Central Health Medi-Medi Plan I (HMO D-SNP) offered by Central Health Plan of California, Inc.

Annual Notice of Changes for 2025

Introduction

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

Additional resources

- This document is available for free in Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, and Vietnamese.
- You can get this *Annual Notice of Changes* for free in other formats, such as large print, braille, or audio. Call 1-866-314-2427, TTY 711, 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). This call is free.
- To request your preferred language other than English and/or alternate format, call Member Services at 1-866-314-2427, TTY 711, 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30).
- We will maintain a record of our member's preferred language and/or format preferences, and we will keep this information as a standing request for future mailings and communications. This will ensure that our members will not have to make a separate request each time.
- To change a standing request, call Member Services at 1-866-314-2427, TTY 711, 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30).

Table of Contents

A. Disclaimers

- Central Health Medicare Plan is an HMO SNP with a Medicare contract. Enrollment in Central Health Medicare Plan depends on contract renewal.
- Central Health Medicare Plan (CHMP) complies with Federal and State laws and does not discriminate or exclude on the basis of race, color, national origin, age, mental or physical disability, sex, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
- The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.
- Eligibility for the Additional Benefits or RI Programs under the VBID Model is not assured and will be determined by the MAO after enrollment, based on relevant criteria e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).
- Medicare approved Central Health Medi-Medi Plan I (HMO D-SNP) to provide lower copayments on Part D Prescription Drugs as part of the VBID program. This program lets Medicare try new ways to improve Medicare Advantage plans.

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

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

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

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

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

B1. Information about Central Health Medi-Medi Plan I (HMO D-SNP)

- Central Health Medi-Medi Plan I (HMO D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to members.

- Coverage under Central Health Medi-Medi Plan I (HMO D-SNP) is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says “we,” “us,” “our,” or “our plan,” it means the Medicare Medi-Cal Plan.

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit and cost changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

If you decide to stay with Central Health Medi-Medi Plan I (HMO D-SNP):

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in Central Health Medi-Medi Plan I (HMO D-SNP)

If you decide to change plans:

If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our plan name

On January 1, 2025, our plan name changes from Brand New Day Classic Care I Plan (HMO) to Central Health Medi-Medi Plan I (HMO D-SNP).

The name change will not impact any other communications you receive from us. You will receive a new member ID card through the mail by January 2025.

D. Changes to our network providers and pharmacies

Our provider and pharmacy networks have changed for 2025.

Please review the 2025 *Provider and Pharmacy Directory* to find out if your providers or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at www.centralhealthplan.com. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

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

E. Changes to benefits and costs for next year

E1. Changes to benefits and costs for medical services

We're changing our coverage for certain medical services and what you pay for these covered medical services next year. The table below describes these changes.

	2024 (this year)	2025 (next year)
Medicare Supplemental Benefit: Worldwide Emergency/ Urgent Coverage	You pay a $100 copay per visit for worldwide emergency services. You pay a $100 copay per visit for worldwide urgently needed services. You pay a $100 copay per visit for worldwide emergency transportation services. There is a maximum plan benefit coverage amount of $50,000 for worldwide emergency services, worldwide urgently needed services and worldwide emergency transportation services combined.	You pay a $0 copay per visit for worldwide emergency services. You pay a $0 copay per visit for worldwide urgently needed services. You pay a $0 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.
Medicare Supplemental Benefit: Routine Chiropractic Care	Routine chiropractic care is covered as a Medicare Supplemental Benefit. You pay a $0 copay for 30 routine chiropractic visits per year. These 30 visits are combined with routine acupuncture visits.	Routine chiropractic care **is not** covered as a Medicare Supplemental Benefit.
	Note: this coverage is for the Medicare Supplemental Routine Chiropractic Care Benefit. You are covered for additional chiropractic care services under your Medicare-covered and your Medi-Cal (Medicaid) benefits through the Plan. Authorization rules and visit limitations may apply.	
Medicare Covered Benefit: Additional Telehealth	Prior authorization may be required.	Prior authorization is not required.
Medicare Covered Benefit: Observation Services	Authorization may be required. Referral may be required.	Authorization is not required. Referral is not required.

