2026

Annual Notice of Change

Central Health Embrace Care Plan (HMO C-SNP)

California H5649-025-004

Effective January 1 through December 31, 2026

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CENTRAL HEALTH MEDICARE PLAN

***Central Health Embrace Care Plan (HMO C-SNP) offered by Central Health Plan of California, Inc*.**

Annual Notice of Change for 2026

You're enrolled as a member of Central Health Embrace Care Plan (HMO C-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Central Health Embrace Care Plan (HMO C-SNP).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You **2026*** handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.centralhealthplan.com or call Member Services at (866) 314-2427 (TTY users call 711) to get a copy by mail. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

More Resources

- This material is available for free in Spanish.

- This material is available for free in Chinese.
- Call Member Services at (866) 314-2427 (TTY users call 711) for more information. Hours are Hours are October 1 – March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. to 8 p.m. local time. This call is free.
- You can get this document for free in other language(s) or other formats, such as large print, braille, or audio. Call (866) 314-2427, (TTY: 711). The call is free.

About Central Health Embrace Care Plan (HMO C-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 material says “we,” “us,” or “our”, it means Central Health Plan of California, Inc. When it says “plan” or “our plan,” it means Central Health Embrace Care Plan (HMO C-SNP).
- On January 1, 2026, Central Health Plan of California, Inc will be combining Central Health Embrace Care Plan (HMO C-SNP) with one of our plans, Central Health Embrace Care Plan (HMO C-SNP). This material tells you about the differences between your current benefits in Central Health Embrace Care Plan (HMO C-SNP) and the benefits you’ll have on January 1, 2026, as a member of Central Health Embrace Care Plan (HMO C-SNP).

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in** Central Health Embrace Care Plan (HMO C-SNP). Starting January 1, 2026, you'll get your medical and drug coverage through Central Health Embrace Care Plan (HMO C-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

The table below compares the 2025 costs and 2026 costs for Central Health Embrace Care Plan (HMO C-SNP) in several important areas. **Please note this is only a summary of costs**.

	2025 (this year)	2026 (next year)
Monthly plan premium* *Your premium may be higher than this amount. Go to Section 1.1 for details.	$0	**$0**
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (Go to Section 1.2 for details.)	$2,750	**$1,800**
Primary care office visits	$0 per visit	**$0 per visit**
Specialist office visits	$0 per visit	**$0 per visit**

	2025 (this year)	2026 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospitals services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	You pay a $0 copay per day for days 1 - 5 You pay $200 copay per day for days 6 - 9 You pay a $35 copay per day for days 10 - 90	**You pay a $0 copay per day for days 1 - 5** **You pay a $200 copay per day for days 6 - 9** **You pay a $35 copay per day for days 10 - 90**
Part D drug coverage deductible (Go to Section 1.6 for details.)	$0	**$615 except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Section 1.6 for details, including Yearly Deducible, Initial	Copayment/ Coinsurance during the Initial Coverage Stage:	**Copayment/ Coinsurance during the Initial Coverage Stage:**

	2025 (this year)	2026 (next year)
Coverage, and Catastrophic Coverage Stages.)	• Drug Tier 1: $0 • Drug Tier 2: $9 • Drug Tier 3: $47 You pay $0 per month supply of each covered insulin product on this tier. • Drug Tier 4: $90 • Drug Tier 5: 33% • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs and for	• **Drug Tier 1: $0** • **Drug Tier 2: 15%** • **Drug Tier 3: 15%** **You pay $35 per month supply of each covered insulin product on this tier.** • **Drug Tier 4: 30%** • **Drug Tier 5: 25%** • **Drug Tier 6: $0** **Catastrophic Coverage:** • **During this payment stage, you**

	2025 (this year)	2026 (next year)
	excluded drugs that are covered under our enhanced benefit.	**pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	**$0**

	2025 (this year)	2026 (next year)
Additional premium for optional supplemental benefits If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.) • Enhanced Dental Benefits Package	$21	**The Optional Supplemental Enhanced Dental Benefit Package is not available**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.

- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

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

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) **count** toward your maximum out-of-pocket amount. Our costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$2,750	**$1,800** **Once you've paid $1,800 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.centralhealthplan.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.centralhealthplan.com.
- Call Member Services at (866) 314-2427 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at (866) 314-2427 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* www.centralhealthplan.com to see pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.centralhealthplan.com.
- Call Member Services at (866) 314-2427 (TTY users call 711) to get current provider information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at (866) 314-2427 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

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

	2025 (this year)	2026 (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 $140 copay per visit for all other emergency services.	**You pay a $150 copay per visit for all emergency services.**
Partial Hospitalization Services and Intensive Outpatient Program Services	You pay a $130 copay per day for partial hospitalization services. You pay a $130 copay per day for intensive outpatient program services.	**You pay a $175 copay per day for partial hospitalization services.** **You pay a $180 copay per day for intensive outpatient program services.**

	2025 (this year)	2026 (next year)
Chiropractic Services - Routine Care	You pay a $0 copay for 12 routine chiropractic visits per year. These 12 visits are combined with routine acupuncture visits.	**You pay a $0 copay for 30 routine chiropractic visits per year.** **These 30 visits are combined with routine acupuncture visits.**
Telehealth	The following Medicare-covered benefits may have additional telehealth benefits covered on the plan. Please see your EOC for more details, including cost shares for each benefit type. • Primary Care Physician Service	**The following Medicare-covered benefits may have additional telehealth benefits covered on the plan. Please see your EOC for more details, including cost shares for each benefit type.**

	2025 (this year)	2026 (next year)
	• Chiropractic Services • Occupational Therapy Services • Physician Specialist • Individual Sessions for Mental Health Specialty Services • Group Sessions for Mental Health Specialty Services • Podiatry Services	• **Cardiac Rehabilitation Services** • **Primary Care Physician Services** • **Chiropractic Services** • **Occupational Therapy Services** • **Physician Specialist Services** • **Individual Sessions for Mental Health Specialty Services**

	2025 (this year)	2026 (next year)
	• Other Health Care Professional Services • Individual Sessions for Psychiatric Services • Group Sessions for Psychiatric Services • Physical Therapy and Speech-Language Pathology Services • Opioid Treatment Program Services	• **Group Sessions for Mental Health Specialty Services** • **Podiatry Services** • **Other Health Care Professional Services** • **Individual Sessions for Psychiatric Services** • **Group Sessions for Psychiatric Services** • **Physical Therapy and Speech-**

	2025 (this year)	2026 (next year)
	• Individual Sessions for Outpatient Substance Abuse • Group Sessions for Outpatient Substance Abuse You pay a $0 copay for telehealth visits.	**Language Pathology Services** • **Opioid Treatment Program Services** • **Individual Sessions for Outpatient Substance Abuse** • **Group Sessions for Outpatient Substance Abuse** **You pay 20% coinsurance or a $0 - $10 copay for telehealth visits, depending on the type of service you receive.**

	2025 (this year)	2026 (next year)
Acupuncture - Routine	You pay a $0 copay for 12 routine acupuncture visits per year. These 12 visits are combined with routine chiropractic visits.	**You pay a $0 copay for 30 routine acupuncture visits per year.** **These 30 visits are combined with routine chiropractic visits.**
Meals for members with a qualifying chronic condition	You pay $0 for 14 meals each week for 12 weeks (168 total meals). This benefit is available only to members diagnosed with a qualifying chronic condition. Please see your Evidence of Coverage (EOC) for more details on the qualifying	**You pay $0 for 14 meals each month for 1 year (168 total meals).** **This benefit is available only to members diagnosed with a qualifying chronic condition. Please see your Evidence of**

