Care1st AdvantageOptimum Plan (HMO) offered by Care1st Health Plan

Annual Notice of Changes for 2017

You are currently enrolled as a member of Care1st AdvantageOptimum Plan. Next year, there will be some changes to the plan’s costs and benefits. This booklet tells about the changes.

- You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

Additional Resources

- This information is available for free in other languages.
- Please contact our Member Services number at 1-800-544-0088 for additional information. (TTY users should call 711. Hours are 8am – 8pm, seven days a week.
- Member Services also has free language interpreter services available for non-English speakers.

Minimum essential coverage (MEC): 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 on the individual requirement for MEC.

About Care1st AdvantageOptimum Plan

- Care1st Health Plan is an HMO and an HMO SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Care1st Health Plan depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Care1st Health Plan. When it says “plan” or “our plan,” it means Care1st AdvantageOptimum Plan.
Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It’s important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

☐ Check the changes to our benefits and costs to see if they affect you. Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes to our prescription drug coverage to see if they affect you. Will your drugs be covered? Are they in a different 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 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 for information about our Provider Directory.

☐ Think about your overall health care costs. How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

If you decide to stay with Care1st AdvantageOptimum Plan:

If you want to stay with us next year, it’s easy - you don’t need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 2.2 to learn more about your choices.
## Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Care1st AdvantageOptimum Plan 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 enclosed Evidence of Coverage to see if other benefit or cost changes affect you.**

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong>*</td>
<td>$22</td>
<td>$49</td>
</tr>
<tr>
<td>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits: $0 per visit</td>
<td>Primary care visits: $0 per visit</td>
<td></td>
</tr>
<tr>
<td>Specialist visits: $5 per visit</td>
<td>Specialist visits: $5 per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Days 1-5 $175 copay per day</td>
<td>Days 1-5 $175 copay per day</td>
</tr>
<tr>
<td>Days 6-90: $0 copay per day</td>
<td>Days 6-90: $0 copay per day</td>
<td></td>
</tr>
<tr>
<td>Unlimited additional days</td>
<td>Unlimited additional days</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>2016 (this year)</td>
<td>2017 (next year)</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| **Part D prescription drug coverage**  
(See Section 1.6 for details.) | Deductible: $0 | Deductible: $0 |
|  | Copayment/Coinsurance during the Initial Coverage Stage: | Copayment/Coinsurance during the Initial Coverage Stage: |
|  | • Drug Tier 1: $0 for a one-month (30-day) supply /$0 for a three-month (90-day) supply | • Drug Tier 1: $0 for a one-month (30-day) supply /$0 for a three-month (90-day) supply |
|  | | • Drug Tier 2: $5 for a one-month (30-day) supply /$12.50 for a three-month (90-day) supply |
|  | | • Drug Tier 2: $5 for a one-month (30-day) supply /$12.50 for a three-month (90-day) supply |
|  | | Drug Tier 3: $30 for a one-month (30-day) supply /$75 for a three-month (90-day) supply |
|  | | Drug Tier 3: $40 for a one-month (30-day) supply /$100 for a three-month (90-day) supply |
|  | | Drug Tier 4: $75 for a one-month (30-day) supply /$187.50 for a three-month (90-day) supply |
|  | | Drug Tier 4: $80 for a one-month (30-day) supply /$200 for a three-month (90-day) supply |
|  | | Drug Tier 5: 33% of the total cost. |
|  | | Drug Tier 5: 33% of the total cost. |
Think about Your Medicare Coverage for Next Year .................................................. 2

Summary of Important Costs for 2017 ........................................................................ 3

SECTION 1 Changes to Benefits and Costs for Next Year ......................................... 6
Section 1.1 – Changes to the Monthly Premium ........................................................... 6
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount .............................. 6
Section 1.3 – Changes to the Provider Network ......................................................... 7
Section 1.4 – Changes to the Pharmacy Network ....................................................... 7
Section 1.5 – Changes to Benefits and Costs for Medical Services ............................ 8
Section 1.6 – Changes to Part D Prescription Drug Coverage .................................... 8

SECTION 2 Deciding Which Plan to Choose ............................................................. 11
Section 2.1 – If you want to stay in Care1st AdvantageOptimum Plan ....................... 11
Section 2.2 – If you want to change plans ................................................................. 11

SECTION 3 Deadline for Changing Plans ............................................................... 12

SECTION 4 Programs That Offer Free Counseling about Medicare ...................... 122

SECTION 5 Programs That Help Pay for Prescription Drugs ................................. 133

SECTION 6 Questions? ............................................................................................ 133
Section 6.1 – Getting Help from Care1st AdvantageOptimum Plan ......................... 133
Section 6.2 – Getting Help from Medicare .............................................................. 144
SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$22</td>
<td>$49</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving “Extra Help” with your prescription drug costs.

