Central Health Ventura Medi-Medi Plan (HMO SNP) offered by Central Health Plan of California

Annual Notice of Changes for 2019

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 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 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?

- Look in Section 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 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** Central Health Ventura Medi-Medi Plan, you don't need to do anything. You will stay in Central Health Ventura Medi-Medi Plan.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Look in Section 2.2, page 12 to learn more about your choices.

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

- If you **don't join another plan by December 31, 2018**, you will stay in Central Health Ventura Medi-Medi Plan.
- If you **join another plan by December 31, 2018**, your new coverage will start the first day of the following month.
- Starting in 2019, there are new limits on how often you can change plans. Look in Section 3, page 13 to learn more.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-866-314-2427 for additional information. (TTY/TDD users should call 1-888-205-7671.) Hours are 8:00 A.M. to 8:00 P.M. (PT), 7 days a week.
- This document may be available in other formats such as Braille, large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Central Health Ventura Medi-Medi Plan

- Central Health Medicare Plan is an HMO plan with a Medicare and Medi-Cal (Medicaid) contract. Enrollment in Central Health Medicare Plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Central Health Plan of California. When it says "plan" or "our plan," it means Central Health Ventura Medi-Medi Plan.

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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Central Health Ventura Medi-Medi 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 separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$35.50	$34.40
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0 per visit.	Primary care visits: $0 per visit Specialist visits: $0 per visit If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $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**.**	You pay $0 for each hospital stay. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.	You pay $0 for each hospital stay. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $405 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 per prescription. • Drug Tier 2: You pay $0 per prescription. • Drug Tier 3: You pay 25% of the total cost. • Drug Tier 4: You pay 25% of the total cost. • Drug Tier 5: You pay 25% of the total cost. • Drug Tier 6: You pay $10.00 per prescription.	Deductible: $415 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 per prescription. • Drug Tier 2: You pay $0 per prescription. • Drug Tier 3: You pay 25% of the total cost. • Drug Tier 4: You pay 25% of the total cost. • Drug Tier 5: You pay 25% of the total cost. • Drug Tier 6: You pay $10.00 per prescription.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$0 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$0 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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SECTION 1 Changes to Medicare Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medi-Cal (Medicaid).)	$35.50	$34.40

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	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medi-Cal (Medicaid), very few members ever reach this out-of-pocket maximum.** If you are eligible for Medi-Cal (Medicaid) assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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.	$0	$0 Once you have paid $0 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 Directory is located on our website at www.centralhealthplan.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 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.
- 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 Pharmacy Directory is located on our website at www.centralhealthplan.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 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 *2019 Evidence of Coverage.* A copy of the *Evidence of Coverage* will be separately mailed to you.

Cost	2018 (this year)	2019 (next year)
Barium Enemas	You pay $0 for Medicare-covered barium enemas. No prior authorization or referral required.	You pay $0 for Medicare-covered barium enemas. Prior authorization and referral required.
Dental Services	You pay $0 for the following preventive dental services: • Two oral exams per year • Two (cleanings) per year • Two dental X-rays per year You may obtain preventive dental services from a network provider.	You pay $0 for the following preventive dental services: • Two oral exams per year • Two (cleanings) per year • Two dental X-rays per year You must obtain preventive dental services from a Delta Dental provider.
Diabetes Self-Management Training	You pay $0 for diabetes self-management training. No prior authorization or referral required.	You pay $0 for diabetes self-management training. Prior authorization and referral required.
Eyewear	You are allowed 1 pair of eyeglasses (frames and lenses) or unlimited pairs of contact lenses per year (up to $300 allowance). Prior authorization required; no referral required.	You are allowed 1 pair of eyeglasses (frames and lenses) or unlimited pairs of contact lenses per year (up to $300 allowance). Prior authorization and referral required.

Cost	2018 (this year)	2019 (next year)
Fitness Benefit	Fitness benefit is not covered.	You will be reimbursed up to $40 per month for monthly gym membership, group fitness classes, and general access to public sports facilities.
Hearing Services	You pay $0 for hearing services. You are allowed one routine hearing exam and one hearing aid fitting / evaluation every year, and up to a $2,000 limit for hearing aids. You are responsible for any amounts beyond this limit. You may obtain hearing aid, routine exam, and fitting from a network provider. Prior authorization and referral required.	You pay $0 for hearing services. You are allowed one routine hearing exam and one hearing aid fitting / evaluation every year, and up to a $2,000 limit for hearing aids. You are responsible for any amounts beyond this limit. You must obtain hearing aid, routine exam, and fitting from NationsHearing. Prior authorization and referral required.
Routine Eye Exams	You pay $0 for routine eye exams (1 exam per year). Prior authorization required; no referral required.	You pay $0 for routine eye exams (1 exam per year). Prior authorization and referral required.