	2025 (this year)	2026 (next year)
	chronic conditions and how to access this benefit.	**Coverage (EOC) for more details on the qualifying chronic conditions and how to access this benefit.**
In-Home Meal Program (for members post-discharge or homebound)	Not covered	**You pay a $0 copay per meal through the in-home meal program.** **You get 2 meals a day for 14 days immediately following surgery or inpatient hospitalization, or if you are ordered to isolate at home for 14 days by a healthcare**

	2025 (this year)	2026 (next year)
		provider due to a COVID-19 diagnosis or exposure. **This benefit is available up to 2 times per calendar year (56 total meals).**
In-Home Support Services	You pay a $0 copay Services are eligible to members following discharge from the hospital or skilled nursing facility or through case management referral. Benefit includes assistance with activities of daily	**Not covered**

	2025 (this year)	2026 (next year)
	living, medication pick-ups, and shopping for groceries or other necessities. Up to 20 hours total for the calendar year.	
Personal Emergency Response System (PERS)	You pay $0 for a mobile PERS device with GPS and fall detection, 24/7/365 monitoring.	**Not covered**

	2025 (this year)	2026 (next year)
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.		
• **Scale**	You pay a $0 copay for plan approved scales.	**Not covered**
Pre-funded Debit Card	You get $60 every month for qualifying fitness expenses.	**Fitness allowance is not covered.**

	2025 (this year)	2026 (next year)
Optional Supplemental Enhanced Dental Benefit	**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%	**The Optional Supplemental Enhanced Dental Benefit is not available.**

	2025 (this year)	2026 (next year)
	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	

	2025 (this year)	2026 (next year)
	70% coinsurance Adjunctive general services: You pay 70% coinsurance Annual benefit limit for out-of-network services: $1,500	

Section 1.6 Changes to Part D 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 calendar 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're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at (866) 314-2427 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and didn’t get this material with this packet, call Member Services at (866) 314-2427 (TTY users call 711) for more information and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 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 no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our

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 don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**The deductible is $615.** **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've reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

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. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*. Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
	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:** $0 **Tier 2 - Generic:** $9 **Tier 3 - Preferred Brand:** $47	**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:** **$0** **Tier 2 - Generic:** **15% of the total cost.** **Tier 3 - Preferred Brand:** **15% of the total cost.**

	2025 (this year)	2026 (next year)
	You pay $0 per month supply of each covered insulin product on this tier. **Tier 4 - Non-Preferred Drug:** $90 **Tier 5 - Specialty Drug:** 33% of the total cost. **Tier 6 - Select Care Drugs:** $0	**You pay $35 per month supply of each covered insulin product on this tier.** **Tier 4 - Non-Preferred Drug:** **30% of the total cost.** **Tier 5 - Specialty Drug:** **25% of the total cost.** **Tier 6 - Select Care Drugs:** **$0**

Changes to the Catastrophic Coverage Stage

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, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Tivity is no longer a contracted vendor for 2026.	Your Fitness/Gym benefits were administered by Tivity D.B.A. SilverSneakers.	**Silver&Fit is the contracted Fitness/Gym vendor for 2026.**
Healthrageous is no longer a contracted vendor for 2026.	Your meal services were available through Healthrageous.	**NationsBenefits is the contracted meals vendor for 2026.**
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will**

	2025 (this year)	2026 (next year)
	covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	**be automatically renewed for 2026.** **To learn more about this payment option, call us at (866) 314-2427 (TTY users call (TTY: 711) or visit www.Medicare.gov**
Your Contract/Plan Benefit Package (PBP) has changed	H5649-025-002	**H5649-025-004**
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	**If you are diagnosed with an eligible chronic condition(s) and meet certain criteria, you may be eligible for special supplemental**

	2025 (this year)	2026 (next year)
	chronically ill. Eligible chronic conditions include: • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes mellitus • Chronic lung disorders • Kidney disease	**benefits for the chronically ill. Eligible chronic conditions include:** • **Cardio-vascular disorders** • **Chronic heart failure** • **Dementia** • **Diabetes mellitus** • **Chronic lung disorders** • **Chronic kidney disease (CKD)** • **Chronic alcohol use disorder and other**