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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum out-of-pocket amount</td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.care1stmedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. Please review the 2017 Provider 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.
- When possible we will 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 Pharmacy Directory is located on our website at www.care1stmedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. Please review the 2017 Pharmacy Directory to see which pharmacies are in our network.
Section 1.5 – Changes to Benefits and Costs for Medical Services

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, Medical Benefits Chart (what is covered and what you pay), in your 2017 Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic radiology services (such as MRIs, CT scans)</strong></td>
<td>$0 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Kidney Disease Education Services</strong></td>
<td>Primary Care Physician $0 copay</td>
<td>Primary Care Physician $0 copay</td>
</tr>
<tr>
<td></td>
<td>Specialist: $0 copay</td>
<td>Specialist: $5 copay</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health (Individual / Group)</strong></td>
<td>You pay $10 copay</td>
<td>You pay $25 copay</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse (Individual / Group)</strong></td>
<td>You pay $10 copay</td>
<td>You pay $25 copay</td>
</tr>
<tr>
<td><strong>Psychiatric Services (Individual / Group)</strong></td>
<td>You pay $10 copay</td>
<td>You pay $25 copay</td>
</tr>
<tr>
<td><strong>Renal Dialysis</strong></td>
<td>You pay $10 copay</td>
<td>You pay $25 copay</td>
</tr>
</tbody>
</table>

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.” A copy of our Drug List is in this envelope.

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.**
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 other 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.

For current members whose drug is no longer covered on the formulary, Care1st Health Plan will
cover a transitional supply of the drug for 30 days if the member has had a refill within the last
120 days. Drugs no longer on the formulary due to its generic version being replaced do not
qualify for a transitional supply.

You and your Provider are notified of the expiration date of current exceptions upon the approval
of your exception. If your exception expires in October, November or December and you
received medication under your exception, you will be allowed a temporary 30-day supply of the
medication within the first 90 days of 2017.

Members who are receiving drugs as a result of an approved formulary exception have been
provided with a letter informing them when the exception will expire. Upon expiration of the
exception, Care1st Health Plan will evaluate if an extension can be granted. If granted, the
member will be notified of the new expiration date. If not granted, the original expiration date
will stand. Please review the formulary exception notification provided by Care1st Health Plan.

### Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information
about costs for Part D prescription drugs may not apply to you.** We 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. If you get “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 at Chapter 6, Sections 6 and 7, in the enclosed Evidence of
Coverage.)
### Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1: Yearly Deductible Stage</strong></td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>

### 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*.

<table>
<thead>
<tr>
<th>Stage</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 2: Initial Coverage Stage</strong></td>
<td>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 Evidence of Coverage.</td>
<td></td>
</tr>
<tr>
<td>Tier 1 Preferred Generic Drugs:</td>
<td>You pay $0 per prescription.</td>
<td>Tier 1 Preferred Generic Drugs: You pay $0 per prescription.</td>
</tr>
<tr>
<td>Tier 2 Generic Drugs:</td>
<td>You pay: $5 per prescription.</td>
<td>Tier 2 Generic Drugs: You pay: $5 per prescription.</td>
</tr>
<tr>
<td>Tier 3 Preferred Brand Drugs:</td>
<td>You pay: $30 per prescription.</td>
<td>Tier 3 Preferred Brand Drugs: You pay: $40 per prescription.</td>
</tr>
<tr>
<td>Tier 4 Non-Preferred Drugs:</td>
<td>You pay: $75 per prescription.</td>
<td>Tier 4 Non-Preferred Drugs: You pay: $80 per prescription.</td>
</tr>
<tr>
<td>Tier 5 Specialty Tier Drugs:</td>
<td>You pay: 33% of the total cost</td>
<td>Tier 5 Specialty Tier Drugs: You pay: 33% of the total cost.</td>
</tr>
<tr>
<td></td>
<td>Once your total drug costs have reached $3,310, you need to move to the next tier of cost-sharing.</td>
<td>Once your total drug costs have reached $3,700, you need to move to the next tier of cost-sharing.</td>
</tr>
</tbody>
</table>
Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look 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 Care1st AdvantageOptimum Plan

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 by December 7, you will automatically stay enrolled as a member of our plan for 2017.

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 2017 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2017, 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 http://www.medicare.gov and click “Find health & drug plans.” Here, you can find information about costs, coverage, and quality ratings for Medicare plans.

As a reminder, Care1st Health Plan offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.
Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from Care1st AdvantageOptimum Plan.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from Care1st AdvantageOptimum Plan.
- 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.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from October 15 until December 7. The change will take effect on January 1, 2017.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medi-Cal (Medicaid), those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website (http://www.cahealthadvocates.org/about/HICAP.html).
SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, 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 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
  - Your State Medi-Cal (Medicaid) Office (applications);

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Office of AIDS, www.cdph.ca.gov/programs/aids. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Ramsdell Public Health Rx at 1-888-311-7632.

SECTION 6 Questions?

Section 6.1 – Getting Help from Care1st AdvantageOptimum Plan

Questions? We’re here to help. Please call Member Services at 1-800-544-0088. (TTY only, call 711). We are available for phone calls, 8 a.m. – 8 p.m., seven days a week. Calls to these numbers are free.

Read your 2017 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 2017. For details, look in the 2017 Evidence of Coverage for Care1st AdvantageOptimum Plan. 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.care1stmedicare.com. As a reminder, our website has the most up-to-date information about our provider network (Provider 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 (http://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 http://www.medicare.gov and click on “Find health & drug plans”).

Read Medicare & You 2017

You can read the Medicare & You 2017 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 (http://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