	2024 (this year)	2025 (next year)
	Note: this coverage is for the Medicare Covered Observation Services Benefit. You are covered for additional outpatient hospital services under your Medicare-covered and your Medi-Cal (Medicaid) benefits through the Plan. Authorization rules may apply.	
Medicare Covered Benefit: Outpatient Blood Services	Authorization is not required. Referral is not required.	Authorization may be required. Referral may be required.
	Note: this coverage is for the Medicare Covered Outpatient Blood Services Benefit. You are covered for additional outpatient hospital services under your Medicare-covered and your Medi-Cal (Medicaid) benefits through the Plan. Authorization rules may apply.	
Medicare Supplemental Benefit: Routine Acupuncture	You pay a $0 copay for 30 routine acupuncture visits per year. These 30 visits are combined with routine chiropractor visits.	You pay a $0 copay for unlimited acupuncture visits per year.
	Note: this coverage is for the Medicare Supplemental Routine Acupuncture Benefit. You are covered for additional acupuncture services under your Medicare-covered and your Medi-Cal (Medicaid) benefits through the Plan. Authorization rules and visit limitations may apply.	
Medicare Supplemental Benefit: Over-the-Counter (OTC) Items	You have a $50 allowance per month for OTC items. OTC benefit does not include access to a health and wellness herbal catalog. OTC hearing aids are not covered.	You have a $175 allowance per quarter for OTC items. OTC benefit includes access to a health and wellness herbal catalog. OTC hearing aids are covered and included in the OTC allowance.
	Note: This coverage is for the Medicare Supplemental OTC benefit. Some over-the-counter (OTC) medications and certain vitamins may be covered by Medi-Cal Rx. Authorization rules may apply. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273.	

	2024 (this year)	2025 (next year)
Medicare Supplemental Benefit: Meals Benefit	You have coverage for **one** meals benefit program. 1. Made Easy Meals: To qualify for this benefit, you must have one of the following chronic conditions: diabetes, chronic heart failure (CHF), cardiovascular disorders, dementia, or chronic lung disorders. You pay a $0 copay for 14 meals each month for 1 year (168 total meals).	You have coverage for **two** meals benefit programs. 1. Made Easy Meals: To qualify for this benefit, you must have one of the following chronic conditions: diabetes, chronic heart failure (CHF), cardiovascular disorders, dementia, or chronic lung disorders. You pay a $0 copay for 14 meals each month for 1 year (168 total meals). 2. In-Home Meal Program Meals are provided immediately following each surgery or inpatient hospitalization, or for a COVID diagnosis or at-home quarantine due to a COVID exposure that requires you to remain at home for a period of time. You pay a $0 copay for 2 meals a day for 14 days. The In-Home Meal Program benefit may be used up to 4 times per year.
	Note: This coverage is for the Medicare Supplemental Meals Benefit. Please call Member Services or contact your Care Manager if you need community resources to help with food insecurities. Authorization rules may apply.	
Medicare Supplemental Benefit: Annual Physical Exam	Benefit **is** covered as a Medicare Supplemental Benefit.	Benefit **is not** covered as a Medicare Supplemental Benefit.

	2024 (this year)	2025 (next year)
	You pay a $0 copay for one routine physical exam each year.	
	Note: This coverage is for the Medicare Supplemental Annual Physical Exam Benefit. You are covered for additional routine preventive care under your Medicare-covered and your Medi-Cal (Medicaid) benefits through the Plan. Authorization rules may apply.	
Medicare Supplemental Benefit: Home and Bathroom Safety Devices and Modifications	Benefit **is not** covered as a Medicare Supplemental Benefit.	Benefit **is** covered as a Medicare Supplemental Benefit. You receive a $3,000 allowance for the purchase and installation of Home and Bathroom Safety Devices and Modifications every year. Please see your Central Health Medi-Medi Plan I (HMO D-SNP) Member Handbook for more information including rules and restrictions.
	Note: This coverage is for the Medicare Supplemental Home and Bathroom Safety Devices and Modifications Benefit. Please call Member Services or contact your Care Manager if you need community resources or assistance with Waiver benefits. Authorization rules may apply.	
Medicare Supplemental Benefit: In-Home Safety Assessment	Benefit **is not** covered as a Medicare Supplemental Benefit.	Benefit **is** covered as a Medicare Supplemental Benefit. You pay a $0 copay. Please see your Central Health Medi-Medi Plan I (HMO D-SNP) Member Handbook for more information including rules and restrictions.
	Note: This coverage is for the Medicare Supplemental In-Home Safety Assessment Benefit. Please call Member Services or contact	

