CENTRAL HEALTH PREMIER PLAN

Central Health Premier Plan I (HMO) offered by Central Health Medicare Plan

Annual Notice of Changes for 2024

You are currently enrolled as a member of Central Health Premier Plan I (HMO). Next year, there will be changes to the plan's costs and benefits*.* ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.centralhealthplan.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ 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 don't join another plan by December 7, 2023, you will stay in Central Health Premier Plan I (HMO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Central Health Premier Plan I (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- This document is available for free in Chinese.
- Please contact our Member Services number at (866) 314-2427 for additional information. (TTY users should call 711.) Hours are 8:00 A.M. to 8:00 P.M. (PT), 7 days a week. This call is free.
- 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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Central Health Premier Plan I (HMO)

- Central Health Medicare Plan is an HMO with a Medicare contract. Enrollment in Central Health Medicare Plan depends on contract renewal.
- When this document says "we," "us," or "our", it means Central Health Medicare Plan. When it says "plan" or "our plan," it means Central Health Premier Plan I (HMO).

Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Central Health Premier Plan I (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
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.)	$899	$3,200
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	You pay a $0 per stay	You pay a $0 copay per day for days 1 - 4 You pay a $100 copay per day for days 5 - 10 You pay a $0 copay per day for days 11 - 90
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $35 You pay $35 per month supply of each covered insulin product on this tier.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $35 You pay $35 per month supply of each covered insulin product on this tier.

Cost	2023 (this year)	2024 (next year)
	• Drug Tier 4: $75 • Drug Tier 5: 33% • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	• Drug Tier 4: $75 • Drug Tier 5: 33% • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for 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	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$899	$3,200 Once you have paid $3,200 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 and Pharmacy Networks

Updated directories are also located on our website at www.centralhealthplan.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within the three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Inpatient Hospital Care	You pay a $0 copay per stay	You pay a $0 copay per day for days 1 - 4 You pay a $100 copay for days 5 - 10 You pay a $0 copay for days 11 - 90
Inpatient Services in a Psychiatric Hospital	You pay $0 copay per stay.	You pay a $275 copay per day for days 1 - 5. You pay a $0 copay for days 6 - 90.
Emergency Care	You pay $0 copay per visit if you are admitted to the emergency room within 72 hours of a prior emergency room discharge and $50 copay per visit for all other emergency services.	You pay $0 copay per visit if you are admitted to the emergency room within 72 hours of a prior emergency room discharge and $100 copay per visit for all other emergency services.

Cost	2023 (this year)	2024 (next year)
Worldwide Emergency Coverage	You pay a $25 copay per visit for Worldwide Emergency services. You pay a $25 copay per visit for Worldwide Urgently Needed services. You pay a $25 copay per visit for Worldwide Emergency Transportation services. There is a maximum plan benefit coverage amount of $100,000 for worldwide emergency services, worldwide urgently needed services and worldwide emergency transportation services combined.	You pay a $50 copay per visit for Worldwide Emergency services. You pay a $50 copay per visit for Worldwide Urgently Needed services. You pay a $50 copay per visit for Worldwide Emergency Transportation services. There is a maximum plan benefit coverage amount of $100,000 for worldwide emergency services, worldwide urgently needed services and worldwide emergency transportation services combined.
Outpatient Mental Health Care	You pay a $0 copay per visit for individual sessions. You pay a $0 copay per visit for group sessions.	You pay a $40 copay per visit for individual sessions. You pay a $40 copay per visit for group sessions.
Psychiatric Services	You pay a $0 copay per visit for individual sessions. You pay a $0 copay per visit for group sessions.	You pay a $40 copay per visit for individual sessions. You pay a $40 copay per visit for group sessions.
Telehealth	Prior Authorization may be required.	Prior Authorization is not required.
Outpatient Diagnostic Radiological Services	You pay a $0 copay for outpatient diagnostic radiological services.	You pay a $0 copay for Ultrasound, other general imaging, diagnostic DEXA scans and diagnostic mammograms. You pay a $50 copay for MRI, CT, and PET scans.

