CENTRAL HEALTH MEDICARE PLAN

Central Health Classic Care Plan II (HMO) offered by Central Health Medicare Plan

Annual Notice of Changes for 2025

You are currently enrolled as a member of Brand New Day Classic Care I Plan (HMO). Next year, there will be changes to the plan's costs and benefits*. **Please see page 5 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

   ☐ 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, 2024, you will stay in Central Health Classic Care Plan II (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, 2025.** This will end your enrollment with Central Health Classic Care Plan II (HMO).
   - If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). 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 Classic Care Plan II (HMO)

- Central Health Medicare Plan is an HMO/HMO SNP 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 Classic Care Plan II (HMO).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Central Health Classic Care Plan II (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$37.60	$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 2.2 for details.)	$2,100	$2,499
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $10 per visit
Inpatient hospital stays	You pay a $50 copay per day for days 1 - 6 You pay $0 copay per day for days 7 - 90	You pay a $150 copay per day for days 1 - 6 You pay a $0 copay per day for days 7 - 90
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100	Deductible: $100 except for covered insulin products and most adult Part D vaccines. 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

Cost	2024 (this year)	2025 (next year)
	• 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.	covered insulin product on this tier. • Drug Tier 4: $100 • Drug Tier 5: 31% • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit.**

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Central Health Classic Care Plan II (HMO) in 2025

On January 1, 2025, Central Health Medicare Plan will be transitioning you from Brand New Day Classic Care I Plan (HMO) to Central Health Classic Care Plan II (HMO). The information in this document tells you about the differences between your current benefits in Brand New Day Classic Care I Plan (HMO) and the benefits you will have on January 1, 2025 as a member of Central Health Classic Care Plan II (HMO).

If you do nothing by December 7, 2024, we will automatically enroll you in our Central Health Classic Care Plan II (HMO). This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through Central Health Classic Care Plan II (HMO). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for “Extra Help,” you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$37.60	$0
Optional Supplemental Enhanced Dental Benefits Package Monthly Premium	The Optional Supplemental Enhanced Dental Benefit Package is not available	$21

- 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 2.2 – 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	2024 (this year)	2025 (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.	$2,100	$2,499 Once you have paid $2,499 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 2.3 – Changes to the Provider and Pharmacy Networks

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.

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 2025 *Provider Directory* www.centralhealthplan.com 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 2025 *Pharmacy Directory* www.centralhealthplan.com 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 2.4 – 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	2024 (this year)	2025 (next year)
Inpatient Hospital Care	You pay a $50 copay per day for days 1 - 6 You pay a $0 copay per day for days 7 - 90	You pay a $150 copay per day for days 1 - 6 You pay a $0 copay per day for days 7 - 90
Inpatient Hospital (Acute) Additional Days	Not covered	Unlimited additional days are covered with a $0 copay.
Inpatient Services in a Psychiatric Hospital	You pay $0 copay per stay.	You pay a $150 copay per day for days 1 - 6. You pay a $0 copay per day for days 7 - 90.

Cost	2024 (this year)	2025 (next year)
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 $100 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 $140 copay per visit for all other emergency services.
Worldwide Emergency 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 $140 copay per visit for Worldwide Emergency services. You pay a $140 copay per visit for Worldwide Urgently Needed services. You pay a $140 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.
Specialist Visits	You pay a $0 for office visits with a specialist.	You pay a $10 for office visits with a specialist.
Outpatient Mental Health Care	You pay a $25 copay per visit for individual sessions. You pay a $25 copay per visit for group sessions.	You pay a $10 copay per visit for individual sessions. You pay 20% coinsurance per visit for group sessions.

Cost	2024 (this year)	2025 (next year)
Other Health Care Professional Services	You pay a $0 copay per visit for other health care professional services.	You pay a $10 copay per visit for other health care professional services.
Psychiatric Services	You pay a $25 copay per visit for individual sessions. You pay a $25 copay per visit for group sessions.	You pay a $10 copay per visit for individual sessions. You pay 20% coinsurance per visit for group sessions.
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 $200 copay for MRI, CT, and PET scans.
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.	You pay a $0 copay for diagnostic colonoscopies in an outpatient setting and a $250 copay for all other services.
Outpatient Hospital Observation	You pay a $0 copay per stay.	You pay a $0 copay for diagnostic colonoscopies in an outpatient setting and a $250 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 colonoscopies in an ASC setting and a $100 copay for all other services.

Cost	2024 (this year)	2025 (next year)
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 $200 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 $250 copay per trip for all other ground ambulance services.
Transportation	Referral is not required.	Referral may be required.
Made Easy Meals	You pay $0 for 14 meals each month for 1 year (168 total meals).	You pay $0 for 15 meals each week for 6 weeks (90 total meals), once per year. Member is eligible to receive up to 30 additional meals Made Easy Meals per year for a $5 copay per meal. Meal delivery is included 1 time per week.
Enhanced Disease Management	Not covered	You pay a $0 copay.
Preventive and Comprehensive Dental Services	<u>Comprehensive Services:</u> Non-routine Services: You pay a $0 - $300 copay Extractions: You pay a $0 - $360 copay Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: You pay a $0 - $2,160 copay There is no maximum plan benefit limit for preventive or	<u>Preventive Services:</u> Other Preventive Dental Services: You pay a $0 - $20 copay <u>Comprehensive Services:</u> Adjunctive General Services: You pay a $0 - $300 copay Prosthodontics, removable: You pay a $0 - $600 copay Prosthodontics, fixed:

Cost	2024 (this year)	2025 (next year)
	comprehensive dental services. Prior Authorization may be required. Referral may be required.	You pay a $0 - $840 copay Implants: You pay a $45 - $2,160 copay Oral and Maxillofacial Surgery: You pay a $0 - $380 copay There is no maximum plan benefit limit for preventive or comprehensive dental services. Prior Authorization may be required. Referral may be required.

