Instructions to Health Plans

* [This version of the ANOC should be used by plans that do not have separate Medi-Cal managed care product lines as a direct contractor to the state.]
* [Plans may include the ANOC in the 2019 Member Handbook (Evidence of Coverage) or provide it to members separately.]
* [Before use and under the appropriate, State-specific material code(s), plans must upload in HPMS only (1) a standalone ANOC and (2) a standalone EOC (Member Handbook). Plans should work with their marketing reviewers to withdraw any duplicate material submitted in error. Plans must enter Actual Mail Dates (AMDs) for ANOCs in accordance with CMS requirements as detailed in the “Update AMD/Beneficiary Link/Function” section of the Marketing Review Users Guide in HPMS. Note that plans must enter AMD information for ANOC mailings only for mailings to current members. Plans should not enter ANOC AMD information for October 1, November 1, or December 1 effective enrollment dates or for January 1 effective enrollment dates for any new members.]
* [Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to [*https://www.hhs.gov/civil-rights/for-individuals/section-1557/*](https://www.hhs.gov/civil-rights/for-individuals/section-1557/).]
* [Plans may modify the language in the ANOC, as applicable, to address Medi-Cal benefits and cost sharing for its dual eligible population.]
* [Plans must revise references to “Medicaid” to use “Medi-Cal” throughout the ANOC.]
* [Plans should follow the instructions in the Medicare Marketing Guidelines and the State’s specific Marketing Guidance regarding use of the standardized plan type (Medicare-Medicaid Plan) following the plan name.]
* [*Plans should replace the reference to “Member Services” with the term the plan uses.*]
* [Where the template uses “medical care,” “medical services,” or “health care services,” plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]
* [Plans should refer members to the 2019 Member Handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY/TDD number and days and hours of operation.]
* [*Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English speaking and non-English speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where an item or text continues on to the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert:* **This section is continued on the next page***).*
* *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple plan-specific examples as applicable.*
* *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low income subsidy (LIS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
  + *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialect in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*
* *Consider producing translated models in large print.*]

**<Plan name> [insert plan type] offered by [insert sponsor name]**

*Annual Notice of Changes* for 2019

[Optional: insert beneficiary name]  
[Optional: insert beneficiary address]

**Introduction**

[If there are any changes to the plan for 2019, insert: You are currently enrolled as a member of <plan name>. Next year, there will be some changes to the plan’s [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section **or** Annual Notice of Changes] tells you about the changes and where to find more information about them. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.]

[If there are no changes whatsoever for 2019 (e.g. no changes to benefits, coverage, rules, costs, networks, etc.), insert: You are currently enrolled as a member of <plan name>. Next year, there are no changes to the plan’s benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section **or** Annual Notice of Changes] to learn about your coverage choices. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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1. **Disclaimers**

* [*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]
* [Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.]

# Reviewing Your Medicare and Medi-Cal Coverage for Next Year

It is important to review your coverage now to make sure it will still meet your needs next year. If it does not meet your needs, you may be able to leave the plan. See section G2 for more information.

If you choose to leave <plan name>, your membership will end on the last day of the month in which your request was made.

If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible.

* You will have a choice about how to get your Medicare benefits (go to page <page number> to see your choices).
* You will get your Medi-Cal benefits through a Medi-Cal managed care plan of your choice (go to page <page number> for more information).

