

UCLA Health Medicare Advantage Prestige Plan (HMO) offered by UCLA Health Medicare Advantage Plan

Annual Notice of Change for 2026

You're enrolled as a member of UCLA Health Medicare Advantage Prestige Plan.

This material describes changes to our plan's costs and benefits for 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 UCLA Health Medicare Advantage Prestige Plan.
- 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 UCLAHealthMedicareAdvantage.org/resources or call Member Services at 1-833-627-8252 (TTY users call 711) to get a copy by mail.

More Resources:

- This material is available for free in Spanish.
- Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.
- Call Member Services at 1-833-627-8252 (TTY users call 711) for more information. Hours are 8am - 8pm PST, Monday - Friday, April 1 through September 30, except on all federal holidays. Hours are 8am - 8pm PST, 7 days a week, October 1 through March 31, except Thanksgiving Day and Christmas Day. This call is free.
- This document is also available in alternative formats (e.g. braille, large print, audio).

About UCLA Health Medicare Advantage Prestige Plan (HMO)

- UCLA Health Medicare Advantage Plan is a Medicare Advantage HMO organization with a Medicare contract. Enrollment into UCLA Health Medicare Advantage depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means UCLA Health Medicare Advantage Plan. When it says “plan” or “our plan,” it means UCLA Health Medicare Advantage Prestige Plan.
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in UCLA Health Medicare Advantage Prestige Plan.** Starting January 1, 2026, you’ll get your medical and drug coverage through UCLA Health Medicare Advantage Prestige Plan. Go to Section 3 for more information about how to change plans and deadlines for making a change.

Table of Contents

Summary of Important Costs for 2026	4
SECTION 1 Changes to Benefits & Costs for Next Year	6
Section 1.1 Changes to the Monthly Plan Premium	6
Section 1.2 Changes to Your Maximum Out-of-Pocket Amount	7
Section 1.3 Changes to the Provider Network	7
Section 1.4 Changes to the Pharmacy Network.....	7
Section 1.5 Changes to Benefits & Costs for Medical Services	8
Section 1.6 Changes to Part D Drug Coverage	14
Section 1.7 Changes to Prescription Drug Benefits & Costs	15
SECTION 2 Administrative Changes	18
SECTION 3 How to Change Plans.....	19
Section 3.1 Deadlines for Changing Plans.....	20
Section 3.2 Are there other times of the year to make a change?	20
SECTION 4 Get Help Paying for Prescription Drugs	21
SECTION 5 Questions?	22
Get Help from UCLA Health Medicare Advantage Prestige Plan (HMO)	22
Get Free Counseling about Medicare	22
Get Help from Medicare	23

Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1 for details.	\$39	\$45
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered services. (Go to Section 1 for details.)	\$1,499	\$1,499
Primary care office visits	\$0 per visit	\$0 per visit
Specialist office visits	\$0 per visit	\$0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital 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.	\$0	\$0

	2025 (this year)	2026 (next year)
Part D drug coverage deductible (Go to Section 1 for details.)	\$0	\$0 deductible applies to Tier 1 and Tier 2, \$250 deductible applies to Tiers 3, 4, and 5 except for covered insulin products and most adult Part D vaccines
Part D drug coverage (Go to Section 1 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	\$0 during the Initial Coverage Stage: Drug Tier 1: \$0 Drug Tier 2: \$0 Drug Tier 3: \$47 per monthly supply (you pay a maximum of \$35 per month of an insulin product on this tier) Drug Tier 4: 45% co-insurance Drug Tier 5: 33% co-insurance Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under an enhanced benefit.	\$0 during the Initial Coverage Stage: Drug Tier 1: \$0 Drug Tier 2: \$0 Drug Tier 3: \$47 per monthly supply (you pay a maximum of \$35 per month of an insulin product on this tier) Drug Tier 4: 45% co-insurance Drug Tier 5: 30% co-insurance Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under the 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.)	\$39	\$45

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.
 - **Extra Help** - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 1 for more information about Extra Help from Medicare.
- Section 1.2 Changes to Your Maximum Out-of-Pocket Amount.

