online or in person.

You can only apply for Covered California coverage on certain dates. To learn when you can apply, go to ***www.coveredca.com*** or call **1-800-300-1506 (TTY 1-888-889-4500)**.

Apply by mail:

You can apply for Medi-Cal and Covered California with the Single Streamlined Application. You can get the application in English and other languages at: ***http://dhcs.ca.gov/mymedi-cal***. Send completed applications to your local county office.

Apply by phone, fax, or email:

Call your local county office. You can find the phone number on the web at ***http://dhcs.ca.gov/mymedi-cal*** or call Covered California at **1-800-300-1506**.

Apply online at:

OR

In person:

Find your local county office at ***http://dhcs.ca.gov/mymedi-cal***. You can get help applying.

You can also find a Covered California Certified Enrollment Counselor or Insurance Agent at ***www.CoveredCA.com/get-help/local/***.

How Long Will it Take for My Application to Be Processed?

It may take up to 45 days to process your Medi-Cal application. If you apply for Medi-Cal based on disability, it may take up to 90 days. Your local county office or Covered California will send you an eligibility decision letter. The letter is called a "Notice of Action." If you do not get a letter within the 45 or 90 days, you may ask for a "State Fair Hearing." You may also ask for a hearing if you disagree with the decision. To learn more, read "Appeal and hearing rights" on page 18.

How do I get services with Share of Cost (SOC)?

campers and trailers.
9. All checking and savings account statements and trust account documents.
10. All stocks (brokerage statements), bonds (including U.S. savings bonds) and mutual funds.
11. All deeds of trust, mortgages, other promissory notes and contracts of sale.
12. All life insurance policies, including cash surrender value.
13. All annuity policies.
14. All burial trusts/prepaid burial contracts/ information on burial plots.
15. Documentation regarding the current value of all trusts.
16. Payment book(s) for all encumbered property.
17. All policies/cards for health insurance you currently have or which are available to you.
18. Application(s) for possible available income (e.g. unemployment benefits, state disability benefits).
19. Court orders relating to income and property.
20. Lease agreements.
21. Life estate documents.
22. Copies of patient trust account ledgers.
23. Rent receipts, current utility bills, or housing statement.
24. Copies of child support orders or divorce decree.
25. Social Security disability or SSI denial or discontinuance notice (if applying for disability-based Medi-Cal).
26. Evidence of California residency. (See Section 6)

10. When You Need to Pay a Share of Cost

Depending upon your monthly income, Medi-Cal may determine that you have to meet a share of cost (SOC) before Medi-Cal will pay for your or your family's medical expenses for the month. The next section explains "meeting a share of cost."

Whether you will have a SOC for a month, and the size of your SOC, depends on how much money or income you and your family get for the month. Medi-Cal allows you to keep a certain amount of your family's income for your living expenses (this portion is called your Maintenance Need). Medi-Cal may also allow you to keep additional amounts of your family's income. Any income for the month which is more than the amount you are allowed to keep becomes your SOC for the month.

In some families, the income of one person cannot be used to decide if another person has a SOC. For example, income of a child cannot be used to decide whether a brother or sister, parent, stepparent or caretaker relative has a SOC. Income of a stepparent cannot be used to see if a stepchild has a SOC.

If you don't have any medical expenses during a month, you do not need to meet your SOC for that month. However, keep your Benefits Identification Card (BIC) in case you need medical services in upcoming months.

11. How to Meet Your Share of Cost

You may meet your Share of Cost (SOC) for the current month by showing Medi-Cal that you paid, or have promised to pay, for your medical expenses (including dental) an amount of money the same as your SOC. There are two ways to show Medi-Cal that you have paid or promised to pay your SOC for a certain month.

These two methods are:

1. In every month that you have a SOC, your county social services office will notify the State of the amount of SOC you must pay. When you go to a medical provider and give the provider your BIC, your provider will get information from a computer system about your SOC. After the provider accepts your promise to pay for the medical services, or you pay for those services, the provider will forward the amount of SOC paid, or promised to be paid, through the computer system to the State. The State will immediately update the SOC system so that future providers that month will know the amount of SOC that remains, if any. When you have met your SOC for the month, all future providers will receive information that you have met your SOC for the month and whether or not you are eligible for covered Medi-Cal services.

