



AlohaCare

For a healthy Hawaii.

ALOHACARE ADVANTAGE PLUS (HMO SNP)

2018 | **ANNUAL NOTICE
OF CHANGES**



MedicareRx
Prescription Drug Coverage X

JANUARY 1, 2018 - DECEMBER 31, 2018

AlohaCare Advantage Plus (HMO SNP) offered by AlohaCare

Annual Notice of Changes for 2018

You are currently enrolled as a member of AlohaCare Advantage Plus. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells you 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 Section 1.5 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 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- 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 1.3 and 1.4 for information about our Provider & Pharmacy 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 2.2 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** AlohaCare Advantage Plus, you don’t need to do anything. You will stay in AlohaCare Advantage Plus.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans at any time. Your new coverage will begin on the first day of the following month. Look in Section 2.2, page 13 to learn more about your choices.

Additional Resources

- Please contact our Member Services number at 1-866-973-6395 for additional information. (TTY/TDD users should call 1-877-447-5990.) Hours are 8 a.m. to 8 p.m, 7 days a week.
- This information is available in large print. Please contact Member Services for more information (phone numbers are in Section 6.1 of this booklet).
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** 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 AlohaCare Advantage Plus

- AlohaCare Advantage Plus is an HMO SNP with a Medicare contract and a contract with the Hawaii Medicaid program. Enrollment in AlohaCare Advantage Plus depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means AlohaCare. When it says “plan” or “our plan,” it means AlohaCare Advantage Plus.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for AlohaCare Advantage Plus 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 *Evidence of Coverage* to see if other benefit or cost changes affect you.**

Cost	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 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 1.6 for details.)	Deductible: \$0 Copayments during the Initial Coverage Stage: <ul style="list-style-type: none"> • Drug Tier 1: For Generic Drugs \$0 or \$1.20 or \$3.30 copay • For all other drugs \$0 or \$3.70 or \$8.25 	Deductible: \$0 Copayment during the Initial Coverage Stage: <ul style="list-style-type: none"> • Drug Tier 1: For Generic Drugs \$0 or \$1.25 or \$3.35 copay • For all other drugs \$0 or \$3.70 or \$8.35

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	\$6,700	\$6,700

Annual Notice of Changes for 2018

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (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 1.2 – 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	2017 (this year)	2018 (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 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider & Pharmacy Directory is located on our website at www.AlohaCare.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider & 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 1.4 – 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 & Pharmacy Directory is located on our website at www.AlohaCare.org. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Provider & Pharmacy Directory to see which pharmacies are in our network.**

Section 1.5 – 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 *2018 Evidence of Coverage*. A copy of the *Evidence of Coverage* was included in this envelope.

Cost	2017 (this year)	2018 (next year)
<p>Dental services - Comprehensive Dental Care includes Preventive and Restorative services</p> <ul style="list-style-type: none"> • Medicare-covered dental benefits • Preventive dental services: <ul style="list-style-type: none"> ○ 2 oral exams every year ○ 2 cleanings every year ○ 2 dental x-rays every year • Restorative dental services: <ul style="list-style-type: none"> ○ Endodontics (root canals) ○ Extractions (removal of teeth) ○ Prosthodontics (dentures, crowns, veneers) 	<p>In-Network</p> <p>\$0 copay for Medicare-covered dental benefits.</p> <p>\$0 copay for preventive dental benefits.</p> <p>\$0 copay for restorative dental services.</p> <p>\$500 plan coverage limit for restorative dental services each year.</p> <p>No additional comprehensive dental benefits covered beyond \$500 max coverage.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered dental benefits.</p> <p>\$0 copay for preventive dental benefits.</p> <p>\$0 copay for restorative dental services.</p> <p>\$2,000 plan coverage limit for preventive and restorative dental services each year.</p> <p>No additional comprehensive dental benefits covered beyond \$2,000 max coverage.</p>

Cost	2017 (this year)	2018 (next year)
Over-the-Counter Items	<p>You pay a \$0 copay.</p> <p>This benefit is a \$60 quarterly credit. The items covered by the benefit are limited to items that are consistent with CMS guidance.</p> <p>Credits do not carry over from quarter to quarter.</p>	<p>You pay a \$0 copay.</p> <p>This benefit is a \$75 quarterly credit. The items covered by the benefit are limited to items that are consistent with CMS guidance.</p> <p>Credits do not carry over from quarter to quarter.</p> <p>Delivery service may be available when medically necessary and prior authorized.</p>
<p>Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation</p>	<p>In-Network \$0 copay for each Medicare-covered chiropractic service.</p>	<p>In-Network 20% coinsurance for each Medicare-covered chiropractic service.</p>

