

Summary of Benefits

2025

Alameda
Contra Costa
Fresno
San Francisco

San Joaquin
Santa Clara
Solano

**Central Health
Premier Plan I
(HMO) (23)**

2025 Summary of Benefits

Central Health Premier Plan I (HMO) H5649-023

January 1, 2025 - December 31, 2025.

Central Health Medicare Plan is an HMO/HMO SNP with a Medicare contract. Enrollment in Central Health Medicare Plan 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)** 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, San Francisco, San Joaquin, Santa Clara and Solano.

Except in emergency or urgent 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 (866) 314-2427, TTY: 711, 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30) or visit our website at www.centralhealthplan.com.

Premium & Benefits	Central Health Premier Plan I (HMO) (23)
<p>Monthly Plan Premium</p> <p>You must keep paying your Medicare Part B premium.</p>	<p>\$0</p>
<p>Deductible</p>	<p>No deductible</p>
<p>Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</p>	<p>No more than \$2,999 annually</p>
<p>Inpatient Hospital*</p>	<p>\$0 copay per day for days 1 - 4</p> <p>\$100 copay per day for days 5 - 10</p> <p>\$0 copay per day for days 11 - 90</p>
<p>Outpatient Hospital*‡</p>	<p>\$0 - \$225 copay</p>
<p>Ambulatory Surgery Center*</p>	<p>\$0 - \$200 copay</p>
<p>Doctor Visits</p> <ul style="list-style-type: none"> • Primary care providers • Specialists* 	<p>\$0 copay</p> <p>\$0 copay</p>
<p>Preventive Care</p> <p>Other preventive services are available.</p> <ul style="list-style-type: none"> • Flu vaccine, diabetic screenings, etc.* 	<p>\$0 copay</p>
<p>Emergency Care</p> <p>Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours</p>	<p>\$0 - \$125 copay</p>
<p>Urgent Care</p>	<p>\$0 copay</p>

* Services may require authorization.

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

Premium & Benefits	Central Health Premier Plan I (HMO) (23)
<p>Diagnostic Services/Labs/Imaging*</p> <ul style="list-style-type: none"> • Diagnostic tests and procedures • Lab services • MRI, CAT scan • X-rays 	<p>\$0 copay \$0 copay \$150 copay \$0 copay</p>
<p>Hearing Services*</p> <ul style="list-style-type: none"> • Medicare-covered hearing exam • Routine hearing exam One per year • Hearing aid fittings and evaluations One per year • Hearing aid 	<p>\$0 copay \$0 copay \$0 copay Hearing aid allowance up to \$2,000 per year through NationsHearing</p>
<p>Dental Services†*</p> <ul style="list-style-type: none"> • Medicare-covered dental services • Preventive dental <ul style="list-style-type: none"> ◦ Oral exams ◦ X-rays ◦ Cleanings <p>Comprehensive Dental*</p> <ul style="list-style-type: none"> • Restorative Services • Endodontics • Periodontics • Prosthodontics removable • Prosthetics • Implant Services • Prosthodontics fixed • Oral and Maxillofacial Surgery • Orthodontics • Adjunctive General Services 	<p>\$0 copay \$0 - \$17 copay \$0 - \$41 copay \$0 copay \$0 - \$424 copay \$0 copay \$0 copay \$0 - \$220 copay Not Covered \$0 - \$2,160 copay \$75 - \$295 copay \$0 - \$237 copay Not Covered \$0 - \$166 copay</p>

* Services may require authorization.

† Limitations may apply. See your EOC for details.

Premium & Benefits	Central Health Premier Plan I (HMO) (23)
Vision Services*† <ul style="list-style-type: none"> • Medicare-covered eye exams • Medicare-covered eyewear • Routine eye exam • Retinal imaging • Eyewear allowance 	\$0 copay \$0 copay \$0 copay One exam per year \$0 copay One exam per year Up to \$300 per year
Mental Health Services* <ul style="list-style-type: none"> • Outpatient individual therapy • Outpatient group therapy 	\$40 copay \$40 copay
Skilled Nursing Facility (SNF)*	\$0 copay per day for days 1–20 \$204 copay per day for days 21–100 These are 2024 cost-sharing amounts and may change for 2025. We will provide updated rates at www.centralhealthplan.com as soon as they are released.
Physical Therapy*	\$20 copay
Ambulance (Ground)*	\$0 - \$300 copay per ride
Ambulance (Air)*	20% coinsurance
Transportation*	\$0 for 12 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 • Part B insulin drugs 	20% coinsurance unless capped by Inflation Reduction Act (IRA) rules 20% coinsurance unless capped by Inflation Reduction Act (IRA) rules \$35 copay

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† Limitations may apply. See your EOC for details.

Outpatient Prescription Drugs

Central Health Premier Plan I (HMO) (23)

**Part D Deductible
(Tiers 2 to 5)**

\$100

Retail Rx 31-day supply

Mail Order 100-day supply

**Part D Insulins
Tier 3 – Preferred Brand**

\$35 copay

\$70 copay

Initial Coverage

You are in the Initial Coverage Phase until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$2,000

Tier 1 – Preferred Generic

\$0 copay

\$0 copay

Tier 2 – Generic

\$0 copay

\$0 copay

Tier 3 – Preferred Brand

\$35 copay

\$70 copay

Tier 4 – Non-Preferred Brand

\$75 copay

\$150 copay

Tier 5 – Specialty Tier

31% of the cost

Not available

Tier 6 – Select Care

\$0 copay

\$0 copay

Catastrophic Coverage

You are in this stage after your year-to-date “out-of-pocket costs” (your payments) reach a total of \$2,000

During this stage, the plan will pay for the full cost of your covered Part D drugs.

Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year (through December 31, 2025).

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) (23)
24/7 Telehealth	\$0 copay
Acupuncture* <ul style="list-style-type: none"> • Medicare-covered acupuncture • Routine acupuncture 	\$0 copay \$0 copay Unlimited visits each year.
Chiropractic Services* <ul style="list-style-type: none"> • Medicare-covered chiropractic care 	\$0 copay
Durable Medical Equipment (DME)*	\$0 - 20% coinsurance
Flex Card You will have one card to use at retail locations for all of your individual benefits listed below: <ul style="list-style-type: none"> • Over-The-Counter (OTC) Items, including OTC Hearing Aids • Fitness Allowance 	Up to \$96 every 3 months Up to \$20 every month
Gym Membership*	\$0 copay
Healthy Foods Allowance‡* This is a special supplemental benefit for the chronically ill (SSBCI). Enrollee must have cardiac arrhythmia, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder, congestive heart failure (CHF), dementia, or diabetes to be eligible. Not all members with qualifying conditions will be eligible for the benefit.	Up to \$50 each month for healthy foods for members with a qualifying chronic condition

* Services may require authorization.

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

Extra Benefits	Central Health Premier Plan I (HMO) (23)
Herbal Catalog	Products in the catalog are covered through your over-the-counter (OTC) allowance. You can only order these items through a plan approved vendor, but not at a retail location. For more information, please call Member Services.
In-Home Support Services*	\$0 copay for up to 20 hours per calendar year. Not all members will qualify, please see your EOC for more details.
Meals (Made Easy Meals)*‡	\$0 copay 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.
Personal Emergency Response System (PERS)*	\$0 copay
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	\$125 copay Coverage up to \$100,000
Optional Supplemental Enhanced Dental Benefits	Additional dental coverage is available for \$45 per month. Coverage is up to \$1,500 per year for non-network providers Preventive dental services: 10% coinsurance Comprehensive dental services: 70% coinsurance

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