2. Another way to show you have paid or promised to pay your SOC is to give your medical bills directly to your county eligibility worker. You may give your bills for medical services you got during the current month to your county eligibility worker to apply toward your SOC. You must give old medical bills from previous months (for which you still owe money and which you want to apply toward your SOC) to your county eligibility worker. Your provider cannot use the SOC computer system for your old medical bills.

   Medical bills given to your county eligibility worker must contain certain kinds of information before your county eligibility worker can apply these bills toward your SOC.

   Your medical bills must show this information:

   a. Provider's name, address, Medi-Cal provider number, or if not a Medi-Cal provider, the provider license number, or federal tax identification number.
   b. Name of person who got the medical service.
   c. Description of the medical service received.
   d. Procedure Code (a medical/dental reference number) for medical/dental services received – your provider will know what this number is.
   e. Date(s) medical service was received.
   f. Date on which the bill was issued. For old medical bills, this date must be within 90 days of the date you give the old medical bills to your county eligibilty worker.
   g. Amount billed to person getting the service.

If any of this information is missing from a medical bill, you must try to get it from your provider. If you are unable to get it, your county eligibility worker will try to help you. Billing statements from collection agencies and credit card statements sometimes may be used as evidence of medical expenses. Under certain conditions, you may give the missing information by making a sworn statement.

If your county eligibility worker is unable to accept a medical bill, you will get a letter giving the reason for the disapproval of the bill. You will have ten days to fix the problem and bring/send the bill again. If you do not do this, you will receive a denial letter within the next 30 days which will give the reason for the denial and tell you what you must do before you may resubmit your medical bill. You will get a separate letter for medical bills which have been accepted and applied toward your SOC.

12. Private Health Insurance and Medi-Cal

You can have Medi-Cal even though you have Other Health Coverage (OHC) through individual or group private health (or dental) insurance coverage. If you are a Medi-Cal beneficiary and have individual or group private health (or dental) insurance coverage, you are required by federal and state law to report it. You can report it directly to Department of Health Care Services (DHCS) by visiting http://dhcs.ca.gov/OHC or call our call center at 800-541-5555 (outside of California, please call 916-636-1980. You can also report it to your county eligibility worker, your health care provider, and/or to the Local Child Support Agency (LCSA), when there is an absent parent who may be responsible for your child(ren)'s medical care, or in establishing paternity of a child born out of wedlock. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanor.

Under federal law, private health insurance belonging to a Medi-Cal beneficiary must be billed first before billing Medi-Cal. Medi-Cal may be billed for the balance, including OHC co-payments, OHC co-insurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any. Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as payment in full. The Medi-Cal provider must submit an Explanation of Benefits or denial letter from the OHC along with the Medi-Cal claim. If Medi-Cal later discovers OHC, Medi-Cal will bill the OHC for the Medi-Cal services. If you have a Medi-Cal share of cost you must pay it before Medi-Cal will pay for your service. If your other health insurance

What Is Fee-for-Service Medi-Cal?

Fee-for-Service is a way Medi-Cal pays doctors and other care providers. When you first sign up for Medi-Cal, you will get your benefits through Fee-for-Service Medi-Cal until you are enrolled in a managed care health plan.

Before you get medical or dental services, ask if the provider accepts Medi-Cal Fee-for-Service payments. The provider has a right to refuse to take Medi-Cal patients. If you do not tell the provider you have Medi-Cal, you may have to pay for the medical or dental service yourself.

How Are Medical or Dental Expenses Paid on Fee-for-Service Coverage?

Your provider uses your BIC to make sure you have Medi-Cal. Your provider will know if Medi-Cal will pay for a medical or dental treatment. Sometimes you may have to pay a "co-payment" for a treatment. You may have to pay $1 each time you get a medical or dental service or prescribed medicine. You may have to pay $5 if you go to a hospital emergency room when you do not need an emergency service. Those beneficiaries enrolled in a managed care plan do not have to pay co-payments.

There are some services Medi-Cal must approve before you may get them. See page 9 for more information.

How Do I Get Medical or Dental Services When I Have to Pay a Share of Cost (SOC)?

Some Non-MAGI Medi-Cal programs require you to pay a SOC. The Notice of Action you get after your Medi-Cal approval will tell you if you have a SOC. It will also tell the amount of the SOC. Your SOC is the amount you must pay or promise to pay to the provider for health or dental care before Medi-Cal starts to pay.

