CENTRAL HEALTH MEDICARE PLAN

2021 SUMMARY OF BENEFITS

CENTRAL HEALTH MEDICARE PLAN (HMO)

CENTRAL HEALTH PREMIER PLAN (HMO)

CENTRAL HEALTH FOCUS PLAN (HMO C-SNP)

CONTACT US:

TOLL FREE: 1-866-314-2427

TTY: 711

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FREQUENTLY ASKED QUESTIONS

Who can join?

To join any of our plans, you must meet all of the following requirements:

- You have both Medicare Part A and Medicare Part B
- You live in our service area
- You are a United States citizen or are lawfully present in the United States

To join Central Health Focus Plan HMO C-SNP (006), you must also have been diagnosed with Diabetes, Chronic Heart Failure (CHF), and/or one of the following cardiovascular disorders: cardiac arrhythmias, coronary artery disease, peripheral vascular disease, or chronic venous thromboembolic disorder.

What is the service area?

- Los Angeles County: all zip codes
- San Bernardino County: all zip codes
- Orange County: all zip codes
- Riverside County: all zip codes for Central Health Medicare Plan (001) and Central Health Premier Plan (004)

Which doctors, hospitals, and pharmacies can I use?

Central Health has a network of doctors, hospitals, pharmacies, and other providers. When you join our plan, you must select a primary care physician (PCP) and a medical group. Your PCP will coordinate your care when you need to see specialists within the medical group or other providers. If you use providers or pharmacies that are not in our network, the plan may not pay for these services. Visit www.centralhealthplan.com to search for a provider or pharmacy.

Are my Part D prescription drugs covered?

You can search our drug formulary on our website or contact Member Services to find out if your drug is covered. The formulary will also tell you whether a covered drug has any restrictions. If a drug you need is not covered, you can ask your doctor to switch you to a comparable drug on our formulary or contact us to request an exception and provide medical notes to justify the request. For more information about requesting an exception, please contact Member Services.

CENTRAL HEALTH MEDICARE PLAN

How much will I pay for Part D prescription drugs?

The Part D drugs we cover are grouped into six different tiers. Check the formulary or contact Member Services to find out which tier your drug is on. The amount you pay depends on the drug's tier, the number of days supply, the benefit stage you have reached, whether you are using a network pharmacy, the type of pharmacy you use (e.g., retail, mail order, long term care, home infusion), and whether you qualify for Extra Help.

What is Part D "Extra Help"?

Medicare provides Extra Help (also referred to as Low Income Subsidy or "LIS") to pay prescription drug costs for people who have limited income and resources. Extra Help can assist with Part D premiums, deductibles, copayments, and coinsurance. Some people qualify for Extra Help automatically and do not need to apply. To find out if you are eligible, contact the Social Security Office at 1-800-772-1213 or TTY users call 1-800-325-0778, Monday through Friday from 7:00 AM to 7:00 PM.

How does coverage work for people with Medicare and Medi-Cal?

If you have both Medicare and Medi-Cal, Central Health will cover all benefits that are covered by Medicare, which includes most of your medical services and prescription drugs. Medi-Cal will help with your Medicare cost-sharing and may cover some services that are not covered by Medicare. Remember to show your Medi-Cal card in addition to your Central Health member ID card when you visit providers. Providers should not bill you for any coinsurance or copay for Medicare-covered services (regardless of whether the provider is contracted with Medi-Cal).

Where can I find more information?

Member Services can help answer any questions you have about eligibility and benefits. Please call 1-866-314-2427 from 8:00 AM to 8:00 PM (PT), 7 days a week. TTY users should call 711.

This Summary of Benefits is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, request the "Evidence of Coverage" or visit www.centralhealthplan.com.

To learn more about Medicare, visit www.medicare.gov and download the "Medicare & You" handbook or call 1-800-Medicare (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

CENTRAL HEALTH MEDICARE PLAN (001)
SUMMARY OF BENEFITS

Premium
$0 per month

Deductible
No deductible

Maximum Out-of-Pocket Responsibility
Limited to $1,800 per year for medical costs

Inpatient Hospital Coverage*
$0 per day for unlimited days

Outpatient Hospital Coverage*
$0 (Refer to the Evidence of Coverage for more details)

Doctor Visits*
Primary Care Physician visit: $0
Specialist visit: $0
Telehealth: $0

Preventive Care*
$0

Emergency Care
$50 ($0 if admitted within 24 hours)

Urgently Needed Services
$0

Services with a * may require prior authorization or a referral from your doctor.

