Anthem

Your guide to your 2023 benefits

Annual Notice of Changes

Anthem MediBlue Full Dual Advantage (HMO D-SNP)

Member Services:
1-833-707-3129 TTY: **711**

www.anthem.com/ca

Anthem

Thank you for being a valued member

We appreciate your continued trust in us as your healthcare partner. Anthem Blue Cross Partnership Plan is committed to delivering affordable healthcare and helping our members to improve and maintain their health. We are focused on delivering care that has the power to improve whole-person health so you can focus on the things you love.

We are putting people at the center of everything we do. This is why our Medicare Advantage plans are created to offer the benefits and services that members like you will find most useful to help save money and be your healthiest.

This booklet makes it easier to understand next year's coverage. Your Annual Notice of Changes compares your 2022 benefits to your 2023 benefits. Your 2023 plan information will be available online within your secure online account at **www.anthem.com/ca** on October 15 in preparation for the Annual Election Period that runs from October 15 through December 7, 2022.

On January 1, 2023, your current Anthem Blue Cross Cal MediConnect (Medicare-Medicaid Plan) plan will be combined with another plan, Anthem MediBlue Full Dual Advantage (HMO D-SNP). This means starting January 1, 2023, you will be receiving your medical coverage through Anthem MediBlue Full Dual Advantage (HMO D-SNP).

Your new plan provides integrated care and information across both Medicare and Medicaid plans beginning January 1, 2023. You will be receiving a new ID card in the mail. No action is needed.

Your Cal MediConnect plan, Anthem Blue Cross Cal MediConnect plan (Medicare-Medicaid plan) will change. You will be enrolled in the same Medicare and Medi-Cal plans, Anthem MediBlue Full Dual Advantage (HMO D-SNP) and Anthem Medi-Cal, provided by the same company that provides your Cal MediConnect plan. These plans will jointly be referred to as the Medicare Medi-Cal Plans (MMPs or Medi-Medi plans) and is designed to coordinate care for people with both Medicare and Medi-Cal. You will still get the same health care benefits as you do now.

You will continue to get services through Cal MediConnect until December 31, 2022. On January 1, 2023, you will automatically start getting services through the Medicare Medi-Cal Plans (MMPs or Medi-Medi plans). If you are in a Cal MediConnect plan now, you do not need to do anything to enroll and keep your current benefits.

The Medicare Medi-Cal Plans (MMPs or Medi-Medi plans) will help you with all of your health care needs and will continue to coordinate your benefits and care. This includes medical and home and community-based services. It also includes medical supplies and medications. The plan will include the doctors you use now or help you find a new doctor that you like. You will start getting letters about this change in October 2022. We will send you integrated member materials, such as one integrated Member ID Card and Member Handbook.

You don't have to do anything this fall to keep getting your health care from the plan you have now. If you have questions about your coverage in 2022, contact your current Cal MediConnect plan.

Thanks again for being a valued Anthem Blue Cross Partnership Plan member. If you have any questions, you can always call us at **1-833-707-3129** (TTY: **711**).

Anthem MediBlue Full Dual Advantage (HMOD-SNP) offered by Anthem Blue Cross

Annual Notice of Changes for 2023

Introduction

You are currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules, and costs. This *Annual Notice of Changes* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook,* which is located on our website at shop.anthem.com/medicare/ca. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Disclaimers

- Anthem Blue Cross is an HMO D-SNP plan with a Medicare contract and a contract with the California Medicaid program. Enrollment in Anthem Blue Cross depends on contract renewal. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Anthem MediBlue Full Dual Advantage (HMO D-SNP) Plan *Member Handbook*.
- Using opioid medications to treat pain for more than seven days has serious risks like - addiction, overdose, or even death. If your pain continues, talk to your doctor about alternative treatments with less risk. Some choices to ask your doctor about are: Non opioid medications, acupuncture, or physical therapy to see if they are right for you. Find out how your plan covers these options by calling Member Services at **1-833-707-3129** (TTY: **711**).
- CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of your health plan.

B. Reviewing your Medicare and Medi-Cal coverage for next year

When this *Annual Notice of Changes* says “we,” “us,” “our,” or “our plan,” it means the Medicare Medi-Cal Coordination Plan.