Cost	2017 (this year)	2018 (next year)
<p>World Wide Benefit for Emergency Care and Urgent Care</p> <p>Outside the U.S., there is a plan annual maximum covered benefit limit of \$1,000. You pay \$0 copay for services up to the \$1,000 benefit maximum. Amounts that you pay above the \$1,000 are excluded from your annual maximum out-of-pocket costs, and are not covered by the plan. You will have to pay the facility or provider directly for services. To file a claim, bring your itemized list and receipts of services received to AlohaCare Advantage Plus. Receipts must be in English with billed charges in U.S. dollars. AlohaCare Advantage Plus will reimburse you up to your benefit limit.</p>	<p>You pay \$0 copay up to the \$1,000 plan coverage limit for emergency services outside the U.S. and its territories every year.</p> <p>You pay for any amount over \$1,000 for world-wide emergency care.</p>	<p>You pay \$0 copay up to the \$1,000 plan coverage limit for emergency and urgent services outside the U.S. and its territories every year.</p> <p>You pay for any amount over \$1,000 for world-wide emergency and urgent care.</p>

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.”

For more information on the Drug List, please call us and request the Comprehensive Formulary (Drug List). You can view the Comprehensive Formulary (Drug List) at our website (<http://www.alohacare.org/Medicare/ACAP/MemberDocuments.aspx>). Or, call us and we will send you a copy of the Comprehensive Formulary (Drug List).

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 Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, 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.

Current formulary exceptions will not be covered for the next year. You must request a new formulary exception for the next year. Contact the plan for more information. Phone numbers are in Section 6.1 of this booklet.

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 does not apply to you.** We sent you 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 haven’t received this insert by September 30th, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are in Section 6.1 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	2017 (this year)	2018 (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	2017 (this year)	2018 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>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; at a network pharmacy that offers preferred cost-sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Drug Tier 1: For Generic Drugs You pay \$0 or \$1.20 or \$3.30 per prescription.</p> <p>For all other drugs: You pay \$0 or \$3.70 or \$8.25 per prescription.</p> <p>Once you have paid \$4,950 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Drug Tier 1: For Generic Drugs You pay \$0 or \$1.25 or \$3.35 per prescription.</p> <p>For all other drugs: You pay \$0 or \$3.70 or \$8.35 per prescription.</p> <p>Once you have paid \$5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

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 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in AlohaCare Advantage Plus

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 2018.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan at any time,
- -- OR-- You can change to Original Medicare at any time.

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 2018*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 AlohaCare Advantage Plus.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from AlohaCare Advantage Plus.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 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 3 Deadline for Changing Plans

Because you are eligible for Medicare and Full Medicaid Benefits you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 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 Hawaii, the SHIP is called Hawaii SHIP.

Hawaii SHIP 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. Hawaii SHIP 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 Hawaii SHIP at (808) 586-7299. You can learn more about Hawaii SHIP by visiting their website (www.hawaiiiship.org).

For questions about your QUEST Integration (Medicaid) benefits, contact (808) 587-3540. Ask how joining another plan or returning to Original Medicare affects how you get your QUEST Integration (Medicaid) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“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 QUEST Integration (Medicaid) Office (applications).

SECTION 6 Questions?

Section 6.1 – Getting Help from AlohaCare Advantage Plus

Questions? We’re here to help. Please call Member Services at 973-6395. (TTY/TDD only, call 1-877-447-5990.) We are available for phone calls 8:00 a.m. to 8:00 p.m., 7 days a week. Calls to these numbers are free.

Read your 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for AlohaCare Advantage Plus. 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. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

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

Section 6.2 – 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 2018*

You can read *Medicare & You 2018* 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 6.3 – Getting Help from QUEST Integration (Medicaid)

To get information from QUEST Integration (Medicaid), you can call Med-QUEST Enrollment Services at 1-800-316-8005. TTY/TDD users should call 1-800-603-1201.

AlohaCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AlohaCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AlohaCare provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact AlohaCare's Compliance Officer.

If you believe that AlohaCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AlohaCare

Attn: Grievance and Appeals Department
1357 Kapiolani Blvd., Ste. 1250
Honolulu, HI 96814
Phone: 973-0712
Toll-free: 1-877-973-0712
TTY/TDD: 1-877-447-5990
Fax: 973-2140
Email: Compliance@alohacare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, AlohaCare's Grievance and Appeals Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



AlohaCare

For a healthy Hawaii.

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