	2024 (this year)	2025 (next year)
	your Care Manager if you need community resources or assistance with Waiver benefits. Authorization rules may apply.	
Medicare Supplemental Benefit: In-Home Support Services (IHSS)	Benefit **is not** covered as a Medicare Supplemental Benefit.	Benefit **is** covered as a Medicare Supplemental Benefit. You pay a $0 copay for up to 20 hours per calendar year through one of our plan's approved vendors. Please see your Central Health Medi-Medi Plan I (HMO D-SNP) Member Handbook for more information including rules and restrictions.
	Note: This coverage is for the Medicare Supplemental IHSS Benefit. If you need help with your Medi-Cal In-Home Supportive Services (IHSS) benefit, contact your local County Social Services Department. The IHSS program can provide services so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities. To apply for IHSS, contact your local County IHSS Office. Authorization rules may apply.	
Medicare Supplemental Benefit: Preventive and Comprehensive Dental Services	<u>Preventive Services:</u> Oral Exams, limit 1 every 6 months: You pay a $0 to $17 copay Prophylaxis (Cleaning), limit 2 every year: You pay a $0 copay Fluoride Treatment: You pay a $0 copay Dental X-Rays, limit 1 every year: You pay a $0 copay <u>Comprehensive Services:</u>	<u>Preventive Services:</u> Oral Exams, limit 2 every year: You pay a $0 copay Prophylaxis (Cleaning), limit 2 every year: You pay a $0 copay Fluoride Treatment, limit 2 every year: You pay a $0 copay Dental X-Rays, limit up to 6 periapical per year, up to 4 bitewings per year, up to 1 panoramic every 5 years: You pay a $0 copay

	2024 (this year)	2025 (next year)
	Non-routine Services: You pay a $0 to $300 copay Diagnostic Services: You pay a $0 to $6 copay Restorative Services: You pay a $25 to $400 copay Endodontics: You pay a $25 to $720 copay Periodontics: You pay a $0 to $780 copay Extractions: You pay a $0 to $360 copay Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services: You pay a $0 to $2,160 copay There is no maximum plan benefit limit for preventive or comprehensive dental services. Benefits may be subject to exclusions and limitations per the American Dental Association (ADA) guidelines. In addition to the dental benefits described above, you also have a $100 dental allowance every 6 months to use for qualifying dental expenses.	<u>Comprehensive Services:</u> Adjunctive General Services: You pay a $0 copay Diagnostic Services: Not covered Restorative Services: You pay a $0 copay Endodontics: You pay a $0 copay Periodontics: You pay a $0 copay Prosthodontics, removable: You pay a $0 copay Oral and Maxillofacial Surgery: You pay a $0 copay There is a $1,000 maximum plan benefit limit for comprehensive dental services Benefits may be subject to exclusions and limitations per the American Dental Association (ADA) guidelines. The additional dental allowance is not covered.
	Note: This coverage is for the Medicare Supplemental Dental Benefit. Some dental services are available through the Medi-Cal Dental Program. Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. Authorization rules may apply. For more information, or if you need help finding a dentist who accepts the	

	2024 (this year)	2025 (next year)
	Medi-Cal Dental Program, contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at dental.dhcs.ca.gov/ for more information.	
Medicare Supplemental Benefit: Hearing Aids	You pay a $149 copay per hearing aid for the basic model. Up to 2 hearing aids are covered every 3 years. You must obtain your hearing aids from a plan-approved vendor.	Central Health Medi-Medi Plan I (HMO D-SNP) will cover up to $3,000 for hearing aids every year. This amount may be used for one ear or for two ears. You are responsible for any amounts beyond this limit. You must obtain your hearing aids from a plan-approved vendor.
	Note: This coverage is for the Medicare Supplemental Hearing Aid Benefit. You are covered for additional hearing aid services under your Medi-Cal (Medicaid) benefit. Authorization rules and cost limitations may apply.	
Medicare Supplemental Benefit: Special Supplemental Benefit for Chronically Ill (SSBCI) – Transportation for Non-Medical Needs	Benefit **is not** covered as a Medicare Supplemental Benefit.	Benefit **is** covered as a Medicare Supplemental Benefit. To qualify for this benefit, you must have one of the following chronic conditions: diabetes, chronic heart failure (CHF), cardiovascular disorders, dementia, or chronic lung disorders. You may use up to half of your one-way trips covered through your Transportation (Additional Routine) benefit. Please see your Central Health Medi-Medi Plan I (HMO D-SNP) Member Handbook for more

	2024 (this year)	2025 (next year)
		information including rules and restrictions.
	Note: This coverage is for the Medicare Supplemental SSBCI – Transportation for Non-Medical Needs. You are covered for additional routine transportation services under your Medi-Cal (Medicaid) benefit. Authorization rules may apply.	

E2. Changes to prescription drug coverage

Changes to our Drug List

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

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover, and changes to the restrictions that apply to our coverage for certain drugs.

Review the *Drug List* to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes are allowed by Medicare and/or the state that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up to date list of drugs. If we make a change that will affect a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page or contact your Care Manager to ask for a *List of Covered Drugs* that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
  - This temporary supply is for up to 31 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

If you currently have an approved formulary exception, your formulary exception will continue to be approved in 2025 up until its expiration date. The expiration date for your formulary exception can be found on your formulary exception approval notice. If your approval is expiring and you want to request an extension, a new formulary exception request will need to be submitted.

