



This is important information on changes in your Central Health Medicare Plan information.

Changes to your 2023 Annual Notice of Changes, Evidence of Coverage and Summary of Benefits:

Where you can find the change in your 2023 Materials:	Original information:	Corrected information:	What does this mean to you?
<p>Annual Notice of Change - Changes to Benefits and Costs for Medical Services - Medicare Part B Prescription Drugs</p>	<p>Not included</p>	<p>2022: You pay 20% coinsurance</p> <p>2023: You pay up to 20% coinsurance.</p> <p>Certain rebatable drugs may be subject to a lower coinsurance. Part B insulin cost sharing is no more than a \$35 copay for a one-month supply.</p>	<p>You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a \$35 copay for a one-month supply of Medicare Part B insulin.</p>
<p>Evidence of Coverage - Chapter 4, Section 2.1 Your medical benefits and costs as a member of the plan - Medicare Part B Prescription Drugs</p>	<p>You pay 20% coinsurance</p>	<p>You pay up to 20% coinsurance. Certain rebatable drugs may be subject to a lower coinsurance. Part B insulin cost sharing is no more than a \$35 copay for a one-month supply.</p>	<p>You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a \$35 copay for a one-month supply of Medicare Part B insulin.</p>

<p>Summary of Benefits - Medicare Part B Drugs</p> <ul style="list-style-type: none"> • Chemotherapy drugs • Other Part B drugs 	<ul style="list-style-type: none"> • 20% coinsurance • 20% coinsurance 	<ul style="list-style-type: none"> • Up to 20% coinsurance • Up to 20% coinsurance. Part B insulin cost sharing is no more than a \$35 copay for a one-month supply 	<p>You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a \$35 copay for a one-month supply of Medicare Part B insulin.</p>
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You are not required to take any action in response to this document, but we recommend you keep this information for future reference.

If you have any questions, please call 1-866-314-2427, TTY 711. Member Service Representatives are available 8 a.m. – 8 p.m., 7 days a week.

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



Summary of Benefits

Central Health Premier Plan I
Central Health Premier Plan II

California

Alameda
Contra Costa
Fresno
Los Angeles
Santa Clara
San Joaquin



2023 Summary of Benefits

Central Health Premier Plan I (HMO) H5649-020-001

Central Health Premier Plan II (HMO) H5649-021-002

January 1, 2023 - December 31, 2023.

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

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please access the “Evidence of Coverage” at www.centralhealthplan.com.

To join **Central Health Premier Plan I (HMO)** or **Central Health Premier Plan II (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in California: Alameda, Contra Costa, Fresno, Los Angeles, Santa Clara, San Joaquin.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) available 24 hours, 7 days a week including some federal holidays. TTY/TDD users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

Have questions? Please call Central Health Medicare Plan Member Services Department at 1-866-314-2427, TTY 711 8:00 A.M. to 8:00 P.M. (PT), 7 days a week or visit our website at www.centralhealthplan.com.

Premium & Benefits	Central Health Premier Plan I HMO (20-1)	Central Health Premier Plan II HMO (21-2)
Monthly Plan Premium You must keep paying your Medicare Part B premium.	\$0	\$34.50 Your premium may be less if you are receiving Extra Help.
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	No more than \$899 annually	No more than \$6,700 annually
Inpatient Hospital*	\$0 per stay \$0 copay for unlimited additional days after 90 days	\$1,600 deductible \$0 copay per day for days 1–60 \$400 copay per day for days 61–90** \$0 copay for unlimited additional days after 90 days**
Outpatient Hospital*‡	\$0 copay	20% coinsurance**
Ambulatory Surgery Center*	\$0 copay	20% coinsurance**
Doctor Visits <ul style="list-style-type: none"> • Primary care providers • Specialists* 	\$0 copay \$0 copay	\$0 copay \$0 copay

** Your costs for Central Health Premier Plan II (HMO) may be less depending on your Medi-Cal status.

* Services may require authorization.

‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Premium & Benefits	Central Health Premier Plan I HMO (20-1)	Central Health Premier Plan II HMO (21-2)
Preventive Care Other preventive services are available. <ul style="list-style-type: none"> Flu vaccine, diabetic screenings, etc.* 	\$0 copay	\$0 copay
Emergency Care Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours	\$0 - \$50 copay	20% coinsurance, up to \$75 maximum**
Urgent Care	\$0 copay	20% coinsurance, up to \$60 maximum**
Diagnostic Services/Labs/Imaging* <ul style="list-style-type: none"> Diagnostic tests and procedures Lab services MRI, CAT scan X-rays 	\$0 copay \$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay 20% coinsurance** 20% coinsurance**
Hearing Services* <ul style="list-style-type: none"> Routine hearing exam One per year Hearing aid fittings and evaluations One per year Hearing aid 	\$0 copay \$0 copay Hearing aid allowance up to \$2,000 per year through NationsHearing	\$0 copay \$0 copay Hearing aid allowance up to \$3,000 per year through NationsHearing

* Services may require authorization.