Cost	2018 (this year)	2019 (next year)
Routine Transportation (Changes to cancellation policy)	You pay $0 for up to 14 one-way non-emergency transportation trips to plan-approved locations (up to 25 miles) to receive healthcare services from network providers. Arrangement for transportation must be made through Member Services at least 2 business days in advance. Cancellations must be received by Member Services at least 2 hours prior to the pickup time to avoid counting against your transportation benefit. Prior authorization and referral are required.	You pay $0 for up to 14 one-way non-emergency transportation trips to plan-approved locations (up to 25 miles) to receive healthcare services from network providers. Arrangement for transportation must be made through Member Services at least 2 business days in advance. Cancellations must be received by Member Services at least 24 hours prior to the pickup time to avoid counting against your transportation benefit. Prior authorization and referral are required.
Viagra®	Viagra® is not covered.	You are allowed up to 6 pills per month of brand-name Viagra® at Tier 4 cost-sharing (25% of the total cost). You are allowed up to 6 pills per month of sildenafil (generic Viagra®) at Tier 1 cost-sharing ($0).

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 provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - 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 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.

If you have a current year formulary exception, you will need to submit a new formulary exception request through a doctor for the next calendar year.

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

Starting in 2019, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 30-day, rather than a 60-day, refill of your brand-name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand-name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, 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	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Preferred Brand, Non-Preferred Drug, Specialty Tier, and Select Care drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $83, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) During this stage, you pay $0 cost-sharing for drugs on Preferred Generic and Generic tiers, and the full cost of drugs on Preferred Brand, Non-Preferred Drug, Specialty Tier, and Select Care Drug tiers until you have reached the yearly deductible.	Your deductible amount is either $0 or $85, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) During this stage, you pay $0 cost-sharing for drugs on Preferred Generic and Generic tiers, and the full cost of drugs on Preferred Brand, Non-Preferred Drug, Specialty Tier, and Select Care Drug tiers until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic:** You pay $0 per prescription. **Generic:** You pay $0 per prescription. **Preferred Brand:** You pay 25% of the total cost. **Non-preferred Drug:** You pay 25% of the total cost. **Specialty Tier:** You pay 25% of the total cost. **Select Care Drugs:** You pay $10.00 per prescription. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic:** You pay $0 per prescription. **Generic:** You pay $0 per prescription. **Preferred Brand:** You pay 25% of the total cost. **Non-preferred Drug:** You pay 25% of the total cost. **Specialty Tier:** You pay 25% of the total cost. **Select Care Drugs:** You pay $10.00 per prescription. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Central Health Ventura Medi-Medi 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, you will automatically stay enrolled as a member of our plan for 2019.

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 2019 follow these steps:

Step 1: Learn about and compare your choices

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

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

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

As a reminder, Central Health Plan of California 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 Central Health Ventura Medi-Medi Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Central Health Ventura Medi-Medi 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.

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 Changing Plans

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

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

In certain situations, changes are also allowed at other times of the year. For example, people with 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 may be allowed to make a change at other times of the year. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage.*

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

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

SECTION 4 Programs That Offer Free Counseling about Medicare and Medi-Cal (Medicaid)

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

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website (www.aging.ca.gov/HICAP).

For questions about your Medi-Cal (Medicaid) benefits, contact Medi-Cal (Medicaid) at 1-800-541-5555 (outside of California, please call 1-916-636-1980) (TTY, please call 1-916-635-6491). The Telephone Service Center is available 8:00 A.M. to 5:00 P.M., Monday through Friday, except holidays. If you are enrolled in a Medi-Cal (Medicaid) HMO Plan, you may contact your plan using the phone number on your Medi-Cal (Medicaid) HMO Plan membership ID card. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal (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 Medi-Cal (Medicaid), you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **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. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050.

SECTION 6 Questions?

Section 6.1 – Getting Help from Central Health Ventura Medi-Medi Plan

Questions? We're here to help. Please call Member Services at 1-866-314-2427. (TTY/TDD only, call 1-888-205-7671.) We are available for phone calls 8:00 A.M. to 8:00 P.M. (PT), 7 days a week. Calls to these numbers are free.

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

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Central Health Ventura Medi-Medi 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* will be separately mailed to you.

Visit our Website

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

Read *Medicare & You 2019*

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

Section 6.3 – Getting Help from Medi-Cal (Medicaid)

To get information from Medi-Cal (Medicaid), you can call the Department of Health Care Services at 1-800-541-5555 (outside of California, please call 1-916-636-1980). TTY users should call 1-916-635-6491. If you are enrolled in a Medi-Cal (Medicaid) HMO Plan, you may contact your plan using the phone number on your Medi-Cal (Medicaid) HMO Plan membership ID card.