2019

Annual Notice of Change

OneCare (HMO SNP)

CalOptima

A Public Agency

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OneCare (HMO SNP)
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OneCare (HMO SNP) offered by CalOptima

Annual Notice of Changes for 2019

You are currently enrolled as a member of *OneCare*. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes*.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click “Find health & drug plans.”
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to keep OneCare, you don’t need to do anything. You will stay in OneCare.
- If you want to change to a different plan that may better meet your needs, you can switch plans between now and December 31. Look in section 4.2, page 16 to learn more about your choices.

4. ENROLL: To change plans, join a plan between now and December 31, 2018

- If you **don’t join another plan by December 31, 2018**, you will stay in OneCare.
- If you **join another plan by December 31, 2018**, your new coverage will start the first day of the following month.
- Starting in 2019, there are new limits on how often you can change plans. Look in Section 5, page 17 to learn more.

Additional Resources

- This document is available for free in Spanish and Vietnamese.
- Please contact our Customer Service number at **1-877-412-2734** for additional information. (TDD/TTY users should call **1-800-735-2929**.) Hours are 24 hours a day, 7 days a week.
- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- Esta información está disponible gratis en otros idiomas.
- Para más información, por favor llame al Departamento de Servicios para Miembros al **1-877-412-2734**, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TDD/TTY pueden llamar al **1-800-735-2929**.
- El Departamento de Servicios para Miembros cuenta con servicios de intérprete gratuitos para aquellos miembros que no hablan inglés. (los números de teléfono se encuentran en la sección 8.1 de este documento).
- Thông tin này cũng có sẵn miễn phí bằng những ngôn ngữ khác.
- Xin vui lòng liên lạc Văn Phòng Dịch Vụ của chúng tôi qua số điện thoại **1-877-412-2734** để biết thêm chi tiết. Thành viên sử dụng máy TDD/TTY có thể liên lạc qua số **1-800-735-2929**. Quý vị có thể liên lạc 24 giờ một ngày, 7 ngày một tuần.
- Văn Phòng Dịch Vụ có dịch vụ thông dịch miễn phí cho các thành viên không nói tiếng Anh (các số điện thoại nằm ở Phần 8.1 của tập tài liệu này).
- This information is available in a different format (e.g., large print, audio tapes). Please call OneCare Customer Service at the number listed above if you need plan information in another format.
- Esta información está disponible en otros formatos (por ejemplo, impresa grande y cintas de audio). Si necesita información del plan en otro formato, por favor llame al Departamento de Servicios para Miembros al número de teléfono que aparece arriba.
- Thông tin này có sẵn bằng những hình thức khác (ví dụ như khổ chữ in lớn, qua băng thâu thanh). Xin vui lòng liên lạc Văn Phòng Dịch Vụ ở số điện thoại ghi phía trên nếu quý vị cần thông tin về chương trình bằng những hình thức khác.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About OneCare

- **OneCare (HMO SNP)** is a Medicare Advantage organization with a Medicare contract. Enrollment in OneCare depends on contract renewal.
- The plan also has a written agreement with the California Medicaid program to coordinate your Medicaid benefits.
- When this booklet says “we,” “us,” or “our,” it means OneCare. When it says “plan” or “our plan,” it means OneCare.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for OneCare in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the Summary of Benefits to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$0	$0
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • **Drug Tier 1: (Generic): $0, $1.25, or $3.35** • **Drug Tier 2: (Brand): $0, $3.70, or $8.35**	Deductible: $0 Copayment during the Initial Coverage Stage: • **Drug Tier 1 (Generic): $0.00** • **Drug Tier 2: (Brand): $0.00**

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details)	$6,700	$6,700

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SECTION 1: Unless You Choose Another Plan, You Will Be Automatically Enrolled in OneCare in 2019

If you do nothing to change your Medicare coverage in 2018, we will automatically enroll you in our *OneCare*. This means starting January 1, 2019, you will be getting your medical and prescription drug coverage through OneCare. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you want to change, you can do so between now and December 31. The change will take effect on January 1, 2019. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the Evidence of Coverage.