** Your costs for Central Health Premier Plan II (HMO) may be less depending on your Medi-Cal status.

Premium & Benefits	Central Health Premier Plan I HMO (20-1)	Central Health Premier Plan II HMO (21-2)
<p>Dental Services*†</p> <ul style="list-style-type: none"> Preventive dental (e.g., oral exam, x-rays, cleanings) <p>Comprehensive Dental*</p> <ul style="list-style-type: none"> Diagnostic services Restorative services Endodontics Periodontics Extractions Prosthodontics, other oral/maxillofacial surgery, other services 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 - \$295 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 - \$295 copay</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 - \$295 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 - \$295 copay</p>
<p>Vision Services*†</p> <ul style="list-style-type: none"> Routine eye exam Retinal imaging Eyewear allowance 	<p>\$0 copay One exam per year</p> <p>\$0 copay One exam per year</p> <p>Up to \$300 per year</p>	<p>\$0 copay One exam per year</p> <p>\$0 copay One exam per year</p> <p>Up to \$300 per year</p>
<p>Mental Health Services*</p> <ul style="list-style-type: none"> Outpatient individual therapy Outpatient group therapy 	<p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay</p> <p>\$0 copay</p>
<p>Skilled Nursing Facility (SNF)*</p>	<p>\$0 copay per day for days 1–20</p> <p>Up to \$200 copay per day for days 21–100</p>	<p>\$0 copay per day for days 1–20</p> <p>Up to \$200 copay per day for days 21–100**</p>
<p>Physical Therapy*</p>	<p>\$0 copay</p>	<p>\$0 copay</p>
<p>Ambulance (Ground)*</p>	<p>\$0 - \$40 copay per ride</p>	<p>20% coinsurance per ride**</p>

* Services may require authorization.

† Limitations may apply. See your EOC for details.

** Your costs for Central Health Premier Plan II (HMO) may be less depending on your Medi-Cal status.

Premium & Benefits	Central Health Premier Plan I HMO (20-1)	Central Health Premier Plan II HMO (21-2)
Transportation*	\$0 for 48 one-way trips to plan approved locations (up to 50 mile limit)	\$0 for 48 one-way trips to plan approved locations (up to 50 mile limit)
Medicare Part B Drugs* <ul style="list-style-type: none"> • Chemotherapy drugs • Other Part B drugs 	20% coinsurance 20% coinsurance	20% coinsurance** 20% coinsurance**

* Services may require authorization.

** Your costs for Central Health Premier Plan II (HMO) may be less depending on your Medi-Cal status.

Outpatient Prescription Drugs

	Central Health Premier Plan I HMO (20-1)		Central Health Premier Plan II HMO (21-2)	
Part D Deductible (Tiers 2 to 5)	No deductible		\$0 or \$104 ¹ ¹ Depending on the level of Extra Help that you receive	
	Retail Rx 30-day supply	Mail Order 90-day supply	Retail Rx 30-day supply	Mail Order 90-day supply
Initial Coverage You are in the Initial Coverage stage until you reach \$4,660 in drug costs (year to date)				
Tier 1 – Preferred Generic	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 2 – Generic	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 3 – Preferred Brand	\$35 copay	\$70 copay	\$0, \$1.45, \$4.15 or 15% for generic drugs ¹	
Tier 4 – Non-Preferred Brand	\$75 copay	\$150 copay	\$0, \$4.30, \$10.35 or 15% for brand drugs ¹	
Tier 5 – Specialty Tier	33% of the cost	Not available		
Tier 6 – Select Care	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Coverage Gap You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$7,400				
Tier 1 – Preferred Generic	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 2 – Generic	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 3 - Preferred Brand	25% of the cost	25% of the cost	\$0, \$1.45, \$4.15 or 15% for generic drugs ¹	
Tier 4 - Non-preferred Drug	25% of the cost	25% of the cost	\$0, \$4.30, \$10.35 or 15% for brand drugs ¹	
Tier 5 - Specialty	25% of the cost	Not available		

Outpatient Prescription Drugs

	Central Health Premier Plan I HMO (20-1)		Central Health Premier Plan II HMO (21-2)	
Tier 6 – Select Care	\$0 copay	\$0 copay	\$0 copay	\$0 copay ¹ Depending on the level of Extra Help that you receive
<p>Catastrophic Coverage You are in this stage after your year-to-date “out-of-pocket costs” (your payments) reach a total of \$7,400</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023).</p> <p>\$4.15 copay or 5% (whichever costs more) for generic drugs or a preferred multi-source drug and \$10.35 copay or 5% (whichever costs more) for all other drugs.</p>		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023).</p> <p>\$4.15 copay or 5% (whichever costs more) for generic drugs or a preferred multi-source drug and \$10.35 copay or 5% (whichever costs more) for all other drugs.</p>	

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you, even if you haven’t paid your deductible (if you have a deductible). Call Member Services for more information.