Cost	2023 (this year)	2024 (next year)
Outpatient Hospital Services	You pay a $0 copay for outpatient hospital services.	You pay a $0 copay for diagnostic mammograms, DEXA scans, and colonoscopies in an outpatient setting and a $150 copay for all other services.
Ambulatory Surgical Center (ASC)	You pay a $0 copay for ambulatory surgical center services.	You pay a $0 copay for diagnostic mammograms, DEXA scans and colonoscopies in an ASC setting and a $100 copay for all other services.
Ambulance services	You pay a $0 copay per trip for ground ambulance services for a transfer from an out-of-network hospital to an in-network hospital and a $40 copay per trip for all other ground ambulance services.	You pay a $0 copay per trip for ground ambulance services for a transfer from an out-of-network hospital to an in-network hospital and a $150 copay per trip for all other ground ambulance services.
Transportation	You pay a $0 copay for 48 one-way non emergency transportation trips.	You pay a $0 copay for 24 one-way non emergency transportation trips.
In-Home Support Services	You pay a $0 copay Services provided immediately following discharge from the hospital or skilled nursing facility to assist with activities of daily living, pick up medications, and shop for groceries and necessities. Up to seven four-hour shifts (28 hours total) per qualifying event.	You pay a $0 copay Services are eligible to members following discharge from the hospital or skilled nursing facility or through case management referral. Benefit includes assistance with activities of daily living, medication pick-ups, and shopping for groceries or other necessities. Up to 20 hours total for the calendar year.

Cost	2023 (this year)	2024 (next year)
Medicare Part B Prescription Drugs	You pay 20% coinsurance.	You pay 20% coinsurance on all Part B drugs unless capped by Inflation Reduction Act (IRA) rules.
Dental Services		
• **Preventive Dental**	You pay a $0 copay	You pay a $0 - $41 copay
• **Non-Routine Services**	Not covered	You pay a $0 - $166 copay.
• **Diagnostic Services**	You pay a $0 copay.	You pay a $0 - $15 copay.
• **Restorative Services**	You pay a $0 - $295 copay.	You pay $0 - $424 copay.
• **Extractions**	You pay a $0 copay.	You pay $0 - $237 copay.
• **Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services**	You pay a $0 - $295 copay.	You pay a $0 - $2,160 copay.
CHP Flex Card	You get $325 every three months for over-the-counter (OTC) items, health and wellness herbal catalog items and qualifying fitness expenses. This is a combined benefit.	You get $41 every month for over-the-counter (OTC) items and health and wellness herbal catalog items. You get $20 every month for qualifying fitness expenses. This benefit is not a combined benefit. The funds in each benefit category may only be used for items/ services contained in that category.

Section 1.5 – 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,” which could include removing or adding drugs, changing to the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

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.

There are four **drug payment stages**. The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (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

Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (next year)
Stage 2: 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**. Most adult Part D vaccines are covered at no cost to you. 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: **Tier 1 - Preferred Generic:** You pay $0 per prescription. **Tier 2 - Generic:** You pay $0 per prescription. **Tier 3 - Preferred Brand:** You pay $35 per prescription. **Tier 4 - Non-Preferred Drug:** You pay $75 per prescription. **Tier 5 - Specialty Drug:** You pay 33% of the total cost. **Tier 6 - Select Diabetic Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $4,660, 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: **Tier 1 - Preferred Generic:** You pay $0 per prescription. **Tier 2 - Generic:** You pay $0 per prescription. **Tier 3 - Preferred Brand:** You pay $35 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 - Non-Preferred Drug:** You pay $75 per prescription. **Tier 5 - Specialty Drug:** You pay 33% of the total cost. **Tier 6 - Select Care Drugs:** You pay $0 per prescription. _____

Stage	2023 (this year)	2024 (next year)
		Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

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.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Extended Day Supply	Allows you to fill up to a 90-day supply of medication. Applicable to tiers 1-4. Tier 6 has a 100-day supply.	Allows you to fill up to a 100-day supply of medication. Applicable to tiers 1-4 and 6.
Part B Step Therapy	Step Therapy not required.	Step Therapy may be required.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Central Health Premier Plan I (HMO)

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 be enrolled in our Central Health Premier Plan I (HMO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Central Health Medicare 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 Central Health Premier Plan I (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Central Health Premier Plan I (HMO).
- 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 so.
  - – *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 4 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, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with 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.

If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), 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 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Insurance Counseling & Advocacy Program (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 Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222. You can learn more about Health Insurance Counseling & Advocacy Program (HICAP) by visiting their website http://www.aging.ca.gov/hicap.

SECTION 6 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. 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; 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 California Department of Public Health, Center for Infectious Diseases, Office of AIDS. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050. Monday through Friday 8 am - 5 pm; COVID-19 Hotline: Monday through Friday 8 am - 8 pm; Saturday, Sunday 8 am - 5 pm.

SECTION 7 Questions?

Section 7.1 – Getting Help from Central Health Premier Plan I (HMO)

Questions? We're here to help. Please call Member Services at (866) 314-2427. (TTY only, call 711). 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 *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for Central Health Premier Plan I (HMO). 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 located on our website at www.centralhealthplan.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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 7.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://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.