Cost	2024 (this year)	2025 (next year)
Hearing Aids	Up to 2 hearing aids every 3 years You pay a $149 copay per Basic Model Aid.	Up to 2 hearing aids every year You pay a $575 copay per aid for Entry Model aids You pay a $699 copay per aid for Basic Model aids You pay a $999 copay per aid for Prime Model aids You pay a $1,399 copay per aid for Preferred Model aids You pay a $1,599 copay per aid for Advanced Model aids You pay a $2,099 copay per aid for Premium Model Aids
Special Supplemental Benefits for the Chronically Ill (SSBCI) SSBCI benefits are available only for members with a qualifying chronic condition. Please see your EOC for more details.		
• **Healthy Food Allowance**	You get a $25 allowance per month to buy healthy foods at plan-approved grocery stores.	You get a $50 allowance per month to buy healthy foods at plan-approved grocery stores.
Flex Card	You get $50 every month for over-the-counter (OTC) items OTC hearing aids are not covered.	You get $129 every 3 months for over-the-counter (OTC) items. OTC hearing aids are covered and included in the OTC allowance.

Cost	2024 (this year)	2025 (next year)
	You get $20 every month for qualifying fitness expenses. You get $100 every six months for qualifying dental expenses.	You get $60 every month for qualifying fitness expenses. Dental allowance is not covered

Cost	2024 (this year)	2025 (next year)
Optional Supplemental Enhanced Dental Benefit	The Optional Supplemental Enhanced Dental Benefit Package is not available	**Premium:** $21 **Out-of-Network:** Oral Exams: You pay 10% coinsurance Dental X-Rays: You pay 10% coinsurance Other diagnostic dental services: You pay 10% coinsurance Prophylaxis (cleaning): You pay 10% coinsurance Fluoride Treatment: You pay 10% coinsurance Other preventive dental services: You pay 10% coinsurance Restorative services: You pay 70% coinsurance Endodontics: You pay 70% coinsurance Periodontics: You pay 70% coinsurance Prosthodontics, removable: You pay 70% coinsurance Implant Services: You pay 70% coinsurance Prosthodontics, fixed: You pay 70% coinsurance Oral and maxillofacial surgery: You pay 70% coinsurance

Cost	2024 (this year)	2025 (next year)
		Adjunctive general services: You pay 70% coinsurance Annual benefit limit for out-of-network services: $1,500

Section 2.5 – 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, we might make other changes that are allowed by Medicare rules 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 your access to a drug you are taking, we will send you a notice about the change.

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.

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 restrictions as the brand name drug it replaces. Also, when adding a new generic, 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 restrictions 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 *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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*.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Because we have no deductible, this payment stage does not apply to you.	The deductible is $100. During this stage, you pay $0 cost-sharing for drugs on Tier 1 and Tier 6 and the full cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (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 (31-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; 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". Most adult Part D vaccines are covered at no cost to you.	The number of days in a one-month supply is 30. Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Tier 1 - Preferred Generic:** You pay $0 per prescription. **Tier 2 - Generic:** You pay $0 per prescription. **Tier 3 - Preferred Brand:** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 - Non-Preferred Drug:** You pay $100 per prescription. **Tier 5 - Specialty Drug:** You pay 33% of the total cost. **Tier 6 - Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached	The number of days in a one-month supply is 31. Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **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 $100 per prescription. **Tier 5 - Specialty Drug:** You pay 31% of the total cost. **Tier 6 - Select Care Drugs:** You pay $0 per prescription. _____

Stage	2024 (this year)	2025 (next year)
	$5,030, you will move to the next stage (the Coverage Gap Stage).	Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stages

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Sections 6 in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
Pharmacy Benefits Manager	Your pharmacy benefits were managed by Express Scripts.	Your pharmacy benefits are managed by CVS Caremark.
Medicare Prescription Payment Plan	Not applicable.	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at (866)

Description	2024 (this year)	2025 (next year)
		314-2427, TTY 711 or visit Medicare.gov.
Your Contract/Plan Benefit Package (PBP) has changed	H0838-050-002	H5649-028-000
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.	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.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Central Health Classic Care Plan II (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 Classic Care Plan II (HMO).

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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 2.1 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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 Classic Care Plan II (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 Classic Care Plan II (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 5 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 6 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 https://www.cahealthadvocates.org/HICAP/.

SECTION 7 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, yearly 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.

- **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. To be eligible for the ADAP operating in your State, 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, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, 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. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at (866) 314-2427 or visit Medicare.gov.

SECTION 8 Questions?

Section 8.1 – Getting Help from Central Health Classic Care Plan II (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 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). Calls to these numbers are free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Central Health Classic Care Plan II (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 8.2 – 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 2025*

Read the *Medicare & You 2025* 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.