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 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. Your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$1,499	\$1,499 (There is no change for the upcoming benefit year) Once you've paid \$1,499 out of pocket for covered services, you'll pay nothing for your covered 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* UCLAHealthMedicareAdvantage.org/providers 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 UCLAHealthMedicareAdvantage.org.
- Call Member Services at 1-833-627-8252 (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 1-833-627-8252 (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* UCLAHealthMedicareAdvantage.org/pharmacy to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at UCLAHealthMedicareAdvantage.org.
- Call Member Services at 1-833-627-8252 (TTY users call 711) to get current pharmacy 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 1-833-627-8252 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
24/7 Nursing Hotline	\$0 copay to speak with a registered nurse (RN) 24 hours a day, 7 days a week ¹	Not covered. Refer to the Telehealth Benefit for new benefit details
Diabetes self-management training, diabetic services, and supplies ²	\$0 copayment	20% coinsurance for Continuous Glucose Monitors \$0 copay for all other diabetic supplies
Flex Allowance Smart Benefits Card & more	\$650 allowance per year to be used for covered dental and vision services through most providers, and hearing services through TruHearing providers. Any unused allowance does not rollover ¹	\$700 allowance per year to be used for covered dental, vision and hearing services at allowed locations. Any unused allowance does not rollover ¹

¹ Benefits are available exclusively through the plan's designated vendors

² May require referral and/or pre-authorization from the plan

	2025 (this year)	2026 (next year)
Personalized Emergency Response System (PERS)	\$0 copay for one personal emergency response system (PERS)	Not covered. You will receive additional information in the mail about available options if you are currently utilizing this service
Post-Discharge Medication Reconciliation	\$0 copay for one in-home medication reconciliation following hospital and skilled nursing facility discharges with a referral	Not covered
Support for Caregivers of Enrollees	\$0 copay for caregiver navigation support and 8 hours per year of respite care	Not covered
Telehealth Benefit	Not covered	24/7 access to virtual non-emergency medical consultations with a licensed provider¹

¹ Benefits are available exclusively through the plan's designated vendors

	2025 (this year)	2026 (next year)
Healthy food benefit Smart Benefits Card & more ¹	\$30 monthly allowance for healthy foods such as fruits, vegetables, whole grains, and more, at select grocers when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI). Any unused allowance does not rollover Special Supplemental Benefits for the Chronically Ill (SSBCI) are special supplemental benefits for qualifying members. Not all members will qualify. To be eligible, you must be enrolled in the Prestige Plan, meet all applicable coverage criteria, and have one or more of the following chronic conditions: Cancer, End-Stage Renal Disease (ESRD), Stroke, chronic heart failure, Dementia, and Diabetes	\$40 monthly allowance for healthy foods such as fruits, vegetables, whole grains, and more, at select grocers when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI). Any unused allowance does not rollover Special Supplemental Benefits for the Chronically Ill (SSBCI) are available to qualifying Prestige Plan members. To be eligible, you must complete the Health Risk Assessment, meet all coverage criteria, and have one or more of the following chronic conditions: Chronic Kidney Disease, Chronic Heart Failure, or Diabetes. Having a condition alone does not guarantee eligibility, as other criteria apply

¹ Benefits are available exclusively through the plan's designated vendors

	2025 (this year)	2026 (next year)
Home safety assessment	\$0 copay for one in-home safety assessment with an occupational therapist through the vendor Jukebox Health ¹	\$0 copay for one in-home safety assessment per year when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI) through the vendor Periscope¹ Special Supplemental Benefits for the Chronically Ill (SSBCI) are available to qualifying Prestige Plan members. To be eligible, you must complete the Health Risk Assessment, meet all coverage criteria, and have one or more of the following chronic conditions: Chronic Kidney Disease, Chronic Heart Failure, or Diabetes. Having a condition alone does not guarantee eligibility, as other criteria apply

