





## Where Is Central Health Medicare Plan Available?

The service area for this plan includes:  
Los Angeles and San Bernardino\* Counties, CA.  
You must live in one of these areas to join the plan.

\* Partial County Coverage

- **Los Angeles County - All Zip Codes**
- **Partial San Bernardino County**

91701	91708	91709	91710	91729	91730
91737	91739	91743	91758	91761	91762
91763	91764	91766	91784	91785	91786
91798	92313	92316	92318	92324	92331
92334	92335	92336	92337	92346	92350
92354	92357	92369	92374	92375	92376
92377	92401	92402	92403	92404	92405
92406	92408	92410	92411	92412	92413
92415	92416	92418	92420	92423	

## Who Is Eligible To Join Central Health Medicare Plan?

You can join Central Health Medicare Plan if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Central Health Medicare Plan unless they are members of our organization and have been since their dialysis began.

You cannot enroll in this plan if your current or former employer or union (or your spouse's current or former employer or union) helps pay for your drugs.

## Can I Choose My Doctors?

Central Health Medicare Plan has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at <http://www.centralhealthplan.com/NetworkProviders/Directory.aspx>. Our customer service number is listed at the end of this introduction.

## What Happens If I Go To A Doctor Who's Not In Your Network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Central Health Medicare Plan nor the Original Medicare Plan will pay for these services.

## Does My Plan Cover Medicare Part B or Part D Drugs?

Central Health Medicare Plan does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## Where Can I Get My Prescriptions If I Join This Plan?

Central Health Medicare Plan has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at <http://www.centralhealthplan.com/NetworkProviders/Directory.aspx>. Our customer service number is listed at the end of this introduction.

## What Is A Prescription Drug Formulary?

Central Health Medicare Plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://www.centralhealthplan.com/Benefits/Formulary.aspx>.

If you are currently taking a drug that is not on our formulary or subject to additional requirement or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## How Can I Get Extra Help With Prescription Drug Plan Costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Central Health Medicare Plan, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## What Are My Protections In This Plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each

year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Central Health Medicare Plan, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

## What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to

participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Central Health Medicare Plan for more details.

## What Types of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Central Health Medicare Plan for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

Please call Central Health Medicare Plan for more information about this Plan.

Visit us at <http://www.centralhealthplan.com> or, call us:

**Customer Service Hours:**  
7 days a week, 8:00 AM to 8:00 PM (PST).

Current and Prospective members should call toll-free 1-866-314-2427 for questions related to the Medicare Advantage program. (TTY/TDD 1-888-205-7671)

Current and Prospective members should call locally 1-626-388-2390 for questions related to the Medicare Advantage program. (TTY/TDD 1-626-388-2391)

Current and Prospective members should call toll-free 1-866-314-2427 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-888-205-7671)

Current and Prospective members should call locally 1-626-388-2390 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-626-388-2391)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact Central Health Medicare Plan for details.

## IMPORTANT INFORMATION

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>1. Premium and Other Important Information</b></p>	<p>In 2009 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$135.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p><b>General</b></p> <p>\$0 monthly plan premium in addition to your \$96.40 monthly Medicare Part B Premium.</p> <p>For 2009 Central Health Medicare Plan will reduce your Medicare Part B premium by up to \$19.</p>
<p><b>2. Doctor and Hospital Choice</b></p> <p>(For more information, see Emergency-#15 and Urgently Needed Care-#16).</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b></p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>

## INPATIENT CARE

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>3. Inpatient Hospital Care</b></p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period are:</p> <p>Days 1 - 60: \$1,068 deductible</p> <p>Days 61 - 90: \$267 per day</p> <p>Days 91 - 150: \$534 per lifetime reserve day</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>In-Network</b></p> <p>\$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

## INPATIENT CARE (continued)

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>4. Inpatient Mental Health Care</b></p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b></p> <p>\$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p><b>5. Skilled Nursing Facility</b></p> <p>(in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day</p> <p>100 day limit per benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for SNF services</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p>

## INPATIENT CARE (continued)

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>6. Home Health Care</b></p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc).</p>	<p>\$0 copay.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered home health visits.</p>
<p><b>7. Hospice</b></p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p><b>In-Network</b></p> <p>You must get care from a Medicare-certified hospice.</p>

## OUTPATIENT CARE

<p><b>8. Doctor Office Visits</b></p>	<p>20% coinsurance</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p>See “Physical Exams” for more information.</p> <p><b>In-Network</b></p> <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$5 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p>
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## OUTPATIENT CARE (continued)

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>9. Chiropractic Services</b></p>	<p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>
<p><b>10. Podiatry Services</b></p>	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered podiatry benefits.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<p><b>11. Outpatient Mental Health Care</b></p>	<p>50% coinsurance for most outpatient mental health services.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$10 copay for each Medicare-covered individual or group therapy visit.</p>

## OUTPATIENT CARE (continued)

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<b>12. Outpatient Substance Abuse Care</b>	20% coinsurance	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$10 copay for Medicare-covered individual or group visits.</p>
<b>13. Outpatient Services/ Surgery</b>	20% coinsurance for the doctor  20% of outpatient facility charges	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p>
<b>14. Ambulance Services</b>  (medically necessary ambulance services)	20% coinsurance	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$50 copay for Medicare-covered ambulance benefits.</p>

## OUTPATIENT CARE (continued)

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>15. Emergency Care</b></p> <p>(You may go to any emergency room if you reasonably believe you need emergency care).</p>	<p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p><b>In-Network</b></p> <p>\$50 copay for Medicare-covered emergency room visits.</p> <p><b>Out-of-Network</b></p> <p>\$50,000 limit for emergency services outside the U.S. every year.</p> <p><b>In and Out-of-Network</b></p> <p>If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>
<p><b>16. Urgently Needed Care</b></p> <p>(This is NOT emergency care, and in most cases, is out of the service area).</p>	<p>20% coinsurance, or a set copay</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b></p> <p>\$5 copay for Medicare-covered urgently needed care visits.</p>
<p><b>17. Outpatient Rehabilitation Services</b></p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>

## OUTPATIENT MEDICAL SERVICES AND SUPPLIES

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>18. Durable Medical Equipment</b></p> <p>(includes wheel-chairs, oxygen, etc).</p>	<p>20% coinsurance</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>10% of the cost for Medicare-covered items.</p>
<p><b>19. Prosthetic Devices</b></p> <p>(includes braces, artificial limbs and eyes, etc).</p>	<p>20% coinsurance</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>10% of the cost for Medicare-covered items.</p>
<p><b>20. Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies</b></p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>

## OUTPATIENT MEDICAL SERVICES AND SUPPLIES (continued)

BENEFIT CATEGORY	ORIGINAL MEDICARE	CENTRAL HEALTH MEDICARE PLAN
<p><b>21. Diagnostic Tests, X-Rays, and Lab Services</b></p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> <li>• lab services</li> <li>• diagnostic procedures and tests</li> <li>• X-rays</li> <li>• diagnostic radiology services.</li> </ul> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>

