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn’t meet your needs, you may be able to leave our plan. Refer to **Section E** for more information.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and Medi-Cal programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2**.
- Medi-Cal services in **Section G2**.

B1. Additional resources

- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-833-707-3129** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. Llame al **1-833-707-3129** (TTY: **711**), de lunes a viernes, de 8:00 a. m. a 8:00 p. m. La llamada es gratuita.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-833-707-3129** (TTY: **711**)，週一至週五上午 8：00-晚上 8：00。通話免費。	Chinese
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ, miễn phí, cho quý vị. Xin gọi số **1-833-707-3129** (TTY: **711**), Thứ Hai đến Thứ Sáu từ 8:00 sáng đến 8:00 tối. Cuộc gọi được miễn tính cước phí.	Vietnamese
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo nang walang bayad ang mga serbisyo ng tulong sa wika. Tumawag sa **1-833-707-3129** (TTY: **711**), Lunes hanggang Biyernes, 8:00 a.m. hanggang 8:00 p.m. Libre ang tawag.	Tagalog

- You can get this *Annual Notice of Changes* for free in other formats, such as large print, braille, or audio. Call **1-833-707-3129** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.
- You can get this document for free in other languages and formats, such as large print, braille, data or audio CD. Call Member Services at the number listed on the bottom of this page. When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at shop.anthem.com/medicare/ca.

B2. Information about our Plan

- Anthem MediBlue Full Dual Advantage (HMO D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to members.
- Coverage under Anthem MediBlue Full Dual Advantage (HMO D-SNP) is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

B3. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit 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 tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - 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 **Anthem MediBlue Full Dual Advantage (HMO D-SNP)**	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 automatically stay enrolled in Anthem MediBlue Full Dual Advantage (HMO D-SNP).	If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare your new coverage will begin on the first day of the following month.

C. Changes to our plan name

On January 1, 2023, our plan name changes from Anthem Blue Cross Cal MediConnect Plan (MMP) to Anthem MediBlue Full Dual Advantage (HMO D-SNP).

We are sending you a new member ID card due to a change in the plan name. Please begin using this new member ID card starting January 1, 2023. Your old card should be destroyed. Please check your new card to make sure your information is accurate. If any corrections need to be made, please contact Member Services at the number listed on your member ID card.

D. Changes to our network providers and pharmacies

Our provider and pharmacy networks have changed for 2023.

We strongly encourage you to **review our current *Provider and Pharmacy Directory*** to find out if your providers or pharmacy are still in our network. An updated *Provider and Pharmacy Directory* is located on our website at shop.anthem.com/medicare/ca. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

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

E. Changes to benefits for next year

E1. Changes to benefits for medical services

We're changing our coverage for certain medical services next year. The table below describes these changes.

	2022 (this year)	2023 (next year)
Routine dental services (Including, but not limited to, routine exams, cleanings, X-rays) **Comprehensive dental services** (Including, but not limited to, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	**$0.00 copay** Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program.	**$0.00 copay** Certain dental services, including exams, cleaning and dental X-rays. Comprehensive dental services are limited to $1,500.00 per year. Prior Authorization is required. Additional benefits may be available through Medi-Cal. Contact your care coordinator or refer to the *Member Handbook* for details.
Vision services (Including glasses and contacts)	**$0.00** copay for eye exams glasses and/or contacts. This plan covers **$100.00** each calendar year for glasses/contacts.	**$0.00** copay for eye exams and glasses and/or contacts This plan covers **$300.00** each calendar year for glasses/contacts. Additional benefits may be available through Medi-Cal. Contact your care coordinator or refer to the *Member Handbook* for details.