The SOC amount resets each month. You only need to pay your SOC in months when you get health and/or dental care services. The SOC amount is owed to the health or dental care provider. It is not owed to Medi-Cal or the State. Providers may allow you to pay for the services later instead of all at once. In some counties, if you have a SOC you cannot enroll in a managed care plan.

If you pay for health care services from someone who does not accept Medi-Cal, you may count those payments toward your SOC. You must take the receipts from those health care expenses to your local county office. They will credit that amount to your SOC.

You may be able to lower a future month's SOC if you have unpaid medical bills. Ask your local county office to see if your bills qualify.

What Is Medi-Cal Managed Care?

Medi-Cal Managed Care is an organized system to help you get high-quality care and stay healthy.

> **"Medi-Cal Managed Care health plans help you find doctors, pharmacies and health education programs."**

Most people must enroll in a managed care plan, unless you meet certain criteria or qualify for an exemption. Your health plan options depend on the county you live in. If your county has multiple health plans, you will need to choose the one that fits your and your family's needs.

Every Medi-Cal managed care plan within each county has the same services. You can get the directory of managed care plans at ***http://dhcs.ca.gov/mymedi-cal***. You can choose a doctor who works with your plan to be your primary care physician. Or your plan can pick a primary care doctor on your behalf. You may choose any Medi-Cal

What if I have other health insurance?

2. Another way to show you have paid or promised to pay your SOC is to give your medical bills directly to your county eligibility worker. You may give your bills for medical services you got during the current month to your county eligibility worker to apply toward your SOC. You must give old medical bills from previous months (for which you still owe money and which you want to apply toward your SOC) to your county eligibility worker. Your provider cannot use the SOC computer system for your old medical bills.

   Medical bills given to your county eligibility worker must contain certain kinds of information before your county eligibility worker can apply these bills toward your SOC.

   Your medical bills must show this information:
   a. Provider's name, address, Medi-Cal provider number, or if not a Medi-Cal provider, the provider license number, or federal tax identification number.
   b. Name of person who got the medical service.
   c. Description of the medical service received.
   d. Procedure Code (a medical/dental reference number) for medical/dental services received – your provider will know what this number is.
   e. Date(s) medical service was received.
   f. Date on which the bill was issued. For old medical bills, this date must be within 90 days of the date you give the old medical bills to your county eligibilty worker.
   g. Amount billed to person getting the service.

If any of this information is missing from a medical bill, you must try to get it from your provider. If you are unable to get it, your county eligibility worker will try to help you. Billing statements from collection agencies and credit card statements sometimes may be used as evidence of medical expenses. Under certain conditions, you may give the missing information by making a sworn statement.

If your county eligibility worker is unable to accept a medical bill, you will get a letter giving the reason for the disapproval of the bill. You will have ten days to fix the problem and bring/send the bill again. If you do not do this, you will receive a denial letter within the next 30 days which will give the reason for the denial and tell you what you must do before you may resubmit your medical bill. You will get a separate letter for medical bills which have been accepted and applied toward your SOC.

12. Private Health Insurance and Medi-Cal

You can have Medi-Cal even though you have Other Health Coverage (OHC) through individual or group private health (or dental) insurance coverage. If you are a Medi-Cal beneficiary and have individual or group private health (or dental) insurance coverage, you are required by federal and state law to report it. You can report it directly to Department of Health Care Services (DHCS) by visiting http://dhcs.ca.gov/OHC or call our call center at 800-541-5555 (outside of California, please call 916-636-1980. You can also report it to your county eligibility worker, your health care provider, and/or to the Local Child Support Agency (LCSA), when there is an absent parent who may be responsible for your child(ren)'s medical care, or in establishing paternity of a child born out of wedlock. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanor.

Under federal law, private health insurance belonging to a Medi-Cal beneficiary must be billed first before billing Medi-Cal. Medi-Cal may be billed for the balance, including OHC co-payments, OHC co-insurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any. Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as payment in full. The Medi-Cal provider must submit an Explanation of Benefits or denial letter from the OHC along with the Medi-Cal claim. If Medi-Cal later discovers OHC, Medi-Cal will bill the OHC for the Medi-Cal services. If you have a Medi-Cal share of cost you must pay it before Medi-Cal will pay for your service. If your other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), you must use the plan facilities for

regular medical care (non-emergency services).