¹ Benefits are available exclusively through the plan's designated vendors

	2025 (this year)	2026 (next year)
Home safety modification Smart Benefits Card & more ¹	\$750 annual allowance for home safety modifications which can include delivery and installation when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI) through the vendor Jukebox Health. Any unused allowance does not rollover to the next year. Limitations and exclusions apply. Special Supplemental Benefits for the Chronically Ill (SSBCI) are special supplemental benefits for qualifying members. Not all members will qualify. To be eligible, you must be enrolled in the Prestige Plan, meet all applicable coverage criteria, and have one or more of the following chronic conditions: Cancer, End-Stage Renal Disease (ESRD), Stroke, chronic heart failure, Dementia, and Diabetes	\$750 annual allowance for home safety modifications on the Smart Benefits Card when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI). Any unused allowance does not rollover to the next year. Limitations and exclusions apply. Special Supplemental Benefits for the Chronically Ill (SSBCI) are available to qualifying Prestige Plan members. To be eligible, you must complete the Health Risk Assessment, meet all coverage criteria, and have one or more of the following chronic conditions: Chronic Kidney Disease, Chronic Heart Failure, or Diabetes. Having a condition alone does not guarantee eligibility, as other criteria apply

¹ Benefits are available exclusively through the plan's designated vendors

	2025 (this year)	2026 (next year)
Medically Tailored Meal Kits	13 meal kits tailored to support chronic conditions. Each meal kit includes a customized meal plan and ingredients to make 10 medically-tailored meals when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI) ¹ Special Supplemental Benefits for the Chronically Ill (SSBCI) are special supplemental benefits for qualifying members. Not all members will qualify. To be eligible, you must be enrolled in the Prestige Plan, meet all applicable coverage criteria, and have one or more of the following chronic conditions: Cancer, End-Stage Renal Disease (ESRD), Stroke, chronic heart failure, Dementia, and Diabetes.	13 meal kits tailored to support chronic conditions. Each meal kit includes a customized meal plan and ingredients to make 10 medically-tailored meals when eligibility criteria is met for the Special Supplemental Benefits for the Chronically Ill (SSBCI) ¹ Special Supplemental Benefits for the Chronically Ill (SSBCI) are available to qualifying Prestige Plan members. To be eligible, you must complete the Health Risk Assessment, meet all coverage criteria, and have one or more of the following chronic conditions: Chronic Kidney Disease, Chronic Heart Failure, or Diabetes. Having a condition alone does not guarantee eligibility, as other criteria apply

¹ Benefits are available exclusively through the plan's designated vendors

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. **You can get the complete Drug List** by calling Member Services at 1-833-627-8252 (TTY users call 711) or visiting our website at UCLAHealthMedicareAdvantage.org/formulary.

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 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 1-833-627-8252 (TTY users call 711) for more information.

Starting in 2026, we can immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and *with* the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

For example: If you take a brand name drug or biological product that's being replaced by a generic or biosimilar version, you may not get notice of the change 30 days in advance, or before you get a month's supply of the brand name drug or biological product. You might get information on the specific change after the change is already made.

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: www.FDA.gov/drugs/biosimilars/multimedia-education-materials-

[biosimilars#For%20Patients](#). You can also call Member Services at 1-833-627-8252 (TTY users call 711) or ask your health care provider, prescriber, or pharmacist 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 sent you 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 call Member Services at 1-833-627-8252 (TTY users call 711) 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 3, 4 and 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	\$250 deductible During this stage, you pay \$0 cost sharing for drugs on Tiers 1 and 2. The annual deductible amount applies to drugs on Tiers 3, 4 and 5 with co-insurance until you've reached the yearly deductible

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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)
Preferred Generic Drugs:	\$0 copayment	\$0 copayment
Generic Drugs:	\$0 copayment	\$0 copayment