CENTRAL HEALTH MEDICARE PLAN

Diagnostic Services/Labs/Imaging*
Diagnostic radiology (e.g., MRI): $0 / Lab services: $0
Diagnostic tests and procedures: $0 / X-rays: $0

Hearing Services*
Free routine hearing exam and hearing aid allowance up to $500 per year through NationsHearing

Dental Services*
Comprehensive dental coverage (including $0 oral exams, cleanings, and X-rays) through DeltaCare® USA

Vision Services*
Routine vision exam: $0, once per year
Eyewear allowance: up to $300 per year

Mental Health Services*
$5 per outpatient visit

Skilled Nursing Facility*
$0 for days 1-20, $75 per day for days 21-65,
$0 for days 66-100 (up to 100 days per benefit period)

Physical Therapy*
$0

Ambulance*
Ground: $40 per one-way trip
Air: 20% per one-way trip

Transportation*
$0 for 42 one-way trips per year (25 mile limit per trip)

CENTRAL HEALTH MEDICARE PLAN (001)
SUMMARY OF BENEFITS

Medicare Part B Drugs*
20%

Ambulatory Surgery Center*
$0

Diabetic Supplies*
Glucometer, test strips, lancets: $0 through mail order
Limited to GLUCOCARD Shine or GLUCOCARD Expression

Durable Medical Equipment (DME)*
0% - 20%
0% DME items include canes, crutches, walkers, attachments, and commodes

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Gym/Fitness
Up to $40 reimbursement per month for qualifying expenses

Acupuncture*
$0 for up to 24 treatments per year

Over-the-Counter (OTC)
Up to $75 allowance every calendar quarter through our mail order catalog
(no roll over)

Viagra®/sildenafil
$75 per 30 day supply (6 pills) for Viagra®
$0 per 30 day supply (6 pills) for sildenafil (generic)

Worldwide Coverage
Up to $50,000 reimbursement for qualifying expenses
(urgently needed or emergency services only)

In-Home Support Services*
$0 for assistance at home with activities of daily living after a hospital or SNF discharge, up to 7 shifts, 4 hours each (28 hours total)

CENTRAL HEALTH MEDICARE PLAN

Part D Prescription Drugs	Central Health Medicare Plan (001)	
Deductible Stage	No deductible	
Initial Coverage Stage after the deductible is met	**Retail** **(30 day supply)**	**Mail Order** **(90 day supply)**
Tier 1 – Preferred Generic Drugs	$0	$0
Tier 2 – Generic Drugs	$0	$0
Tier 3 – Preferred Brand Drugs	$35	$70
Tier 4 – Non-Preferred Drugs	$75	$150
Tier 5 – Specialty Tier Drugs	33%	N/A
Tier 6 – Select Care Drugs	$10	$20
Coverage Gap Stage after total yearly drug costs reach $4,130	**Retail** **(30 day supply)**	**Mail Order** **(90 day supply)**
Tier 1 – Preferred Generic Drugs	$0	$0
Tier 2 – Generic Drugs	$0	$0
Tier 3 – Preferred Brand Drugs	Generic: You pay 25% of the cost Brand: You pay 25% of the cost and a portion of the dispensing fee (Long term supply not available for Tier 5)	
Tier 4 – Non-Preferred Drugs		
Tier 5 – Specialty Tier Drugs		
Tier 6 – Select Care Drugs		
Catastrophic Coverage Stage after out-of-pocket costs reach $6,550	The greater of: 5% of the cost or $3.70 for generic (including brand drugs treated as generic) and $9.20 for all other drugs	