Send any payment you get directly from an insurance carrier for services paid by Medi-Cal to DHCS at:

Department of Health Care Services
Third Party Liability and Recovery Division
Cost Avoidance Section
P.O. Box 997424, MS 4719
Sacramento, CA 95899-7424

Send any medical support payment you get from the absent parent to DHCS at this address:

Department of Health Care Services
Third Party Liability and Recovery Division
Cost Avoidance Section
P.O. Box 997422, MS 4719
Sacramento, CA 95899-7425

If you have other health insurance coverage, the computer system will be coded to show other health insurance. If this information is incorrect you can contact your county eligibility worker to temporarily override this information. The correct information then needs to be reported to DHCS by visiting http://dhcs.ca.gov/OHC or call our call center at 800-541-5555 (outside of California, please call 916-636-1980.

If you are having a claims payment problem with a provider, you may call the Beneficiary and HIPAA Privacy Help Desk at (916) 636-1980.

Note: Beginning January 1, 2006, if you are a recipient of both Medicare and Medi-Cal, Medicare (not Medi-Cal) will pay for most prescription drugs for Medi-Cal beneficiaries who are eligible for Medicare Part A (hospital) or Part B (outpatient). For information on Medicare Part D (drug coverage), please contact 1-800-MEDICARE (1-800-633-4227).

13. Medi-Cal May Pay Private Health Insurance Premiums

If you are a Medi-Cal beneficiary and you have a very high-cost medical condition which requires a physician's care, the DHCS may pay your private health insurance premiums, if it is cost effective, under the Health Insurance Premium Payment (HIPP) program. There are specific requirements to qualify for the program and not all applicants are approved for HIPP. For more information on HIPP:

- ask your county eligibility worker to refer you, or
- call the DHCS' HIPP Program at 1-866-298-8443 (toll-free) or
- visit their website at **www.dhcs.ca.gov** or
- send an email to **HIPP@dhcs.ca.gov** or
- send a fax to (916) 440-5676.

A HIPP representative in Sacramento will explain the process and requirements for the program. If it appears that you may meet the eligibility requirements, an application will be sent to you.

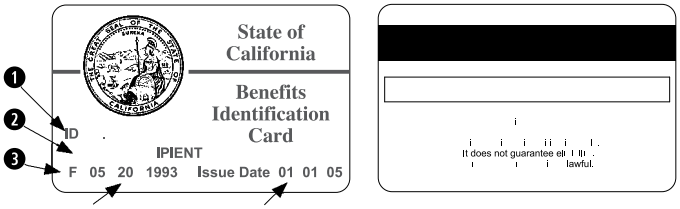
14. The Medi-Cal Identification Card

Medi-Cal mails plastic Benefits Identification Cards (BICs) to all beneficiaries. The 14 numbers and letters on your card identify you. Your health care providers need your BIC to provide services and to bill Medi-Cal. If you have an "Immediate Need" or get Confidential Medical Services (Minor Consent) as described in Section 2D, your county social services office will give you a paper Medi-Cal card.

Note: Your BIC does not guarantee Medi-Cal eligibility. Take your BIC or paper card to your doctor, dentist, pharmacy, hospital or other medical provider. The provider will use this card to verify that you are eligible for Medi-Cal.

15. What the Benefits Identification Card (BIC) Looks Like

A BIC looks like this:



family planning provider of your choice, including one outside of your plan. Contact your managed care plan to learn more.

Managed care health plans also offer:

- Care coordination
- Referrals to specialists
- 24-hour nurse advice telephone services
- Customer service centers

Medi-Cal must approve some services before you may get them. The provider will know when you need prior approval. Most doctors' services and most clinic visits are not limited. They do not need approval. Talk with your doctor about your treatment plan and appointments.

How Do I Enroll in a Medi-Cal Managed Care Plan?

If you are in a county with more than one plan option, you must choose a health plan within 30 days of Medi-Cal approval. You will get an information packet in the mail. It will tell you the health plan(s) available in your county. The packet will also tell you how to enroll in the managed care plan you choose. If you do not choose a plan within 30 days of getting your Medi-Cal approval, the State will choose a plan for you.