**NOTE**: If you are in a drug management program, you may not be able to join a different plan. See Chapter 5 [plans may insert reference, as applicable] of your Member Handbook for information about drug management programs.

| **Resources** |
| --- |
| B1. Additional Resources  * ATTENTION: If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation]. The call is free. [*This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.*] * You can get this [Insert as applicable: section **or** Annual Notice of Changes] for free in other formats, such as large print, braille, or audio. Call [insert Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation]. The call is free. * [*Plans must also describe how members can make a standing request to get this document, now and in the future, in a language other than English or in an alternate format*.]  B2. Information about <plan name>  * [Insert plan’s legal or marketing name] is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. * Coverage under <plan name> qualifies as minimum essential coverage (MEC). It 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 on the individual shared responsibility requirement for MEC. * <Plan name> is offered by [insert sponsor name]. When this *Annual Notice of Changes* says “we,” “us,” or “our,” it means [insert sponsor name]. When it says “the plan” or “our plan,” it means <plan name>*.* |

| B3. Important things to do:  * **Check if there are any changes to our benefits** [insert if applicable: **and costs**] **that may affect you.**    + Are there any changes that affect the services you use? * It is important to review benefit [insert if applicable: and cost] changes to make sure they will work for you next year. * Look in sections <section number> [plans may insert reference, as applicable] and <section number> [plans may insert reference, as applicable] for information about benefit [insert if applicable: and cost] changes for our plan. * **Check if there are any changes to our prescription drug coverage that may affect you.** * Will your drugs be covered? Are they in a different [*insert if applicable*: cost-sharing] tier? Can you continue to use the same pharmacies? * It is important to review the changes to make sure our drug coverage will work for you next year. * Look in section <section number> [plans may insert reference, as applicable] for information about changes to our drug coverage. * **Check to see if your providers and pharmacies will be in our network next year.** * Are your doctors in our network? What about your pharmacy? What about the hospitals or other providers you use? * Look in section <section number> [plans may insert reference, as applicable] for information about our *Provider and Pharmacy Directory.* * **Think about your overall costs in the plan.** * [*Insert if applicable*: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?] * How do the total costs compare to other coverage options? * **Think about whether you are happy with our plan.** |
| --- |

| **If you decide to stay with <2019 plan name>:** | **If you decide to change plans:** |
| --- | --- |
| If you want to stay with us next year, it’s easy – you don’t need to do anything. If you don’t make a change, you will automatically stay enrolled in our plan. | [*Plans should revise this paragraph as necessary*] If you decide other coverage will better meet your needs, you may be able to switch plans (see section G2 for more information). If you enroll in a new plan, your new coverage will begin on the first day of the following month. Look in section <section number>, page <page number> [*plans may insert additional reference, as applicable*] to learn more about your choices. |

# Changes to the plan’s name

[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]

On January 1, 2019, our plan name will change from <2018 plan name> to <2019 plan name>.

[Insert language to inform members whether they will get new Member ID Cards and how, as well as how the name change will affect any other beneficiary communication.]

# Changes to the network providers and pharmacies

[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.

However, it is important that you know that we may make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, see Chapter 3 of your Member Handbook.]

[Plans with changes to provider and/or pharmacy networks, as described in Chapter 4 of the Medicare Managed Care Manual, Chapter 5 of the Medicare Prescription Drug Benefit Manual, and the Provider and Pharmacy Directories Requirements subsection in the Introduction to the State’s specific Marketing Guidance, insert: Our[insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2019.

We strongly encourage you to **review our current *Provider and Pharmacy Directory*** to see if your providers or pharmacy are still in our network**.** An updated Provider and Pharmacy Directory is located on our website at <web address>. You may also call Member Services at <phone number> for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It is important that you know that we may also make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, see Chapter 3 of your *Member Handbook*.]

# Changes to benefits [*insert if applicable:* and costs] for next year

## E1. Changes to benefits [insert if applicable: and costs] for medical services

[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits [insert if applicable: or amounts you pay] for medical services. Our benefits [insert if applicable: and what you pay for these covered medical services] will be exactly the same in 2019 as they are in 2018.]

We are changing our coverage for certain medical services [insert if applicable: and what you pay for these covered medical services] next year. The table below describes these changes.