The information in this document tells you about the differences between your current benefits in OneCare and the benefits you will have on January 1, 2019, as a member of OneCare.

SECTION 2: Changes to Medicare Benefits and Costs for Next Year

Section 2.1: Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	**$0**	**$0**

Section 2.2: Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3: Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider and Pharmacy Directory is located on our website at **www.caloptima.org/onecare**. You may also call Customer Service for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. Please review the **2019 Provider and Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4: Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Provider and Pharmacy Directory is located on our website at **www.caloptima.org/onecare**. You may also call Customer Service for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2019 Provider and Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5: Changes to Benefits and Costs for Medical Services

Please note that the Annual Notice of Changes only tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Benefits Chart (*what is covered and what you pay*), in your 2019 *Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Dental Services	$0 copay for limited dental services	Dental services are not covered. Eligible members can access dental services through Denti-Cal.
Hearing Services	$0 copay for Medicare-covered services. Hearing aids are not covered.	$0 copay for Medicare-covered services. For hearing aids, our plan pays up to $500 every year. This benefit may only be used once during the calendar year.
Non-Medical Transportation	You pay $0 copay for up to 60 one-way trips to plan-approved locations every year.	You pay $0 copay for unlimited trips to plan-approved locations every year. Plan-approved locations will include trips to and from Gym as the Fitness membership is offered as a benefit to this plan.
Vision care	Our plan pays up to $50 every two years for contact lenses, and up to $150 every two years for eyeglasses (frames and lenses).	Our plan pays up to $250 every two years for contact lenses or eyeglasses (frames and lenses).
Worldwide Emergency/ Urgent Coverage	Not covered	You pay for your emergency and urgent care outside of the U.S. and we will reimburse you up to $25,000 per year.

Section 2.6: Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List". A copy of our Drug List is provided electronically. We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* or call Customer Service.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

How do I change my prescription?

If your drug was removed from our Drug List, or if we made changes to the restrictions that apply for coverage, you can ask us if we cover another drug used to treat your medical condition. If we cover another drug for your condition, we encourage you to ask your doctor if these drugs that we cover are an option for you. If your doctor tells you that none of the drugs we cover for treating your condition is medically appropriate, you have the right to request an exception from us to cover the drug that was originally prescribed. You also have the right to request an exception if your doctor tells you that a prior authorization, quantity limit, or other limit we have placed on a drug you are taking is not medically appropriate for treating your condition.

What if my request for an exception was already approved this year?

In some situations, we will still cover drugs that are not on our Drug List, or are on our Drug List, but with restrictions. If you and your doctor requested an exception to our coverage rules this year and we approved your request, then we mailed you a letter telling you how long your request is approved. In that letter, we also tell you what to do when your approval

expires. You can request a copy of your letter(s) by calling Customer Service (see the back cover).

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30- day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 8.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your Summary of Benefits or at Chapter 6, Sections 6 and 7, in the Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your Evidence of Coverage.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1(Generic):** You pay $0, $1.25, or $3.35 per prescription **Tier 2 (Brand)**: You pay $0, $3.70 or $8.35 per prescription Once you have paid $5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1(Generic):** You pay $0 per prescription. **Tier 2 (Brand)**: You pay : $0 per prescription. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your Summary of Benefits or at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

SECTION 3: Administrative Changes

Cost	2018 (this year)	2019 (next year)
Acupuncture	Requires prior authorization and a referral	Will not require prior authorization or a referral
Dental Services	Dental services was offered through Liberty Dental	Not Covered
Inpatient Mental Health Care	Requires a referral	Does not require a referral
Medicare-covered Glaucoma Screening	Requires prior authorization	Will not require prior authorization
Medicare-covered Diabetes Self-Management Training	Requires prior authorization	Will not require prior authorization
Other Medicare Covered Preventative Services	Not Applicable for 2018	In 2019, Medicare-covered Barium Enemas, Medicare- Covered Digital Rectal Exams, and Medicare-covered EKG following Welcome Visit will not require prior authorization

SECTION 4: Deciding Which Plan to Choose

Section 4.1: If you want to stay in OneCare

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2019.

