Central Health Medicare Plan (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

How much is the monthly premium?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Central Health Medicare Plan is an HMO plan with a Medicare contract. Enrollment in Central Health Medicare Plan depends on contract renewal.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:
SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.
SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

OUTPATIENT CARE AND SERVICES

Acupuncture[1,2]	For up to 24 visit(s) every year: You pay nothing. All Central Health Plan members receive 24 acupuncture visits at no cost to you. Prior authorization may be required. Please consult with your Primary Care Physician or IPA/Medical Group.
Ambulance[1]	$50 copay
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing
Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing Preventive dental services: Cleaning (for up to 2 every year): You pay nothing Dental x-ray(s) (for up to 1 every six months): You pay nothing Fluoride treatment (for up to 2 every year): You pay nothing Oral exam: You pay nothing Dental benefits are covered through Delta Care• USA, provided and administered by Delta Dental of California. Members may contact Delta Dental Customer Services at 1-866-247-2486, Monday through Friday, 5:00 AM to 6:00 PM (PT). TTY/TDD users may call 1-800-735-2929.
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing
Diagnostic Tests, Lab and Radiology Services, and X-Rays ***(Costs for these services may vary based on place of services)***[1,2]	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
Doctor's Office Visits[1,2]	Primary care physician visit: You pay nothing Specialist visit: You pay nothing
Durable Medical Equipment ***(wheelchairs, oxygen, etc.)***[1]	0-20% of the cost, depending on the equipment

Emergency Care	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. If you are traveling outside the United States and its territories and you require medically necessary urgent or emergency care, the plan will reimburse your out-of-pocket expenses up to $50,000 per year after you provide appropriate documentation and proof of payment.
Foot Care *(podiatry services)*[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: You pay nothing Routine hearing exam (for up to 1 every year): You pay nothing Hearing aid fitting/evaluation (for up to 1 every year): You pay nothing Hearing aid: $0 copay Our plan pays up to $500 every year for hearing aids.
Home Health Care[1,2]	You pay nothing
Mental Health Care[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay nothing Outpatient group therapy visit: $5 copay Outpatient individual therapy visit: $5 copay
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse[1,2]	Group therapy visit: $5 copay Individual therapy visit: $5 copay
Outpatient Surgery[1,2]	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing

Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. Members receive a monthly benefit allowance to purchase over-the-counter items through our mail order program. The allowance does not roll over to the following month. There is a $15 maximum monthly benefit.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 10-20% of the cost, depending on the device Related medical supplies: 10-20% of the cost, depending on the supply
Renal Dialysis[1,2]	20% of the cost
Transportation[1,2]	You pay nothing Members are offered 36-one way trips for medically related services. There is a 25-mile maximum per trip. Call Member Services and allow 2 business days' notice. To cancel, call at least 2 hours prior to your trip. If you do not cancel in time, the trips will be deducted from your benefit.
Urgently Needed Services	You pay nothing
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): $0 copay Eyeglasses (frames and lenses) (for up to 1 every year): $0 copay Eyeglass frames (for up to 1 every year): $0 copay Eyeglass lenses (for up to 1 every year): $0 copay Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $200 every year for eyewear.
Preventive Care[1,2]	You pay nothing Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) Depression screening Diabetes screenings

Preventive Care[1,2] (continued)	HIV screening Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots "Welcome to Medicare" preventive visit (one-time) Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

INPATIENT CARE	
Inpatient Hospital Care[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay nothing
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20 $75 copay per day for days 21 through 65 You pay nothing per day for days 66 through 100

PRESCRIPTION DRUG BENEFITS

How much do I pay?

For Part B drugs such as chemotherapy drugs[1]: 20% of the cost

Other Part B drugs[1]: 20% of the cost

Initial Coverage

You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$5 copay	$15 copay
Tier 3 (Preferred Brand)	$35 copay	$105 copay
Tier 4 (Non-Preferred Brand)	$75 copay	$225 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered
Tier 6 (Select Care Drugs)	$10 copay	$30 copay

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$70 copay
Tier 4 (Non-Preferred Brand)	$150 copay
Tier 6 (Select Care Drugs)	$20 copay

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it

<table>
<tr><td>Coverage Gap (continued)</td><td>will cost you.
Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>Drugs Covered</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>All</td><td>$0</td><td>$0</td></tr>
<tr><td>Tier 2 (Generic)</td><td>All</td><td>$5 copay</td><td>$15 copay</td></tr>
</table>
Standard Mail Order Cost-Sharing
<table>
<tr><th>Tier</th><th>Drugs Covered</th><th>Three-month supply</th></tr>
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<tr><td>Tier 2 (Generic)</td><td>All</td><td>$10 copay</td></tr>
</table></td></tr>
<tr><td>Catastrophic Coverage</td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:
5% of the cost, or
$2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.</td></tr>
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