[The table must include:

* all new benefits that will be added or 2018 benefits that will end for 2019;
* new limitations or restrictions on benefits for 2019; and
* all changes in cost sharing for 2019 for covered medical services, including any changes to service category out-of-pocket maximums.]

|  | **2018 (this year)** | **2019 (next year)** |
| --- | --- | --- |
| **[Insert benefit name]** | [For benefits that were not covered in 2018, insert:  [insert benefit name] is **not** covered.]  [For benefits with a  copay insert:  You pay a **$<2018  copay amount>**  copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].] | [For benefits that will not be covered in 2019, insert:  [insert benefit name] is **not** covered.]  [For benefits with a  copay insert:  You pay a **$<2019  copay amount>**  copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].] |
| **[Insert benefit name]** | [Insert 2018 cost or coverage, using format described above.] | [Insert 2019 cost or coverage, using format described above.] |

## E2. Changes to prescription drug coverage

**Changes to our Drug List**

[*Plans that did not include a List of Covered Drugs in the envelope, insert*: You will get a 2019 *List of Covered Drugs* in a separate mailing]

[*Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert*: An updated *List of Covered Drugs* is located on our website at <web address>. You may also call Member Services at <phone number> for updated drug information or to ask us to mail you a *List of Covered Drugs*.]

[*Plans that included a List of Covered Drugs in the envelope, insert*: We sent you a copy of our 2019 *List of Covered Drugs* in this envelope.] The *List of Covered Drugs* is also called the “Drug List.”

[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List for next year. The drugs included on our Drug List will be the same in 2019 as in 2018. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. See the 2019 Drug List for more information.]

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, we encourage you to:

* Work with your doctor (or other prescriber) to find a different drug that we cover.
* You can call Member Services at <phone number> [*insert if applicable:* or contact your care coordinator] to ask for a list of covered drugs that treat the same condition. [*Plans should replace the term “care coordinator” with the term they use*.]
* This list can help your provider find a covered drug that might work for you.
* [Plans should include the following language if they have an advance transition process for current members:]Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.
* You can ask for an exception before next year and we will give you an answer within 72 hours after we get your request (or your prescriber’s supporting statement).
* To learn what you must do to ask for an exception, see Chapter 9 of the *2019 Member Handbook* [plans may insert reference, as applicable] or call Member Services at <phone number>.
* If you need help asking for an exception, you can contact Member Services [*insert if applicable*: or your care coordinator]. See Chapter 2 and Chapter 3 of the *Member Handbook* to learn more about how to contact your care coordinator. [Plans should replace the term “care coordinator” with the term they use.]
* [Plans should include the following language if all current members will not be transitioned in advance for the following year:]Ask the plan to cover a temporary supply of the drug.
* In some situations, we will cover a **temporary** supply of the drug during the first [must be at least 90] days of the calendar year.
* This temporary supply will be for up to [insert supply limit (must be the number of days in plan’s one-month supply)] days. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5 of the *Member Handbook* [plans may insert reference, as applicable].)
* When you get 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.

[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]

[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]

**Changes to prescription drug costs** [option for plans with two drug payment stages]

[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]

[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2019. Read below for more information about your prescription drug coverage.]

There are two payment stages for your Medicare Part D prescription drug coverage under <2019 plan name>. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| **Stage 1**  **Initial Coverage Stage** | **Stage 2**  **Catastrophic Coverage Stage** |
| --- | --- |
| During this stage, the plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.  You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2019.  You begin this stage when you have paid a certain amount of out-of-pocket costs. |

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches [*insert as applicable****:* $<initial coverage limit>** *or* **$<TrOOP amount*>***]. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. See Chapter 6 of your *Member Handbook* for more information on how much you will pay for prescription drugs.

## E3. Stage 1: “Initial Coverage Stage”

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

[Insert if applicable: **We moved some of the drugs on the Drug List to a lower or higher drug tier.** If your drugs move from tier to tier, this could affect your copay. To see if your drugs will be in a different tier, look them up in the Drug List.]