Please wait for your health plan information packet in the mail.

> **"If your county only has one health plan, the county chooses the plan for you."**

If you live in **San Benito County**, there is only one health plan. You may enroll in this health plan. Or you may choose to stay in Fee-for-Service Medi-Cal.

If your county has more than one health plan, you will need to choose the one that fits your and your family's needs.

To see what plans are in your county, go to *https://www.healthcareoptions.dhcs.ca.gov/*

How Do I Disenroll, Ask for an Exemption from Mandatory Enrollment, or Change My Medi-Cal Managed Care Plan?

Most Medi-Cal beneficiaries must enroll in a Medi-Cal managed care plan. If you enrolled in a health care plan **by choice**, you may disenroll at any time. To disenroll, call Health Care Options at **1-800-430-4263.**

When your county has more than one plan, you can call Health Care Options if you want to change your managed care health plan.

If you are getting treatment now from a Fee-for-Service Medi-Cal provider, you may qualify for a temporary exemption from mandatory enrollment in a Medi-Cal managed care plan. The Fee-for-Service provider cannot be part of a Medi-Cal managed care plan in your county. The provider must be treating you for a complex condition that could get worse if you have to change providers.

Ask your provider if he or she is part of a Medi-Cal managed care plan in your county. If your provider is not part of a Medi-Cal managed care plan in your county, have your provider fill out a form with you to ask for an exemption from enrolling in a Medi-Cal managed care plan.

Your provider will need to sign the form, attach required proof, and mail or fax the form to Health Care Options. They will review it and decide whether you qualify for a temporary exemption from enrollment in a Medi-Cal managed care plan. You can find the form and instructions at ***http://dhcs.ca.gov/mymedi-cal***.

If you have questions, call **1-800-430-4263.**

What if I Have Other Health Insurance?

Even if you have other health coverage such as health insurance from your work, you may still qualify for Medi-Cal. If you qualify, Medi-Cal will cover allowable costs not paid by your primary insurance. Under federal

law, Medi-Cal beneficiaries' private health insurance must be billed first before billing Medi-Cal.

Medi-Cal beneficiaries are required by federal and state law to report private health insurance. To report or change private health insurance, go to ***http://dhcs.ca.gov/mymedi-cal*** or call **1-800-541-5555 (TTY 1-800-430-7077)**. Outside of California, call **1-916-636-1980.**

You also must report it to your local county office and your health care provider. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanor crime.

Can I Get Medi-Cal Services When I Am Not in California?

When you travel outside California, take your BIC or proof that you are enrolled in a Medi-Cal health care plan. Medi-Cal can help in some cases, such as an emergency due to accident, injury or severe illness. Except for emergencies, your managed care plan must approve any out-of-state medical services before you get the service. If the provider will not accept Medicaid, you will have to pay medical costs for services you get outside of California. Remember: there may be many providers involved in emergency care. For example, the doctor you see may accept Medicaid but the x-ray department may not. Work with your managed care plan to limit what you have to pay. The provider should first make sure you qualify by calling **1-916-636-1960.**

If you live near the California state line and get medical service in the other state, some of these rules do not apply. To learn more, contact your Medi-Cal managed care plan.

> **"You will not get Medi-Cal if you move out of California. You may apply for Medicaid in the state you move to."**

If you are moving to a new county in California, you also need to tell the county you live in or the county you are moving to. This is to make sure you keep getting Medi-Cal benefits. You should tell your local county office within 10 days of moving to a new county.

What Should I Do if I Can't Get an Appointment or Other Care I Need?

The Medi-Cal Managed Care Office of the Ombudsman helps solve problems from a neutral standpoint. They make sure you get all necessary required covered services.

The Office of the Ombudsman:

- Helps solve problems between Medi-Cal managed care members and managed care plans without taking sides
- Helps solve problems between Medi-Cal beneficiaries and county mental health plans without taking sides
- Investigates member complaints about managed care plans and county mental health plans
- Helps members with urgent enrollment and disenrollment problems
- Helps Medi-Cal beneficiaries access Medi-Cal specialty mental health services
- Offers information and referrals
- Identifies ways to make the Medi-Cal managed care program more effective
- Educates members on how to navigate the Medi-Cal managed care and specialty mental health system

To learn more about the Office of the Ombudsman, you can call:

1-888-452-8609

or go to:

http://dhcs.ca.gov/mymedi-cal

How do I use my Medi-Cal benefits?

county CHDP or county mental health department agree you need them. You can ask for services as often as you think you need them.

