Aspire Health Plus HMO-POS offered by Aspire Health Plan

Annual Notice of Changes for 2024

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

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

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

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

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

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

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

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

Additional Resources

- This document is available for free in *Spanish.*
- Please contact our Member Services number at (855) 570-1600 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm PT Monday through Friday from April 1 through September 30, and 8 am to 8 pm PT seven days a week for the period of October 1 through March 31 (except certain holidays).This call is free.
- This document is also available in alternative formats (i.e., large print, braille and audio CD).
- **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 *Aspire Health Plus*

- Aspire Health Plan is a Medicare Plus HMO-POS plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal.
- When this document says "we," "us," or "our", it means *Aspire Health Plan.* When it says "plan" or "our plan," it means *Aspire Health Plus*.

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

The table below compares the 2023 costs and 2024 costs for *Aspire Health Plus* in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$269.00	$312.00
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,000	$3,400
Doctor office visits	Primary care visits: **In-network:** You pay a $0 co-pay per visit. **Out-of-network*:** You pay a 20% co-insurance for each primary care doctor visit. Specialist visits: **In-network:** You pay a $20 co-pay for each specialist visit. **Out-of-network*:** You pay a 20% co-insurance for each specialist visit.	Primary care visits: **In-network:** You pay a $0 co-pay per visit. **Out-of-network*:** You pay a 30% co-insurance for each primary care doctor visit. Specialist visits: **In-network:** You pay a $20 co-pay for each specialist visit. **Out-of-network*:** You pay a 30% co-insurance for each specialist visit.

Doctor office visits (continued)	*Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.	*Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Inpatient hospital stays	**In-network:** Days 1-5: You pay a $220 co-pay per day. Days 6-90: You pay a $0 co-pay per day. **Out-of-network*:** Days 1-90: You pay a 20% co-insurance per stay. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.	**In-network:** Days 1-5: You pay a $250 co-pay per day. Days 6-90: You pay a $0 co-pay per day. **Out-of-network*:** Days 1-90: You pay a 30% co-insurance per stay. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Thirty (30) day retail cost-sharing (in network):	Deductible: $0 Copayment/Coinsurance as applicable during the Initial Coverage Stage: Thirty (30) day retail cost-sharing (in network):

Part D prescription drug coverage (continued)	• **Drug Tier 1**: $0 • **Drug Tier 2:** $10 • **Drug Tier 3:** $42 You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4:** $90 You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** 33% You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 6:** $11	• **Drug Tier 1:** $0 • **Drug Tier 2:** $10 • **Drug Tier 3:** $42 You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4:** $90 You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** 33% You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 6:** $11
	Ninety (90) day retail cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 • **Drug Tier 4:** $180 You pay $105 per 90-day supply of each covered insulin product on this tier. • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22	One-hundred (100) day retail cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 • **Drug Tier 4:** $180 You pay $70 per 100-day supply of each covered insulin product on this tier. • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22

Part D prescription drug coverage (continued)	Ninety (90) day mail-order cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 • **Drug Tier 4:** $180 You pay $105 per 90-day supply of each covered insulin product on this tier. • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22 Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.).	One-hundred (100) day mail-order cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 You pay $70 per 100-day supply of each covered insulin product on this tier. • **Drug Tier 4:** $180 You pay $70 per 100-day supply of each covered insulin product on this tier. • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22 Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$269.00	$312.00
Enhanced Benefits – Option A This optional supplemental benefit includes comprehensive dental coverage and an eyewear benefit, and is available for an additional monthly premium.	$44.90 in additional premium per month if you choose to enroll in this optional coverage.	$44.90 in additional premium per month if you choose to enroll in this optional coverage.
Enhanced Benefits – Option B This optional supplemental benefit includes comprehensive dental coverage, an eyewear benefit, a routine hearing exam, a hearing aid benefit, 10 additional one-way rides to in-network appointments, and 14 meals following each inpatient hospital or skilled nursing facility stay or for certain chronic conditions for a temporary period and is available for an additional monthly premium.	$49.90 in additional premium per month if you choose to enroll in this optional coverage.	$49.90 in additional premium per month if you choose to enroll in this optional coverage.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

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

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,000 In-network. Once you have paid $3,000 out-of-pocket for in-network covered Part A and Part B services, you will pay nothing for your in-network covered Part A and Part B services for the rest of the calendar year.	$3,400 In-network. Once you have paid $3,400 out-of-pocket for in-network covered Part A and Part B services, you will pay nothing for your in-network covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at *www.aspirehealthplan.org*. 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 no changes to our network of providers for next year.

There are no changes to our network of pharmacies for next year.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2023 (this year)	2024 (next year)
Ambulance services	You pay a $200 co-payment for Medicare-covered ambulance benefits per one-way trip via ground transportation. You pay a 20% co-insurance for Medicare-covered ambulance benefits per one-way trip via air transportation. The ambulance co-payment or co-insurance will be waived if admitted or placed under observation within 24 hours.	You pay a $300 co-payment for Medicare-covered ambulance benefits per one-way trip via ground transportation. You pay a 20% co-insurance for Medicare-covered ambulance benefits per one-way trip via air transportation. The ambulance co-payment or co-insurance will not be waived if admitted or placed under observation within 24 hours.
Hearing Services	You pay a $0 co-payment for each Medicare-covered diagnostic hearing exam.	You pay a $20 co-payment for each Medicare-covered diagnostic hearing exam.
Inpatient hospital care	Days 1-5: You pay $220 co-pay per day. Days 6-90: You pay $0 co-pay per day.	Days 1-5: You pay $250 co-pay per day. Days 6-90: You pay $0 co-pay per day.
Inpatient services in a psychiatric hospital	Days 1-5: You pay $220 co-pay per day. Days 6-90: You pay $0 co-pay per day.	Days 1-5: You pay $250 co-pay per day. Days 6-90: You pay $0 co-pay per day.