The following table shows your costs for drugs in each of our <number of tiers> drug tiers. These amounts apply **only**during the time when you are in the Initial Coverage Stage.

[Plans must list all drug tiers in the following table.]

|  | **2018 (this year)** | **2019 (next year)** |
| --- | --- | --- |
| **Drugs in Tier <Tier number>**  ([Insert short description of tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | [Insert 2018 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] | [Insert 2019 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX>** **per prescription**.] |
| **Drugs in Tier <Tier number>**  ([Insert short description of tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | [Insert 2018 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX>** **per prescription**.] | [Insert 2019 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX>** **per prescription**.] |

The Initial Coverage Stage ends when your total out-of-pocket costs reach [insert as applicable: **$<initial coverage limit>** or **$<TrOOP amount>**]***.*** At that point the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. See Chapter 6 of your *Member Handbook* for more information how much you will pay for prescription drugs.

## E4. Stage 2: “Catastrophic Coverage Stage”

When you reach the out-of-pocket limit [*insert:* **$<TrOOP amount>**] for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year.

* [*Plans that do not reduce the copays for Medi-Cal-covered drugs in the catastrophic coverage stage should insert the following language:* To locate more information about which of your prescriptions are covered by Medi-Cal versus Medicare, see the *List of Covered Drugs*,[*plans may insert reference, as applicable*].]

**Changes to prescription drug costs** [*option for plans with a single payment stage*]

[Plans with one payment stage (i.e., those with no cost-sharing for all Part D drugs), include the following information.]

[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2019. Read below for more information about your prescription drug coverage.]

[Insert if applicable: **We moved some of the drugs on the Drug List to a lower or higher drug tier**. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To see if your drugs will be in a different tier, look them up in the Drug List.]

The following table shows your costs for drugs in each of our <number of tiers> drug tiers.

[Plans must list all drug tiers in the following table.]

|  | 2018 (this year) | **2019 (next year)** |
| --- | --- | --- |
| **Drugs in Tier <Tier number>**  ([Insert short description of tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | [Insert 2018 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] | [Insert 2019 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription.**] |
| **Drugs in Tier <Tier number>**  ([Insert short description of tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | [Insert 2018 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] | [Insert 2019 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription.**] |

**F. Administrative changes**

[This section is optional. Plans with administrative changes that impact members (e.g., changes in prior authorization requirements, change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below.]

|  | **2018 (this year)** | **2019 (next year)** |
| --- | --- | --- |
| [Insert a description of the administrative process/item that is changing] | [Insert 2018 administrative description] | [Insert 2019 administrative description] |
| [Insert a description of the administrative process/item that is changing] | [Insert 2018 administrative description] | [Insert 2019 administrative description] |

**G. How to choose a plan**

## G1. How to stay in our plan

We hope to keep you as a member next year.

You do not have to do anything to stay in your health plan.If you do not sign up for a different Cal MediConnect plan, change to a Medicare Advantage Plan, or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2019.

## G2. How to change plans

[*Plans in states that continue to implement a continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) insert:* You can end your membership at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Cal MediConnect plan, or moving to Original Medicare.]

[*Plans in states that implement the new duals SEP effective 2019, insert:* Most people with Medicare can end their membership during certain times of the year. Because you have Medi-Cal, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

* January to March
* April to June
* July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

* The **Annual Enrollment Period,** which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in <plan name> will end on December 31 and your membership in the new plan will start on January 1.
* The **Medicare Advantage Open Enrollment Period,** which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan will start the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

* Medicare or the state of California has enrolled you into a Cal MediConnect plan,
* Your eligibility for Medi-Cal or Extra Help has changed,
* You are getting care in a nursing home or a long-term care hospital, or
* You have moved.]

**NOTE**: If you are in a drug management program, you may not be able to join a different plan. See Chapter 5 [*plans may insert reference, as applicable*] of your *Member Handbook* for information about drug management programs.