	2022 (this year)	2023 (next year)
Hearing aids (Including fittings, associated accessories and supplies)	**$0.00** copay for hearing aids Coverage is limited to **$1,510.00** for plan approved hearing aids.	**$0.00** copay for prescribed hearing aids This plan covers **$3,000.00** each calendar year for hearing aids covered by the plan and prescribed by a doctor. Prior Authorization is required. Additional benefits may be available through Medi-Cal. Contact your care coordinator or refer to the *Member Handbook* for details.
Podiatry services (Including routine exams)	**$0.00** copay for 12 routine podiatry visits each year Prior Authorization is required.	**$0.00** copay for unlimited routine podiatry visits each year Prior Authorization and referral are required.
Over the Counter (OTC)	This plan only covers OTC prescribed by a doctor and approved by Medi-Cal.	This plan offers **$200.00** per quarter for non-prescribed OTC health products. The allowance rolls over each quarter but does not roll over annually. Additional coverage is available through Medi-Cal Rx for non-health OTC and other prescribed OTC. Refer to your *Member Handbook* for details.

	2022 (this year)	2023 (next year)
Fitness Programs	**SilverSneakers©:** $0.00 copay **Nifty After Fifty fitness program:** This plan includes coverage for virtual and in-person exercise programs to help you stay fit.	**SilverSneakers©:** $0.00 copay **Nifty After Fifty fitness program:** This plan no longer offers this benefit **Fitness Tracker:** $0.00 copay Members are eligible to receive a wearable fitness tracker device for a $0.00 copay once every 2 years. **Flex Account- Active Fitness**: $0.00 copay This plan covers $25.00 per month allowance for the payment of access fees for fitness and recreational classes/programs provided by sports fitness facilities such as golf courses, swimming pools, and tennis courts where access fees apply. Any unused funds will roll over from month to month but do not roll over to the next calendar year.

	2022 (this year)	2023 (next year)
Transportation	**$0.00** copay Unlimited trips to plan approved locations	**$0.00** copay for unlimited trips to plan approved locations. Please refer to your *Member Handbook* for details and limitations.
Meals	**Post Discharge Meals:** **$0.00** copay for 2 meals per day for up to 7 days following an inpatient hospital or skilled nursing facility stay.	**Post Discharge Meals:** **$0.00** copay for 2 meals per day up to 7 days following an inpatient hospital or skilled nursing facility stay. **Healthy Meals:** **$0.00** copay for 2 meals per day for up to 90 days to assist in managing a healthy lifestyle.
Personal Emergency Response (PERS)	This plan does not cover this benefit.	**$0.00** copay This plan offers one Personal Emergency Response (PERS) Unit which includes the monitoring device and monitoring service.
Smoking Cessation	This plan does not cover this benefit.	**$0.00** copay This plan includes coverage for certain smoking cessation products. Refer to your *Member Handbook* for details.

	2022 (this year)	2023 (next year)
Essential Extras	This plan does not offer essential extras.	**$0.00** copay This plan covers additional services not covered by Original Medicare. You may choose two (2) Essential Extras supplemental benefits from the options below to add to your coverage. There is no additional cost for these benefits. **Assistive Devices**: $500.00 annual allowance **Flex Account – Dental, Vision, Hearing**: $500.00 annual allowance **Flex Account - Utilities**: $50.00 every month **In-Home Support:** 60 hours per year **Transportation:** 60 one-way trips every year **Healthy Groceries**: $50.00 monthly allowance To make a benefit selection, contact member services or refer to your *Member Handbook* for more details.
Worldwide Emergency Coverage (Includes emergency and urgently needed services while out of the United States)	This plan covers up to $10,000 for worldwide emergency care.	This plan covers up to $100,000 for worldwide emergency care.

E2. Changes to prescription drug costs

Changes to our Drug List

An updated List of Covered Drugs is located on our website at shop.anthem.com/medicare/ca. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a List of Covered Drugs.

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 find out if there are 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 the numbers at the bottom of the page to ask for a list of covered drugs that treat the same condition.
    - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
    - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
    - This temporary supply is for up to 30 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
    - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

Some drugs may require new Formulary exceptions next year.

Changes to prescription drug costs
The following table shows your costs for drugs in each of our 5 drug tiers.