If you have severe emotional problems, contact your county mental health department. Look in the government section of your phone book under Mental Health Department. If you cannot reach the county mental health department, call the state mental health ombudsman toll-free at 1-800-896-4042.

If you, your doctor or dentist thinks that health services which are not usually covered by Medi-Cal may be needed, you should talk to:

- Your local county CHDP Program
- Your Managed Care Plan
- Your County Mental Health Department

Or ask your doctor or dentist to contact:

- Your local Medi-Cal Field Office, or
- The California Children's Services program

20. How to Get Medi-Cal Services

How you get your Medi-Cal services will depend on the area you live in. In some areas, you may choose your providers from those who accept Medi-Cal, or you may choose to sign up for a Medi-Cal health and/or dental care plan if there are any in your area. In other areas, some Medi-Cal beneficiaries must sign up for a health and/or dental care plan. In the areas where you must sign up for a health care plan, there are exceptions. The exceptions will be explained to you at the same time your choices for getting Medi-Cal services are explained to you.

You will get information about health/dental care plans at the time you apply or reapply for benefits. You may be required to go to a presentation at the county social services office where they tell you about the health care plans you can sign up for. You may also get information in the mail about the health care plans in your area.

There are two ways to get your Medi-Cal services:

1. In those areas where you can choose your own providers, you should know how to use the Benefits Identification Card (BIC) before you see a doctor or other provider of health services. Please read Sections 16 and 18. If you are not enrolling in a health care plan and choosing your own providers, you must tell the health care provider that you have Medi-Cal before you first get care. If you do not tell the provider that you have Medi-Cal, the provider may legally bill you for all services you get. Providers of health care do not have to take Medi-Cal patients or may only take a few Medi-Cal patients. **If you don't use your BIC card correctly, you may have to pay for the services you get.**
2. If you sign up for a Medi-Cal health/dental care plan, you may choose a provider from a provider list the plan gives you. As a plan member, you can get all of the services covered by regular Medi-Cal. Some plans offer extra services which you cannot get with your BIC card.

21. Payments for Medical/Dental Expenses

Your BIC will pay for many kinds of medical/dental expenses. When your provider uses your BIC to verify your Medi-Cal eligibility, your provider will know if Medi-Cal will pay for a medical/dental treatment or if you need to make a "co-payment" for any treatment. You may have to pay a co-payment when you get medical/dental services, a prescribed drug, or if you go to the hospital or emergency room.

Note: If you have Medi-Cal and Medicare, Medicare (not Medi-Cal) pays for most of your prescribed drugs.

22. Getting Help from Medi-Cal If You Are Out of State

Take your BIC or proof of enrollment in a Medi-Cal health care plan with you when you travel outside California. Medi-Cal can help in limited situations; for example, in an emergency due to accident, injury, or severe illness, or when your health would be endangered by postponing treatment until you return to California. Medi-Cal must first approve any out-of-state in-patient medical services before you get the service. You will be responsible for medical costs for services you got out-of-state if the medical provider is not a Medi-Cal provider or does not wish to become a Medi-Cal provider.

Medi-Cal covers most medically necessary care. This includes doctor and dentist appointments, prescription drugs, vision care, family planning, mental health care, and drug or alcohol treatment. Medi-Cal also covers transportation to these services. Read more in "Covered Benefits" on page 12.

Once you are approved, you can use your Medi-Cal benefits right away. New beneficiaries approved for Medi-Cal get a Medi-Cal Benefits Identification Card (BIC). Your health care and dental providers need your BIC to provide services and to bill Medi-Cal. New beneficiaries and those asking for replacement cards get the new BIC design showing the California poppy. Both BIC designs shown here are valid:

How Do I See a Doctor?

Most people who are in Medi-Cal see a doctor through a Medi-Cal managed care plan. The plans are like the health plans people have with private insurance. Read more about managed care plans starting on the next page.

It may take a few weeks to assign your Medi-Cal managed care plan. When you first sign up for Medi-Cal, or if you have special situations, you may need to see the doctor through "Fee-for-Service Medi-Cal."