**How you will get Medicare services**

You will have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our Cal MediConnect plan:

|  |  |
| --- | --- |
| **1. You can change to:**  **A Medicare health plan, such as a Medicare Advantage plan or, if you meet eligibility requirements, a Program of All-inclusive Care for the Elderly (PACE)** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan.  For PACE inquiries, call 1-855-921-PACE (7223).  If you need help or more information:   * Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. [*TTY/TDD phone number is optional.*]For more information or to find a local HICAP office in your area, please visit <https://www.aging.ca.gov/HICAP/>.   You will automatically be disenrolled from <plan name> when your new plan’s coverage begins. |
| **2. You can change to:**  **Original Medicare with a separate Medicare prescription drug plan** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. [*TTY/TDD phone number is optional.*]For more information or to find a local HICAP office in your area, please visit <https://www.aging.ca.gov/HICAP/>.   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |
| **3. You can change to:**  **Original Medicare without a separate Medicare prescription drug plan**  **NOTE**: 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 tell Medicare you don’t want to join.  You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit <http://www.aging.ca.gov/HICAP/>. | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. [*TTY/TDD phone number is optional.*]For more information or to find a local HICAP office in your area, please visit <https://www.aging.ca.gov/HICAP/>.   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |

**How you will get Medi-Cal services**

If you leave our Cal MediConnect plan, you will be enrolled in a Medi-Cal managed care plan of your choice. Your Medi-Cal services include most long-term services and supports and behavioral health care.

When you ask to end your membership in our Cal MediConnect plan, you will need to let Health Care Options know which Medi-Cal managed care plan you want to join. You can call Heath Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077.

**H. How to get help**

## H1. Getting help from <plan name>

Questions? We’re here to help. Please call Member Services at <phone number> (TTY only, call <TTY number>). We are available for phone calls <days and hours of operation>.

**Read your *2019 Member Handbook***

The *2019* *Member Handbook* is the legal, detailed description of your plan benefits. It has details about next year's benefits [*insert if applicable:* and costs]. It explains your rights and the rules you need to follow to get covered services and prescription drugs.

[If the ANOC is sent or provided separately from the Member Handbook, include the following: The 2019 Member Handbook will be available by October 15.] An up-to-date copy of the *2019 Member Handbook* is always available on our website at <web address>. You may also call Member Services at <phone number> to ask us to mail you a *2019* *Member Handbook*.

**Our website**

You can also visit our website at <web address>. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

## H2. Getting help from the state enrollment broker

[Plans should insert information about the enrollment broker, including a brief description on what kind of help the enrollment broker can provide.] You can call Heath Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077.

## H3. Getting help from the Cal MediConnect Ombuds Program

The Cal MediConnect Ombuds Program can help you if you are having a problem with <plan name>. The ombudsman’s services are free. The Cal MediConnect Ombuds Program:

* Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.
* Makes sure you have information related to your rights and protections and how you can get your concerns resolved.
* Is not connected with us or with any insurance company or health plan. The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077.

## H4. Getting help from the Health Insurance Counseling and Advocacy Program

You can also call the State Health Insurance Assistance Program (SHIP). In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can help you understand your Cal MediConnect plan choices and answer questions about switching plans. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. HICAP’s phone number is 1-800-434-0222. [*TTY/TDD phone number is optional.*] For more information or to find a local HICAP office in your area, please visit <https://www.aging.ca.gov/HICAP/>.

## H5. Getting help from Medicare

To get information directly from Medicare, 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.

**Medicare’s Website**

You can visit the Medicare website (<https://www.medicare.gov/>). If you choose to disenroll from your Cal MediConnect plan and enroll in a Medicare Advantage plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare Medicare Advantage plans. You can find information about Medicare Advantage 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.”)

***Medicare & You 2019***

You can read the *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.

## H6. Getting help from the California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at [insert health plan's telephone number] and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site [http://www.dmhc.ca.gov](http://www.dmhc.ca.gov/?referral=hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.