	2022 (this year)	2023 (next year)
Drugs in Tier 1 Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy.	Your copay for a one-month 30-day supply is $0.00 per prescription. Tier 1 includes coverage for both generic and brand name drugs.	Your copay for a one-month 30-day supply is $0.00 per prescription. Tier 1 is limited to preferred generic drugs. 100-day supply is available for the same price as a 30-day supply. Additional drug coverage may be available for non-formulary drugs through Medi-Cal Rx. Refer to your *Member Handbook* for details.
Drugs in Tier 2 Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy.	Your copay for a one-month 30-day supply is $0.00-$9.85 copay per prescription. Tier 2 includes coverage for Medicare Part D preferred and non-preferred brand and generic drugs.	Your copay for a one-month 30-day supply is $0.00 copay per prescription. Tier 2 is limited to Generic drugs. Brand Name drugs have moved to Tier 3 and 4. Additional drug coverage is offered through Medi-Cal Rx. Refer to your *Member Handbook* for details.

	2022 (this year)	2023 (next year)
Drugs in Tier 3 Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy.	Your copay for a one-month 30-day supply is $0.00 copay per prescription. Tier 3 is limited to Medi-Cal State approved prescription generic and brand name drugs.	Your copay for a one-month 30-day supply is $0.00 copay per prescription. Tier 3 is limited to Preferred Brand drugs. Additional drug coverage is offered through Medi-Cal Rx. Refer to your *Member Handbook* for details.
Drugs in Tier 4 Cost for a one-month supply of a drug in Tier 4 that is filled at a network pharmacy.	Your copay for a one-month 30-day supply is $0.00 copay per prescription. Tier 4 is limited to prescribed Medi-Cal State approved over-the-counter (OTC) drugs. Coverage is limited to Medi-Cal State approved over the counter (OTC) drugs that require a prescription from your provider.	Your copay for a one-month 30-day supply is $0.00 copay per prescription. Tier 4 is limited to Non-Preferred Brand name drugs. Additional coverage is offered for over-the-counter (OTC) drugs through Medi-Cal Rx. Refer to your *Member Handbook* for details.
Drugs in Tier 5 Cost for a one-month supply of a drug in Tier 5 that is filled at a network pharmacy.	This plan does not include a Tier 5 on the Drug List.	Your copay for a one-month 30-day supply is $0.00 copay per prescription. Tier 5 is limited to Specialty Drugs. Additional drug coverage is offered through Medi-Cal Rx. Refer to your *Member Handbook* for more details.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

F. Administrative changes

	2022 (this year)	2023 (next year)
Pharmacy benefit manager (PBM)	Your pharmacy benefit manager name is IngenioRx.	Your pharmacy benefit manager name is CarelonRx. This name change will not impact your benefits or how you fill your prescriptions.
Advanced Directives	This plan does not offer an advance planning service.	You will have access to an online advance care planning resource.
Drug List	This plan uses the MMP Drug List.	This plan uses the Advantage drug list. Please refer to the Drug List to see if coverage for the drugs you are taking has changed.

G. Choosing a plan

G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2023.

G2. Changing plans

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 our plan ends on December 31 and your membership in the new plan starts 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 starts 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:

- You moved out of our service area,
- Your eligibility for Medi-Cal or Extra Help changed, **or**
- If you recently moved into, currently are getting care in, or just moved out of a nursing home or a long-term care hospital.

Your Medicare services

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

1. You can change to:	Here is what to do:
Another Medicare health plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. 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. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare plan. You will automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan may change.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

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 have drug coverage from another source, such as an employer or union. 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 www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

H. Getting help

H1. Our plan

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits for 2023. It explains your rights and the rules to follow to get services and prescription drugs we cover.

The *Member Handbook* for 2023 will be available by October 15. You can also review the *Member Handbook* to find out if other benefit changes affect you. An up-to-date copy of the *Member Handbook* is available on our website at shop.anthem.com/medicare/ca. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2023.

Our website

You can visit our website at shop.anthem.com/medicare/ca. 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. Health Insurance Counseling and Advocacy Program (HICAP)

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 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. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/.

H3. Ombuds Program

The Health Consumer Alliance Ombuds Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Health Consumer Alliance 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 Health Consumer Alliance Ombuds Program is 1-888-804-3536.

H4. Medicare

To get information directly from Medicare, 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 (www.medicare.gov)

If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")

Medicare & You 2023

You can read the *Medicare & You 2023* 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. The handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

H5. California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. The DMHC Help Center can help you with appeals and complaints about Medi-Cal services. If you have a grievance against your health plan, you should first telephone your health plan at **1-833-707-3129** (TTY: **711**) 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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