	2025 (this year)	2026 (next year)
Preferred Brand Drugs:	\$47 copayment	\$47 copayment
Non-Preferred Drugs	45% of the total cost	45% of the total cost
Specialty Tier Drugs	33% of the total cost	30% of the total cost

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)
Paying by credit card or debit card in the MyChart member portal	One-time payments and automatic recurring payments of your monthly plan premium or Part D late enrollment penalty may be made automatically using credit card, debit card, ApplePay or GooglePay in the Member Portal (MyChart) at no charge. If you do not have a Member Portal (MyChart) account, you can pay as a Guest. There is no fee to use this service. Generally, we will charge your selected form of payment on the 1st of each month. To choose this option, please contact Member Services. We will be happy to walk you through this option	One-time payments and automatic recurring payments of your monthly plan premium or Part D late enrollment penalty may be automatically withdrawn from your checking or savings account, using credit card, debit card, ApplePay or GooglePay in the Member Portal (MyChart) at no charge. If you do not have a Member Portal (MyChart) account, you can pay as a Guest. There is no fee to use this service. Generally, we will charge your selected form of payment on the 1st of each month. To choose this option, please contact Member Services. We will be happy to walk you through this option

	2025 (this year)	2026 (next year)
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 covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-833-627-8252 (TTY users call 711) or visit www.Medicare.gov
Post-Discharge Meals	\$0 copay for 28 home-delivered meals immediately after inpatient hospitalizations or skilled nursing facility (SNF) stays with qualifying referrals through the vendor GA Foods ¹	\$0 copay for 28 home-delivered meals immediately after inpatient hospitalizations or skilled nursing facility (SNF) stays with qualifying referrals through the vendor Rx Diet ^{1,2}

¹ Benefits are available exclusively through the plan's designated vendors

² May require referral and/or prior authorization from the plan

SECTION 3 How to Change Plans

To stay in UCLA Health Medicare Advantage Prestige 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 UCLA Health Medicare Advantage Prestige Plan.

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 UCLA Health Medicare Advantage Prestige Plan.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from UCLA Health Medicare Advantage Prestige Plan.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-833-627-8252 (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).
- **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 4), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, UCLA Health Medicare Advantage Plan offers another Medicare health plan. The other plan can have different coverage, monthly plan premiums, and cost-sharing amounts.

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 separate 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 separate 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 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.
- **Help from your state's pharmaceutical assistance program (SPAP).** California has a program called California Rx Card that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **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 California AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call at 1-844-421-7050. 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 1-833-627-8252 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from UCLA Health Medicare Advantage Prestige Plan

- **Call Member Services at 1-833-627-8252. (TTY users call 711.)**
We're available for phone calls, hours are 8am - 8pm PST, Monday - Friday, April 1 through September 30, except on all federal holidays. Hours are 8am - 8pm PST, 7 days a week, October 1 through March 31, except Thanksgiving Day and Christmas Day. 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 UCLA Health Medicare Advantage Prestige Plan. 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 UCLAHealthMedicareAdvantage.org or call Member Services at 1-833-627-8252 (TTY users call 711) to ask us to mail you a copy.
- **Visit UCLAHealthMedicareAdvantage.org/resources**
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).

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 California Rx Card.

Call California Rx Card to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call California Rx Card at 1-800-726-4232.

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 at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Required Information:

UCLA Health Medicare Advantage Plan (HMO) has a contract with Medicare and enrollment in the plan depends on contract renewal. UCLA Health Medicare Advantage Plan includes Part D drug coverage. To enroll in UCLA Health Medicare Advantage Plan, you must have both Medicare Parts A and B and reside in the plan service area, Los Angeles County. In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Every year, Medicare evaluates plans based on a 5-star rating system. Star ratings may vary by contract or market. For plan year 2026, UCLA Health Medicare Advantage Plan's H4647 (HMO) contract is too new to be measured for a Star rating.

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