CENTRAL HEALTH MEDICARE PLAN

Central Health Dual Access Plan (HMO D-SNP) offered by Central Health Medicare Plan

Annual Notice of Changes for 2025

You are currently enrolled as a member of Brand New Day Dual Access Plan (HMO D-SNP). Next year, there will be some changes to the plan's costs and benefits*.* ***Please see page 5 for a Summary of Important Costs, included 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*.

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 the 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 Dual Access Plan (HMO D-SNP).
- To **change to a different plan** that may better meet your needs, 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 Dual Access Plan (HMO D-SNP).
- Look in section 4.2, page 21 to learn more about your choices.
- 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 Dual Access Plan (HMO D-SNP)

- 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 booklet says "we," "us," or "our," it means Central Health Medicare Plan. When it says "plan" or "our plan," it means Central Health Dual Access Plan (HMO D-SNP).

Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Central Health Dual Access Plan (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$41	$2.20
Doctor office visits	Primary care visits: 40% of the total cost per visit Specialist visits: 40% of the total cost per visit If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.	Primary care visits: 35% of the total cost per visit Specialist visits: 35% of the total cost per visit If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.
Inpatient hospital stays	You pay a $1,632 deductible per benefit period. You pay a $0 copay per day for days 1–60 You pay a $408 copay per day for days 61–90 You pay a $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). If you are eligible for Medicare cost-sharing assistance under	You pay a $1,632 deductible per benefit period. You pay a $0 copay per day for days 1–60 You pay a $408 copay per day for days 61–90 You pay a $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). These are 2024 cost-sharing amounts and may change for 2025. Central Health Dual

Cost	2024 (this year)	2025 (next year)
	Medi-Cal (Medicaid), you pay $0.	Access Plan (HMO D-SNP) will provide updated rates as soon as they are released. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $545 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Phase: • Drug Tier 1: You pay $0. • Drug Tier 2: You pay 25% of the total cost. • Drug Tier 3: You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: You pay 25% of the total cost. • Drug Tier 5: You pay 25% of the total cost. • Drug Tier 6: You pay $0. Catastrophic Coverage:	Deductible: $0 for members with Extra Help, through our Value-Based Insurance Design (VBID) benefit Copayment/Coinsurance during the Initial Phase: Part D covered drugs on the formulary will be on one tier in 2025. **Generic and preferred multi-source drugs:** For members with Extra Help, you pay $0 per prescription through our Value-Based Insurance Design (VBID) benefit **All other drugs:** For members with Extra Help, you pay $0 per prescription through our Value-Based Insurance Design (VBID) benefit Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
	• 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.	
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.)	$8,850 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$9,350 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Central Health Dual Access Plan (HMO D-SNP) in 2025

On January 1, 2025, Central Health Medicare Plan will be combining Brand New Day Dual Access Plan (HMO D-SNP) with one of our plans, Central Health Dual Access Plan (HMO D-SNP). The information in this document tells you about the differences between your current benefits in Brand New Day Dual Access Plan (HMO D-SNP) and the benefits you will have on January 1, 2025 as a member of Central Health Dual Access Plan (HMO D-SNP).

If you do nothing in 2024, we will automatically enroll you in our Central Health Dual Access Plan (HMO D-SNP). This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through Central Health Dual Access Plan (HMO D-SNP). If you want to change plans or switch to Original Medicare and get your

prescription drug coverage through a Prescription Drug Plan you must do so between October 15 and December 7. The change will take effect on January 1, 2025.

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 unless it is paid for you by Medi-Cal (Medicaid).)	$41	$2.20

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	$8,850	$9,350
Because our members also get assistance from Medi-Cal (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medi-Cal (Medicaid) assistance with Part A and Part B copays, you are not		Once you have paid $9,350 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

Cost	2024 (this year)	2025 (next year)
responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		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 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 three business days.

There are changes to our network of providers for next year. **Please review the 2025 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 2025 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 a 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

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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)
Cardiac Rehabilitation Services	You pay a $30 copay per visit for cardiac rehabilitation. You pay a $55 copay per visit for intensive cardiac rehabilitation. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $35 copay per visit for cardiac rehabilitation. You pay a $45 copay per visit for intensive cardiac rehabilitation. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Pulmonary Rehabilitation Services	You pay a $15 copay per visit for pulmonary rehabilitation services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $25 copay per visit for pulmonary rehabilitation services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	You pay a $25 copay per visit for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $20 copay per visit for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2024 (this year)	2025 (next year)
Emergency Care	You pay a $100 copay per visit for all emergency services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $110 copay per visit for all emergency services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
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 $110 copay per visit for Worldwide Emergency services. You pay a $110 copay per visit for Worldwide Urgently Needed services. You pay a $110 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.
Partial Hospitalization Services	You pay a $70 copay per day. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $80 copay per day. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2024 (this year)	2025 (next year)
Primary Care Physician (PCP) Visits	You pay 40% coinsurance for each PCP visit. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 35% coinsurance for each PCP visit. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Occupational Therapist	You pay a $40 copay for each therapy visit for occupational therapy. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $35 copay for each therapy visit for occupational therapy. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Specialist Visits	You pay 40% coinsurance for office visits with a specialist. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 35% coinsurance for office visits with a specialist. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2024 (this year)	2025 (next year)
Outpatient Mental Health Care	You pay a $45 copay per visit for individual sessions. You pay a $45 copay per visit for group sessions. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $50 copay per visit for individual sessions. You pay a $50 copay per visit for group sessions. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Other Health Care Professional Services	You pay 40% coinsurance per visit for other health care professional services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 35% coinsurance per visit for other health care professional services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Transportation	You pay a $0 copay for 12 one-way non emergency transportation trips.	You pay a $0 copay for 24 one-way non emergency transportation trips.