CENTRAL HEALTH PREMIER PLAN (004)
SUMMARY OF BENEFITS

	Your cost w/ Medicare only	Your cost w/ Medicare+full Medi-Cal
	**Premium** $31.50 per month	$0 if you qualify for Extra Help (LIS 1, 2, or 3)
	**Deductible** No deductible	No deductible
	**Maximum Out-of-Pocket Responsibility** Limited to $6,700 per year for medical costs	
	**Inpatient Hospital Coverage*** $1,408 deductible, $0 for days 1-60, $352 per day for days 61-90, $704 per lifetime reserve day up to 60 days (may change in 2021)	$0
	**Outpatient Hospital Coverage*** 20%	$0
	**Doctor Visits*** Primary Care Physician visit: $0 Specialist visit: $0 Telehealth: $0	Primary Care Physician visit: $0 Specialist visit: $0 Telehealth: $0
	**Preventive Care*** $0	$0
	**Emergency Care** 20% (up to $75) $0 if admitted within 24 hours	$0
	**Urgently Needed Services** 20% (up to $65)	$0

Services with a * may require prior authorization or a referral from your doctor.

	Your cost w/ Medicare only	Your cost w/ Medicare+full Medi-Cal
	**Diagnostic Services/Labs/Imaging***	
	Diagnostic radiology: 20% / Lab services: $0 Diagnostic tests and procedures: $0 X-rays: 20%	Diagnostic radiology: $0 / Lab services: $0 Diagnostic tests and procedures: $0 X-rays: $0
	**Hearing Services***	
	Free routine hearing exam and hearing aid allowance up to $2,000 per year through NationsHearing	
	**Dental Services***	
	Comprehensive dental coverage (including $0 oral exams, cleanings, and X-rays) through DeltaCare® USA	
	**Vision Services***	
	Routine vision exam: $0, once per year Eyewear allowance: up to $300 per year	
	**Mental Health Services***	
	$0 per outpatient therapy visit	$0 per outpatient therapy visit
	**Skilled Nursing Facility***	
	$0 for days 1-20, $176 per day for days 21-100 per benefit period (may change in 2021)	$0 per day up to 100 days per benefit period
	**Physical Therapy***	
	$0	$0
	**Ambulance***	
	20%	$0
	**Transportation***	
	$0 for 42 one-way trips per year (25 mile limit per trip)	

CENTRAL HEALTH PREMIER PLAN (004)
SUMMARY OF BENEFITS

	Your cost w/ Medicare only	Your cost w/ Medicare+full Medi-Cal
	**Medicare Part B Drugs*** 20%	$0
	**Ambulatory Surgery Center*** 20%	$0
	**Diabetic Supplies*** Glucometer, test strips, lancets: $0 through mail order Limited to GLUCOCARD Shine or GLUCOCARD Expression	
	**Durable Medical Equipment (DME)*** 20%	$0
	**Gym/Fitness** Up to $40 reimbursement per month for qualifying expenses	
	**Acupuncture*** $0 for up to 30 treatments per year	
	**Over-the-Counter (OTC)** Up to $150 allowance every calendar quarter through our mail order catalog (no roll over)	
	**Viagra®/sildenafil** 25% per 30 day supply (6 pills) for Viagra® $0 per 30 day supply (6 pills) for sildenafil (generic)	
	**Worldwide Coverage** Up to $50,000 reimbursement for qualifying expenses (urgently needed or emergency services only)	
	**In-Home Support Services*** $0 for assistance at home with activities of daily living after a hospital or SNF discharge, up to 7 shifts, 4 hours each (28 hours total)	

CENTRAL HEALTH MEDICARE PLAN

Part D Prescription Drugs	Central Health Premier Plan (004)	
Deductible Stage	$445 deductible (waived for Tiers 1-2) No deductible if you have full Extra Help	
Initial Coverage Stage after the deductible is met	**Your cost without Extra Help (30 day supply)**	**Your cost with full Extra Help (per prescription)**
Tier 1 – Preferred Generic Drugs	$0	$0
Tier 2 – Generic Drugs	$0	$0
Tier 3 – Preferred Brand Drugs	25%	Depending on your level of Extra Help, you pay: Generic: $0, $1.30, or $3.70 Brand: $0, $4.00, or $9.20
Tier 4 – Non-Preferred Drugs	25%	
Tier 5 – Specialty Tier Drugs	25%	
Tier 6 – Select Care Drugs	$10	
Coverage Gap Stage after total yearly drug costs reach $4,130	**Your cost without Extra Help (30 day supply)**	**Your cost with full Extra Help (per prescription)**
Tier 1 – Preferred Generic Drugs	$0	$0
Tier 2 – Generic Drugs	$0	$0
Tier 3 – Preferred Brand Drugs	Generic: You pay 25% of the cost Brand: You pay 25% of the cost and a portion of the dispensing fee	Depending on your level of Extra Help, you pay: Generic: $0, $1.30, or $3.70 Brand: $0, $4.00, or $9.20
Tier 4 – Non-Preferred Drugs		
Tier 5 – Specialty Tier Drugs		
Tier 6 – Select Care Drugs		
Catastrophic Coverage Stage after out-of-pocket costs reach $6,550	The greater of: 5% of the cost or $3.70 for generic (including brand drugs treated as generic) and $9.20 for all other drugs	$0