Section 4.2: If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2019, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." Here, you can find information about costs, coverage, and quality ratings for Medicare plans.

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from OneCare.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from OneCare.
- To change to Original Medicare without a prescription drug plan, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
  - – or – Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 5: Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 31. The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

Note: Effective January 1, 2019, if you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 6: Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP). HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website **(www.coaoc.org).**

For questions about your Medi-Cal benefits, contact Medi-Cal Managed Care of the Ombudsman at 1-888-452-8609, Monday through Friday, 8 a.m. to 5 p.m.; excluding holidays. TTY users should call **1-800-735-2929**. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

SECTION 7: Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- "Extra Help" from Medicare. Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/ 7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

SECTION 8: Questions?

Section 8.1: Getting Help from OneCare

Questions? We're here to help. Please call Customer Service at **1-877-412-2734.** (TDD/TTY only, call **1-800-735-2929**. We are available for phone calls 24 hours a day, 7 days a week. Calls to these numbers are free.

Read your 2019 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 Evidence of Coverage for OneCare. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. *

Visit our Website

You can also visit our website at **www.caloptima.org/onecare**. As a reminder, our website has the most up-to-date information about our provider network (Provider and Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 8.2: Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website **(https://www.medicare.gov)**. It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read Medicare & You 2019

You can read Medicare & You 2019 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website **(https://www.medicare.gov)** or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 8.3: Getting Help from Medicaid

To get information from Medi-Cal (Medicaid), you can call Medi-Cal at 1-800-281-9799. TTY users should call **1-800-735-2929**.

Orange County Social Services — Medi-Cal (California's Medicaid Program)	
Call	1-800-281-9799
TTY	**1-800-735-2929** (California Relay Service)
Write	Call the toll-free number above or use the website below to find the office that services the city in which you live.
Website	**www.ssa.ocgov.com**

The Medi-Cal Managed Care Office of the Ombudsman helps people enrolled in Medi-Cal (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

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Medi-Cal Managed Care Office of the Ombudsman	
Call	1-888-452-8609 Monday through Friday, 8 a.m. to 5 p.m. PST; excluding holidays
TTY	**1-800-735-2929** (California Relay Service)
Website	http://www.dhcs.ca.gov/services/medi cal/Pages/ MMCDOfficeoftheOmbudsman.aspx

OneCare (HMO SNP) is a Medicare Advantage Oraginzation with a Medicare contract. Enrollment in OneCare depends on contract renewal.

This information is not a complete description of benefits. Call Customer Service at **1-877-412-2734**, TDD/TTY **1-800-735-2929** for more information.

OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TDD/TTY: **1-800-735-2929**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TDD/TTY: **1-800-735-2929**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TDD/TTY: **1-800-735-2929**).

OneCare Customer Service

Method	Customer Service – Contact Information
CALL	**1-877-412-2734** Calls to this number are free. You can call Customer Service 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**1-800-735-2929** Calls to this number are free. You can call Customer Service 24 hours a day, 7 days a week.
FAX	**1-714-246-8711**
WRITE	OneCare Customer Service 505 City Parkway West Orange, CA 92868
WEBSITE	www.caloptima.org/onecare

Health Insurance Counseling and Advocacy Program (California's State Health Insurance Program)

Health Insurance Counseling and Advocacy Program (HICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	**1-800-434-0222** (Calls to this number are free.) **1-714-560-0424** (Calls to this number are not free.)
TTY	**1-800-735-2929** California State Relay Service Calls to this number are free.
WRITE	HICAP c/o Council on Aging – Southern California 2 Executive Circle, Suite 175 Irvine, CA 92614
WEBSITE	www.coasc.org