Cost	2023 (this year)	2024 (next year)
Medicare Part B prescription drugs	You pay a $50 co-payment for Medicare-covered Part B prescription drugs.	You pay a $35 co-payment for a 30-day supply of Medicare-covered Part B insulin. You pay a 0% to 20% co-insurance for all other Medicare-covered Part B prescription drugs. Prior authorization and step therapy rules may apply.
Outpatient hospital observation	You pay a $250 co-payment per stay for Medicare-covered observation services at Medicare-covered facilities.	You pay a $250 co-payment per day for Medicare-covered observation services at Medicare-covered facilities.
Outpatient rehabilitation services	Prior authorization rules may apply after 12 visits.	Prior authorization rules may apply after 6 visits.
Podiatry services	You pay a $0 co-payment for each Medicare-covered service visit.	You pay a $20 co-payment for each Medicare-covered service visit.

Cost	2023 (this year)	2024 (next year)
Point-of-Service (POS) Benefits *Out-of-network coverage is restricted to Medicare-eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.	Out-of-Network*: You pay a $0 co-payment for Medicare-covered preventive services. You pay a $200 co-payment for Medicare-covered ambulance benefits per one-way trip via ground transportation. You pay a 20% co-insurance for Medicare-covered ambulance benefits per one-way trip via air transportation. The ambulance co-payment or co-insurance will be waived if admitted or placed under observation within 24 hours. You pay a 20% co-insurance for Medicare-covered renal dialysis services. You pay a 20% co-insurance for all other Medicare-covered services.	Out-of-Network*: You pay a $0 co-payment for Medicare-covered preventive services. You pay a $300 co-payment for Medicare-covered ambulance benefits per one-way trip via ground transportation. You pay a 20% co-insurance for Medicare-covered ambulance benefits per one-way trip via air transportation. The ambulance co-payment or co-insurance will not be waived if admitted or placed under observation within 24 hours. You pay a 20% co-insurance for Medicare-covered renal dialysis services. You pay a 30% co-insurance for all other Medicare-covered services.
Skilled nursing facility (SNF) care	Days 1-20: You pay $0 co-pay per day. Days 21-100: You pay $50 co-pay per day.	Days 1-20: You pay $0 co-pay per day. Days 21-100: You pay $100 co-pay per day.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Members may qualify for the following benefits, if the criteria for participation is met: • Transportation • Meals • Food and Produce • Indoor Air Quality Equipment and Services • Social Benefit Needs • General Supports for Living	Members may qualify for the following benefits, if the criteria for participation is met: • Transportation • Meals • Food and Produce
Vision Care	You pay a $0 co-payment for each Medicare-covered exam to diagnosis and treat conditions of the eye (including yearly glaucoma screening).	You pay a $20 co-payment for each Medicare-covered exam to diagnosis and treat conditions of the eye (including yearly glaucoma screening).

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

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

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can

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

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by *September 30, 2023* please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic:** You pay $0 per prescription.	Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic:** You pay $0 per prescription.

Stage	2023 (this year)	2024 (next year)
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List."	**Generic:** You pay $10 per prescription. **Preferred Brand:** You pay $42 per prescription. **Non-Preferred Drug:** You pay $90 per prescription. **Specialty:** You pay 33% of the total cost. **Select Insulins:** You pay $11 per prescription. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	**Generic:** You pay $10 per prescription. **Preferred Brand:** You pay $42 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Non-Preferred Drug:** You pay $90 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Specialty:** You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Select Insulins:** You pay $11 per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

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

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Pharmacy Days' Supply	You can fill a prescription up to 90 days at retail or mail for the following tiers: 1,2,3,4 and 6.	You can fill a prescription up to 100 days at retail or mail for the following tiers: 1,2,3,4 and 6.
Routine Vision Vendor – Enhanced Benefit Option A and B	The routine vision vendor is MES Vision.	The routing vision vendor is VSP.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Aspire Health Plus*

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 *Aspire Health Plus.*

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2). As a reminder, Aspire Health 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 *Aspire Health Plus*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Aspire Health Plus*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called **California Department of Aging's Health Insurance Counseling and 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. **California Department of Aging's Health Insurance Counseling and 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 **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** at local: 831-655-1334 or toll free: 800-434-0222. You can learn more about **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** by visiting their website (https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Monterey County ADAP Office located at 340 Church Street, Salinas, CA 93901. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP office at 831-975-5016.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Aspire Health Plus*

Questions? We're here to help. Please call Member Services at (855) 570-1600. (TTY only, call 711). We are available for phone calls 8 am to 8 pm PT Monday through Friday from April 1 through September 30, and 8 am to 8 pm PT seven days a week for the period of October 1 through March 31 (except certain holidays). Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for *Aspire Health Plus*. 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.aspirehealthplan.org*. 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.aspirehealthplan.org*. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/"Drug List").*

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

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

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.