CENTRAL HEALTH FOCUS PLAN (006)
SUMMARY OF BENEFITS

Premium
$0 per month

Deductible
No deductible

Maximum Out-of-Pocket Responsibility
Limited to $2,995 per year for medical costs

Inpatient Hospital Coverage*
$0 per day for unlimited days

Outpatient Hospital Coverage*
$0 (Refer to the Evidence of Coverage for more details)

Doctor Visits*
Primary Care Physician visit: $0
Specialist visit: $0
Telehealth: $0

Preventive Care*
$0

Emergency Care
$50 ($0 if admitted within 24 hours)

Urgently Needed Services
$0

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CENTRAL HEALTH MEDICARE PLAN

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Diagnostic radiology (e.g., MRI): $0 / Lab services: $0
Diagnostic tests and procedures: $0 / X-rays: $0

Hearing Services*
Free routine hearing exam and hearing aid allowance up to $1,000 per year through NationsHearing

Dental Services*
Comprehensive dental coverage (including $0 oral exams, cleanings, and X-rays) through DeltaCare® USA

Vision Services*
Routine vision exam: $0, once per year
Eyewear allowance: up to $150 per year

Mental Health Services*
$5 per outpatient visit

Skilled Nursing Facility*
$0 for days 1-20, $75 per day for days 21-65,
$0 for days 66-100 (up to 100 days per benefit period)

Physical Therapy*
$0

Ambulance*
Ground: $50 per one-way trip
Air: 20% per one-way trip

Transportation*
$0 for 42 one-way trips per year (25 mile limit per trip)

CENTRAL HEALTH FOCUS PLAN (006)
SUMMARY OF BENEFITS

Medicare Part B Drugs*
20%

Ambulatory Surgery Center*
$0

Diabetic Supplies
Glucometer, test strips, lancets: $0 through mail order
Limited to GLUCOCARD Shine or GLUCOCARD Expression

Durable Medical Equipment (DME)*
0% - 20%
0% DME items include canes, crutches, walkers, attachments, and commodes

Gym/Fitness
Up to $40 reimbursement per month for qualifying expenses

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$0 for up to 24 treatments per year

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Part D Prescription Drugs	Central Health Focus Plan (006)	
Deductible Stage	No deductible	
Initial Coverage Stage after the deductible is met	**Retail** **(30 day supply)**	**Mail Order** **(90 day supply)**
Tier 1 – Preferred Generic Drugs	$0	$0
Tier 2 – Generic Drugs	$0	$0
Tier 3 – Preferred Brand Drugs	$35	$70
Tier 4 – Non-Preferred Drugs	$75	$150
Tier 5 – Specialty Tier Drugs	33%	N/A
Tier 6 – Select Care Drugs	$0	$0
Coverage Gap Stage after total yearly drug costs reach $4,130	**Retail** **(30 day supply)**	**Mail Order** **(90 day supply)**
Tier 1 – Preferred Generic Drugs	$0	$0
Tier 2 – Generic Drugs	$0	$0
Tier 3 – Preferred Brand Drugs	Generic: You pay 25% of the cost Brand: You pay 25% of the cost and a portion of the dispensing fee (Long term supply not available for Tier 5)	
Tier 4 – Non-Preferred Drugs		
Tier 5 – Specialty Tier Drugs		
Tier 6 – Select Care Drugs	$0	$0
Catastrophic Coverage Stage after out-of-pocket costs reach $6,550	The greater of: 5% of the cost or $3.70 for generic (including brand drugs treated as generic) and $9.20 for all other drugs	

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