Cost	2024 (this year)	2025 (next year)
In-Home Support Services	Not covered	$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.
Preventive and Comprehensive Dental Services	Preventive Services: Oral Exams: You pay a $0 - $17 copay Prophylaxis (Cleaning: You pay a $0 copay Fluoride Treatment: You pay a $13 copay Dental X-Rays: You pay a $0 copay Comprehensive Services: Non-routine Services: You pay a $20 copay Diagnostic Services: You pay a $2 - $3 copay Restorative Services: You pay a $0 copay Endodontics: You pay a $0 copay	Preventive Services: Oral Exams: Not covered Prophylaxis (Cleaning: Not covered Fluoride Treatment: Not covered Dental X-Rays: Not covered Comprehensive Services: Diagnostic Services: Not covered Restorative Services: Not covered Endodontics: Not covered Periodontics: Not covered

Cost	2024 (this year)	2025 (next year)
	Periodontics: You pay a $0 copay Extractions: You pay a $0 - $350 copay Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: You pay a $0 - $350 copay There is no maximum plan benefit limit for preventive or comprehensive dental services. Prior Authorization may be required. Referral may be required.	Implants: Not covered Oral and Maxillofacial Surgery: Not covered Supplemental dental benefits are not covered through our plan. 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 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

Cost	2024 (this year)	2025 (next year)
		dental.dhcs.ca.gov/ for more information.
Hearing Aids	You pay a $149 copay per Basic Model Aid.	You pay a $49 copay per aid for Entry Model aids You pay a $149 copay per aid for Basic Model aids You pay a $449 copay per aid for Prime Model aids You pay a $849 copay per aid for Preferred Model aids You pay a $1,049 copay per aid for Advanced Model aids You pay a $1,549 copay per aid for Premium Model Aids
Flex Card	You get $33 every month for over-the-counter (OTC) items. OTC hearing aids are not covered.	You get $150 every 3 months for over-the-counter (OTC) items. OTC hearing aids are covered and included in the OTC allowance.

Summary of Medi-Cal covered dental benefits

Services available through *Central Health Dual Access Plan (HMO D-SNP)*

In addition to the Medicare-covered dental services described in the Annual Notice of Change, you may be eligible for additional Medi-Cal dental benefits based on the level of your Medi-Cal coverage.

For a full list of services covered by the Medi-Cal Dental Program, call 1-800-322-6384 (TTY 1-800-735-2922) or visit: www.smilecalifornia.org. These resources can also help you locate a Medi-Cal dental provider and file a grievance or complaint.

To view the Medi-Cal Provider Directory, visit: www.smilecalifornia.org/partners-and-providers/

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 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 your 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

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 Part D 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.	The deductible is $545. 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.	Because we have no deductible, this payment stage does not apply to you.

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 Phase. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**.	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:**	The number of days in a one-month supply is 31. Part D covered drugs on the formulary will be on one tier. Your cost for a one-month supply filled at a network

Stage	2024 (this year)	2025 (next year)
The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy. The number of days in a one-month supply has changed from 2024 to 2025 as noted in the chart. 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.	You pay $0 per prescription. **Tier 2 - Generic:** You pay 25% of the total cost. **Tier 3 - Preferred Brand:** You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 - Non-Preferred Drug:** You pay 25% of the total cost. **Tier 5 - Specialty:** You pay 25% of the total cost. **Tier 6 - Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	pharmacy with standard cost sharing is: **Generic and preferred multi-source drugs:** You pay $0 per prescription. **All other drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $2,000, you will move to the next stage (the Catastrophic Stage).

Changes to your VBID Part D Benefit

Medicare approved Central Health Dual Access Plan (HMO D-SNP) to provide Part D Prescription Drug coverage as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans. Under VBID you pay $0 for all covered Part D prescriptions in all stages of the benefit.

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 Stage, you pay nothing for your covered Part D drugs.

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) 314-2427, TTY 711 or visit Medicare.gov.
Your Contract/Plan Benefit Package (PBP) has changed	H0838-024-000	H5649-024-000
Special Supplemental Benefits for the Chronically Ill	If you are diagnosed with an eligible chronic condition(s) and meet certain criteria, you may be eligi-	If you are diagnosed with an eligible chronic condition(s) and meet certain criteria, you may be eligi-

Description	2024 (this year)	2025 (next year)
	ble for special supplemental benefits for the chronically ill.	ble 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 Dual Access Plan (HMO D-SNP)

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 Dual Access Plan (HMO D-SNP).

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.

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 Dual Access Plan (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Central Health Dual Access Plan (HMO D-SNP).
- 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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 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 Medi-Cal (Medicaid), those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Medi-Cal (Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don’t like your plan choice, you can also 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 and Medi-Cal (Medicaid)

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/.

For questions about your Medi-Cal benefits, contact Medi-Cal at (916) 449-5000 (TTY 711). Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medi-Cal (Medicaid), you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;

- The Social Security Office at 1-800-772-1213 between 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 Medi-Cal (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.

SECTION 8 Questions?

Section 8.1 – Getting Help from Central Health Dual Access Plan (HMO D-SNP)

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 Dual Access Plan (HMO D-SNP). 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.

Section 8.3 – Getting Help from Medi-Cal (Medicaid)

To get information from Medi-Cal (Medicaid) you can call Medi-Cal at (916) 449-5000. TTY users should call 711.