	2025 (this year)	2026 (next year)
		substance use disorders (SUDs) • Cancer • Autoimmune disorders • Overweight, obesity, and metabolic syndrome • Chronic gastro-intestinal disease • Severe hematologic disorders • HIV/AIDS • Chronic and disabling mental health conditions

	2025 (this year)	2026 (next year)
		• Neurologic disorders • Stroke • Post-organ trans-plantation • Immuno-deficiency and Immuno-suppressive disorders • Conditions associated with cognitive impairment • Conditions with functional challenges • Chronic conditions that impair

	2025 (this year)	2026 (next year)
		vision, hearing (deafness), taste, touch, and smell • **Conditions that require continued therapy services in order for individuals to maintain or retain functioning**

SECTION 3 How to Change Plans

To stay in Central Health Embrace Care Plan, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Central Health Embrace Care Plan (HMO C-SNP).

If you want to change plans for 2026 follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Central Health Embrace Care Plan (HMO C-SNP).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Central Health Embrace Care Plan (HMO C-SNP).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at (866) 314-2427 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don’t enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 - December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, you 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 drugs

that are also covered by ADAP qualify for prescription cost-sharing help through the 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 getting help, call (916) 449-5900. 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 payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the **calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at (866) 314-2427 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Section 5.1 Get Help from Central Health Embrace Care Plan (HMO C-SNP)

- **Call Member Services at (866) 314-2427. (TTY users call 711).**

We're available for phone calls Hours are October 1 – March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. to 8 p.m. local time. Calls to these numbers are free.

- **Read your *2026 Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the *2026 Evidence of Coverage* for Central Health Embrace Care Plan (HMO C-SNP). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.centralhealthplan.com or call Member Services at (866) 314-2427 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.centralhealthplan.com**

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs (formulary/Drug List).*

Section 5.2 Get 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
San Francisco County:
Self-Help for the Elderly (San Francisco County)
(415) 677-7520
San Mateo County:
Self Help For The Elderly (San Mateo County)
(650) 627-9350

Call to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Learn more by visiting https://www.aging.ca.gov/hicap.

Section 5.3 Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Additional Important Healthcare and Member Resource Information

- Electronic Notice (ELN) - How to Get Important Documents
- Notice of Availability (NOA) – Language Assistance Services
- Non-Discrimination Notice (NDN) – Section 1557
- Notice of Privacy Practices (NPP)

How to Get Important Plan Documents

CENTRAL HEALTH MEDICARE PLAN

You are important to us! We make it easy for you to get the information you need. Go online to view important plan documents and find a network provider or pharmacy. You can also look up your prescription drugs, anytime, anywhere, from any device. Your 2026 plan documents, like your Evidence of Coverage, Formulary, and Provider/ Pharmacy Directory will be available online by October 15, 2025.

Get to know your plan documents

- **Evidence of Coverage (EOC):** A guide to what's covered under your plan. It has details about your plan benefits and coverage, member rights, and more.
- **Formulary (Drug List):** A list of covered drugs under your plan.
- **Provider/Pharmacy Directory:** A list of network doctors, specialists, and pharmacies with phone numbers and addresses. You can find a network provider or pharmacy using our online directory at **CentralHealthPlan.com/doctor**.
- **Notice of Privacy Practice:** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This is located on our website at **CentralHealthPlan.com/chp/Member/PrivacyNotice**.

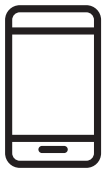
How to view or request a copy of a plan document

Online at CentralHealthPlan.com

View or download a copy of your plan documents online anytime, anywhere. Use any device, like your computer, tablet, or mobile phone. Your 2026 plan documents will be available online by October 15, 2025.

Online at MyCHPportal.com.

Visit our self-service member portal to view your plan documents online 24/7, or to find a network provider or pharmacy. Sign in to your Member Portal or set up an account at **MyCHPportal.com**. Click "Create an Account" and follow the step-by-step instructions to sign up.