Important Message About What You Pay for Insulin

You won’t pay more than \$35 (or less, depending on your level of Extra Help or if your Tier 3 copay is less than \$35) for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on, even if you haven’t paid your deductible (if you have a deductible).

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.

Extra Benefits*	Central Health Premier Plan I HMO (20-1)	Central Health Premier Plan II HMO (21-2)
Flex Card	\$325 every three months Flex card funds can be used for over-the-counter (OTC) items, fitness fees and health and wellness items from our Herbal Catalog	\$440 every three months Flex card funds can be used for over-the-counter (OTC) items, fitness fees and health and wellness items from our Herbal Catalog
Healthy Foods Allowance‡ These are Special Supplemental Benefits for Chronic Illnesses. Certain qualifying conditions are required for members to access these benefits.	Up to \$25 each month for healthy foods for members with a qualifying chronic condition	Up to \$25 each month for healthy foods for members with a qualifying chronic condition
Meals and Nutritional Counseling (Made Easy Meals)‡	Receive 2 meals a day, for 14 days immediately following surgery or inpatient hospitalization, or for a medical condition or potential medical condition that requires you to remain at home for a period of time. Can be used up to 4 times per year.	Receive 2 meals a day, for 14 days immediately following surgery or inpatient hospitalization, or for a medical condition or potential medical condition that requires you to remain at home for a period of time. Can be used up to 4 times per year.
Acupuncture* <ul style="list-style-type: none"> • Medicare-covered acupuncture • Routine acupuncture - unlimited visits each year. 	\$0 copay \$0 copay	\$0 copay \$0 copay
Chiropractic Services* <ul style="list-style-type: none"> • Medicare-covered chiropractic care 	\$0 copay	\$0 copay

‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Extra Benefits*	Central Health Premier Plan I HMO (20-1)	Central Health Premier Plan II HMO (21-2)
Scales These are Special Supplemental Benefits for Chronic Illnesses. Certain qualifying conditions are required for members to access these benefits.	\$0 copay	\$0 copay
Herbal Catalog	Products in the catalog are covered through CHP flex card, members can order online. For more information call Member Services.	Products in the catalog are covered through CHP flex card, members can order online. For more information call Member Services.
Gym Membership	\$0 copay	\$0 copay
24/7 Telehealth	\$0 copay	\$0 copay
Personal Emergency Response System (PERS)	\$0 copay	\$0 copay
Durable Medical Equipment (DME)*	\$0 - 20% coinsurance	20% coinsurance**
Worldwide Emergency Care <ul style="list-style-type: none"> • Urgent Care • Emergency Room • Emergency Transportation 	\$25 copay Coverage up to \$100,000	\$0 copay Coverage up to \$100,000

** Your costs for Central Health Premier Plan II (HMO) may be less depending on your Medi-Cal status.

NOTICE OF NON-DISCRIMINATION

Central Health Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Central Health Medicare Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Central Health Medicare Plan

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Member Services Department at: 1-866-314-2427 (TTY 711). Hours are: 8:00 A.M. to 8:00 P.M. (PT), 7 days a week.

If you believe that Central Health Medicare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling our Customer Service Department or mailing a letter to:

Central Health Medicare Plan
ATTN: Member Services
PO Box 14244
Orange, CA 92863
Phone: 1-866-314-2427, TTY: 711
Fax: 1-626-388-2361
Email: memberservices@centralhealthplan.com

If you need help filing a grievance, Central Health Medicare Plan Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 1-800-537-7697
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Multi-Language Insert Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-314-2427. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-314-2427. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-314-2427。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-314-2427。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-314-2427. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-314-2427. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-314-2427 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-314-2427. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-314-2427 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-314-2427. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-314-2427. سيقوم شخص ما يتحدث العربية مساعدتك. هذه خدمة مجانية.

Hindi:

हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-314-2427 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-314-2427. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-314-2427. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-314-2427. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-314-2427. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-866-314-2427にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。