We currently can immediately remove a brand name drug on our *Drug List* if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer rules as the brand name drug it replaces. Also, when adding a new generic drug, we may also decide to keep the brand name drug on our *Drug List*, but immediately move it to a different cost-sharing tier or add new rules or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see **Chapter 12** of your *Member Handbook*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Refer to the FDA website: www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services at the number at the bottom of the page or ask your health care provider, prescriber, or pharmacist for more information.

Changes to prescription drug costs

We moved all of the drugs on the *Drug List* to one tier

The following table shows your costs for drugs in our one drug tier.

	2024 (this year)	2025 (next year)
Part D Prescription Drugs Cost for a one-month supply of a drug that is filled at a network pharmacy	Part D covered drugs on the Plan formulary are on 6 different tiers. Because you have Medi-Cal, you are already enrolled in "Extra Help," also called the Low-Income Subsidy (LIS). In 2024, your cost for a one month (30-day) prescription filled at a network pharmacy will depend on your Low-Income	Part D covered drugs on the Plan formulary will be on one tier. Because you have Medi-Cal, you are already enrolled in "Extra Help," also called the Low-Income Subsidy (LIS). In 2025, your cost for a one month (31-day) prescription filled at a network pharmacy will be a $0 copay through all stages of the Part D Prescription Drug

	2024 (this year)	2025 (next year)
	Subsidy (LIS) copay and the tier the medication is on. You have coverage for excluded drugs under our enhanced benefit.	Benefit with the Value Based Insurance Design (VBID) enhanced benefit. You do not have coverage for excluded drugs under our enhanced benefit.
	Note: This coverage is for Medicare covered Part D Prescription Drugs. Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access Medi-Cal Rx covered drugs.	

F. Administrative changes

	2024 (this year)	2025 (next year)
Your Contract/Plan Benefit Package (PBP) has changed	H0838-050-002	H5649-002-000
Pharmacy Benefits Manager	Your pharmacy benefits are managed by Express Scripts	Your pharmacy benefits are managed by CVS Caremark
Part D Prescription Drugs: One-Month Day Supply	A one-month prescription filled at a network pharmacy is a 30-day supply	A one-month prescription filled at a network pharmacy is a 31-day supply
Special Supplemental Benefits for the Chronically Ill (SSBCI)	If you are diagnosed with an eligible chronic condition(s) and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.	If you are diagnosed with an eligible chronic condition(s) and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill. Additionally: • You must complete a Health Risk Assessment every year. • We will review your eligibility annually. • You may need prior authorization.

G. Choosing a plan

G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2025.

G2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have Medi-Cal, you can end your membership in our plan any month of the year.

In addition, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for Medi-Cal or Extra Help changed, **or**
- you recently moved into or are currently receiving care in an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It is for people who have both	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services. **Note:** The term Medi-Medi Plan is the name for integrated dual eligible special needs plans (D-SNPs) in California.	For Program of All-inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare plan. You will automatically be disenrolled from our plan when your new plan's coverage begins. Your Medi-Cal plan will change to match your Medi-Medi Plan.
2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change change unless you request a change.
3. You can change to:	**Here is what to do:**

Original Medicare without a separate Medicare prescription drug plan **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change unless you request a change.
4. You can change to: **Any Medicare health plan** during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare plan.

	You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan may change.

Your Medi-Cal services

For questions about how to choose a Medi-Cal plan or get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-800-430-4263, Monday – Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

H. Getting help

H1. Our plan

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

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2025. It explains your rights and the rules to follow to get services and prescription drugs we cover.

The *Member Handbook* for 2025 will be available by October 15. You can also review the separately mailed *Member Handbook* to find out if other benefit or cost changes affect you. An up-to-date copy of the *Member Handbook* is available on our website at www.centralhealthplan.com. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

Our website

You can visit our website at www.centralhealthplan.com. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List* (*List of Covered Drugs*).

H2. Health Insurance Counseling and Advocacy Program (HICAP)

You can also call the State Health Insurance Assistance Program (SHIP). In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can help you understand your plan choices and answer questions about switching plans. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. HICAP's phone number is 1-800-434-0222. TTY 711. For more information or to

find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/.

H3. Ombuds Program

The Medicare Medi-Cal Ombuds Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Medicare Medi-Cal Ombuds Program:

- works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.
- makes sure you have information related to your rights and protections and how you can get your concerns resolved.
- is not connected with us or with any insurance company or health plan. The phone number for the Medicare Medi-Cal Ombuds Program is 1-855-501-3077.

H4. Medicare

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

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

Medicare & You 2025

You can read the *Medicare & You 2025* 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. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1--800--MEDICARE (1--800--633--4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

H5. California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-866-314-2427** and use your health plan's grievance process before contacting the department. Utilizing

this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online. Refer to **Chapter 9, Section F4** of your *Member Handbook* for more information.