Call toll-free

Let us know if you don't have computer access or if you prefer to have a printed copy of an EOC, Formulary, or Provider/Pharmacy Directory mailed to you. To request a printed copy of a plan document, call Member Services toll-free at **the number located on the back of your ID card, Monday - Friday, 8 a.m. to 8 p.m., local time**.

We’re here to help

If you have questions about your benefits or need help finding a network provider or pharmacy, call Member Services toll-free at **the number located on the back of your ID card**.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you need help in your language call 1-866-314-2427(TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-866-314-2427(TTY: 711). These services are free of charge.

العربية (Arabic)

يرجى الانتباه،: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-866-314-2427، (وبالنسبة لمستخدمي الهاتف النصي TTY: يمكنهم الاتصال على 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير، اتصل بـ 1-866-314-2427 (وبالنسبة لمستخدمي الهاتف النصي TTY: يمكنهم الاتصال على 711). هذه الخدمات مجانية.

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. եթե ձեզ հարկավոր է աջակցություն ձեր լեզվով, ապա զանգահարեք 1-866-314-2427 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող անձանց համար գործումեն նաև օժանդակ միջոցներ ու

ծառայություններ, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպատառով տրամադրվող նյութեր: Տվյալ դեպքում զանգահարեք 1-866-314-2427 (TTY՝ 711) հեռախոսահամարով: Ծառայությունները գործում են անվճար:

ខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក
សូមទូរសព្ទទៅលេខ 1-866-314-2427(TTY: 711)។
ជំនួយ និងសេវាកម្មសម្រាប់ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរផុសសម្រាប់ជនពិការភ្នែក
ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។
ទូរសព្ទមកលេខ 1-866-314-2427(TTY: 711)។
សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文 (Chinese)

请注意：如果您需要以您的语言提供帮助，请致电 1-866-314-2427(TTY: 711)。另外还提供针对残疾人士的辅助工具和服务，例如盲文文件和大字体文件。请致电 1-866-314-2427(TTY: 711)。这些服务均免费提供。

CENTRAL HEALTH MEDICARE PLAN

Notice of Availability/Taglines – Section 1557
Central Health Plan

فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود راهنمایی دریافت کنید، با (711 :TTY) 1-866-314-2427تماس بگیرید. کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌هایی به خط بریل و چاپ درشت، نیز موجود است. با 1-866-314-2427 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-866-314-2427(TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बडे प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-866-314-2427(TTY: 711) पर कॉल करें। ये सेवाएं निशुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-866-314-2427 (TTY: 711). Tsis tas li ntawd, kuj tseem muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-866-314-2427(TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

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日本語 (Japanese)

注記：日本語での対応が必要な場合は 1-866-314-2427 (TTY: 711) までお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスもご用意しております。
1-866-314-2427(TTY: 711)までお電話ください。これらのサービスは無料です。

CENTRAL HEALTH MEDICARE PLAN

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한국어 (Korean)

알림: 귀하의 언어로 도움을 받고 싶으시면
1-866-314-2427 (TTY: 711)번으로 전화하십시오.
점자나 큰 활자로 된 문서와 같이 장애가 있는
분들을 위한 지원 및 서비스도 이용하실 수
있습니다. 1-866-314-2427(TTY: 711)번으로
전화하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ:
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໃ_
ຫ້ໂທຫາເບີ 1-866-314-2427(TTY: 711).
ນອກນີ້ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະ
ການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນ:
ເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່
ໃຫ້ໂທຫາເບີ 1-866-314-2427(TTY: 711).
ການບໍລິການເຫົ່ານີ້ແມ່ນຟຣີ.

CENTRAL HEALTH MEDICARE PLAN

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Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-866-314-2427(TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-866-314-2427(TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ 1-866-314-2427(TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। 1-866-314-2427(TTY: 711)'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

CENTRAL HEALTH MEDICARE PLAN

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Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-866-314-2427(TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-866-314-2427(TTY: 711). Такие услуги = бесплатны.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-866-314-2427(TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-866-314-2427(TTY: 711). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-866-314-2427(TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-866-314-2427(TTY: 711). Libre ang mga serbisyong ito.

CENTRAL HEALTH MEDICARE PLAN

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ภาษาไทย (Thai)
โปรดทราบ:
หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-866-314-2427(TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-866-314-2427(TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Українська (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-866-314-2427(TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами й послугами, наприклад отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-866-314-2427(TTY: 711). Ці послуги безкоштовні.

CENTRAL HEALTH MEDICARE PLAN

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Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-866-314-2427 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-866-314-2427 (TTY: 711). Các dịch vụ này đều miễn phí.

Non-Discrimination Notice
Section 1557
Central Health Plan

CENTRAL HEALTH MEDICARE PLAN

Discrimination is against the law. Central Health Plan follows State and Federal civil rights laws. Central Health Plan does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Central Health Plan provides:

- Free aids and services in a timely manner to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services in a timely manner to people whose primary language is not English, such as:
  - Qualified interpreters
  - Written information in other languages

If you need these services, contact Central Health Plan between 8:00 a.m. to 8:00 p.m. by calling 1-866-314-2427. If you cannot hear or speak well, please call 711. Upon request, this document can be made available to you in braille, large print,

audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Central Health Plan
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

By phone: 1-866-606-3889. If you cannot hear or speak well, please call 711.

HOW TO FILE A GRIEVANCE

If you believe that Central Health Plan has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Central Health Plan's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact Central Health Plan's Civil Rights Coordinator between 8:30 a.m. to 5:30 p.m. by calling 1-866-606-3889. Or, if you cannot hear or speak well, please call 711.

- **In writing:** Fill out a complaint form or write a letter and send it to:
  Central Health Plan
  Civil Rights Coordinator
  200 Oceangate, Suite 100
  Long Beach, CA 90802

- **In person:** Visit your doctor's office or Central Health Plan and say you want to file a grievance.
- **Electronically:** Send an email to **Civil.Rights@MolinaHealthcare.com**. You can also visit Central Health Plan's website at **MolinaHealthcare.Alertline.com**.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call 916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- **In writing:** Fill out a complaint form or send a letter to:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413
  Sacramento, CA 95899-7413

  Complaint forms are available at **DHCS.ca.gov/Pages/Language_Access.aspx**.
- **Electronically:** Send an email to **CivilRights@dhcs.ca.gov**.

OFFICE OF CIVIL RIGHTS – U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file

a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone, in writing, or electronically:

- **By phone:** Call 1-800-368-1019. If you cannot speak or hear well, please call TTY/TDD: 1-800-537-7697.
- **In writing:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at **HHS.gov/ocr/office/file/index.html**.
- **Electronically:** Visit the Office for Civil Rights Complaint Portal at **OCRportal.hhs.gov/ocr/portal/lobby.jsf**.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Molina Healthcare's affiliated health plans (referred to herein as "**Molina**", "**we**" or "**our**"). We use and share protected health information ("**PHI**") about you to provide your health benefits as a Molina member. We use and share your PHI to carry out treatment, payment and health care operations. We also use and share your PHI for other reasons as allowed and required by law. We have the duty to keep your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2026.

PHI is health information that includes your name, member number or other identifiers, and is used or shared by us. PHI includes health information about substance use disorders and biometric information (like a voiceprint).

Why do we use or share your PHI?

We use or share your PHI to provide you with health care benefits. Your PHI is also used or shared for treatment, payment, and health care operations.

For Treatment

We may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment

We may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations

We may use or share PHI about you to run our health plan(s). For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve your concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Addressing member needs, including solving complaints and grievances.

We will share your PHI with other companies ("**business associates**") that perform different kinds of activities for our health plan(s). We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment(s), or other health-related benefits and services.

When can we use or share your PHI without getting written authorization (approval) from you?
In addition to treatment, payment and health care operations, the law allows or requires Molina to use and share your PHI for several other purposes including the following:

Required by law
We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health
Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight
Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research
Your PHI may be used or shared for research in certain cases, such as when approved by a privacy or institutional review board.

Legal or Administrative Proceedings
Your PHI may be used or shared for legal proceedings, such as in response to a court order.

Law Enforcement
Your PHI may be used or shared with police for law enforcement purposes, such as to help find a suspect, witness or missing person.

Health and Safety
Your PHI may be shared to prevent a serious and imminent threat to the health or safety of a person or the public.

Government Functions
Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence
Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers' Compensation
Your PHI may be used or shared to obey Workers' Compensation laws.

Other Disclosures
Your PHI may be shared with funeral directors or coroners to help them do their jobs.

Additional Restrictions on Use and Disclosure.
Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain types of health information. Such laws may protect the following types of information: alcohol and substance use disorders, biometric information, child or adult abuse or neglect including sexual assault, communicable diseases, genetic information, HIV/AIDS, mental health, minors' information, prescriptions, reproductive health, and sexually transmitted diseases. We will follow the more stringent law, where it applies to us.

Substance Use Disorder (SUD) Information. Although we are not a substance use disorder treatment program under federal law (a "SUD Program"), we may receive information from a SUD Program about you. We may not disclose SUD information for use in a civil, criminal, administrative, or legislative proceeding against you unless we have

(i) your written consent, or (ii) a court order accompanied by a subpoena or other legal requirement compelling disclosure issued after we and you were given notice and an opportunity to be heard.

When do we need your written authorization (approval) to use or share your PHI?

We need your written approval to use or share your PHI for a purpose other than those listed in this Notice. We need your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**
  You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use our form to make your request.

- **Request Confidential Communications of PHI**
  You may ask Molina to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use our form to make your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions about you as our member. You will need to make your request in writing. You may use our form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases, we may deny the request. *Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.*

- **Amend Your PHI**
  You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use our form to make your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law;
  - PHI released in the interest of national security or for intelligence purposes; or
  - as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if you ask for this list more than once in a 12- month period. You will need to make your request in writing. You may use our form to make your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Member Services department at the toll-free number on the back of your ID card, 7 days a week, 8 a.m. to 8 p.m., local time. TTY/ TDD users, please call 711.

What can you do if your rights have not been protected?
You may complain to us and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care and benefits will not change in any way.

You may file a complaint with us at:

Call Member Services at the toll-free number on the back of your ID card, 7 days a week, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711. Or write to us at:

Molina Healthcare
Attn: Appeals and Grievances
P.O. Box 22816
Long Beach, CA 90801-9977

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

U.S. Department of Health &
Human Services Office for Civil
Rights
200 Independence
Ave., S.W. Suite
509F, HHH Building
Washington, D.C.
20201
(800) 368-1019; (800) 537-7697 (TDD); (202) 619-3818 (FAX)

What are our duties?

We are required to:

- Keep your PHI private;
- Give you written information such as this on our duties and privacy practices about your PHI;
- Provide you with a notice in the event of any breach of your unsecured PHI;
- Not use or disclose your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

We reserve the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, we will post the revised Notice on our website and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by us. This Notice is available on our website at www.molinahealthcare.com.

Contact Information

If you have any questions about this Notice, please contact us.

Call our Member Services department at the toll-free number on the back of your ID card; 7 days a week, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711. Or write to Molina Member Services, 200 Oceangate, Suite 100, Long Beach, CA 90802.

You can get this document for free in other formats, such as large print, braille, or audio. Call (855) 882-3901, TTY/TDD: 711, 7 days a week, 8 a.m. to 8 p.m., local time. The call is free.

PO Box 298
Monroe, WI 53566-0298
Attn: Enrollment Accounting

Important Molina Healthcare Information

CENTRAL HEALTH MEDICARE PLAN

CAACEN26L00051