

Introduction to the Summary of Benefits for CENTRAL HEALTH MEDICARE PLAN (HMO) & CENTRAL HEALTH MEDI-MEDI PLAN (HMO SNP)

January 1 - December 31

2012

LOS ANGELES COUNTY

PARTIAL ORANGE COUNTY

PARTIAL SAN BERNARDINO COUNTY

Thank you for your interest in Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP). Our plans are offered by CENTRAL HEALTH PLAN OF CALIFORNIA, INC./Central Health Medicare Plan, a Medicare Advantage Health Maintenance Organization (HMO).

Central Health Medi-Medi Plan (HMO SNP) is a Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria. You may be eligible to join this plan if you receive assistance from the state and Medicare. All cost sharing pertaining to Central Health Medi-Medi Plan (HMO SNP) in this Summary of Benefits is based on your level of Medicaid eligibility. Please call Central Health Medi-Medi Plan (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP) and ask for the "Evidence of Coverage".

You Have Choices in Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time. Otherwise, you may join or leave a plan only at certain times.

Please call Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Introduction

Where Is Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP) Available?

The service area for CENTRAL HEALTH MEDICARE PLAN (HMO) includes the following counties: Los Angeles, San Bernardino*, and Orange* Counties, CA. You must live in one of these areas to join the plan.

The service area for CENTRAL HEALTH MEDI-MEDI PLAN (HMO SNP) includes the following counties: Los Angeles, San Bernardino* Counties, CA. You must live in one of these areas to join the plan.

*denotes partial county

Los Angeles County – All Zip Codes

| | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90001 | 90002 | 90003 | 90004 | 90005 | 90006 | 90007 | 90008 | 90009 |
| 90010 | 90011 | 90012 | 90013 | 90014 | 90015 | 90016 | 90017 | 90018 |
| 90019 | 90020 | 90021 | 90022 | 90023 | 90024 | 90025 | 90026 | 90027 |
| 90028 | 90029 | 90030 | 90031 | 90032 | 90033 | 90034 | 90035 | 90036 |
| 90037 | 90038 | 90039 | 90040 | 90041 | 90042 | 90043 | 90044 | 90045 |
| 90046 | 90047 | 90048 | 90049 | 90050 | 90051 | 90052 | 90053 | 90054 |
| 90055 | 90056 | 90057 | 90058 | 90059 | 90060 | 90061 | 90062 | 90063 |
| 90064 | 90065 | 90066 | 90067 | 90068 | 90069 | 90070 | 90071 | 90072 |
| 90073 | 90074 | 90075 | 90076 | 90077 | 90078 | 90079 | 90080 | 90081 |
| 90082 | 90083 | 90084 | 90086 | 90087 | 90088 | 90089 | 90090 | 90091 |
| 90093 | 90094 | 90095 | 90096 | 90097 | 90099 | 90101 | 90102 | 90103 |
| 90174 | 90185 | 90189 | 90198 | 90201 | 90202 | 90209 | 90210 | 90211 |
| 90212 | 90213 | 90220 | 90221 | 90222 | 90223 | 90224 | 90230 | 90231 |
| 90232 | 90233 | 90239 | 90240 | 90241 | 90242 | 90245 | 90247 | 90248 |
| 90249 | 90250 | 90251 | 90254 | 90255 | 90260 | 90261 | 90262 | 90263 |
| 90264 | 90265 | 90266 | 90267 | 90270 | 90272 | 90274 | 90275 | 90277 |
| 90278 | 90280 | 90290 | 90291 | 90292 | 90293 | 90294 | 90295 | 90296 |
| 90301 | 90302 | 90303 | 90304 | 90305 | 90306 | 90307 | 90308 | 90309 |
| 90310 | 90311 | 90312 | 90313 | 90397 | 90398 | 90401 | 90402 | 90403 |
| 90404 | 90405 | 90406 | 90407 | 90408 | 90409 | 90410 | 90411 | 90501 |
| 90502 | 90503 | 90504 | 90505 | 90506 | 90507 | 90508 | 90509 | 90510 |
| 90601 | 90602 | 90603 | 90604 | 90605 | 90606 | 90607 | 90608 | 90609 |
| 90610 | 90612 | 90623 | 90630 | 90631 | 90637 | 90638 | 90639 | 90640 |
| 90650 | 90651 | 90652 | 90659 | 90660 | 90661 | 90662 | 90665 | 90670 |
| 90671 | 90701 | 90702 | 90703 | 90704 | 90706 | 90707 | 90710 | 90711 |
| 90712 | 90713 | 90714 | 90715 | 90716 | 90717 | 90723 | 90731 | 90732 |
| 90733 | 90734 | 90744 | 90745 | 90746 | 90747 | 90748 | 90749 | 90755 |
| 90801 | 90802 | 90803 | 90804 | 90805 | 90806 | 90807 | 90808 | 90809 |
| 90810 | 90813 | 90814 | 90815 | 90822 | 90831 | 90832 | 90833 | 90834 |

Section I

| | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90835 | 90840 | 90842 | 90844 | 90845 | 90846 | 90847 | 90848 | 90853 |
| 90888 | 90895 | 90899 | 91001 | 91003 | 91006 | 91007 | 91008 | 91009 |
| 91010 | 91011 | 91012 | 91016 | 91017 | 91020 | 91021 | 91023 | 91024 |
| 91025 | 91030 | 91031 | 91040 | 91041 | 91042 | 91043 | 91046 | 91050 |
| 91051 | 91066 | 91077 | 91101 | 91102 | 91103 | 91104 | 91105 | 91106 |
| 91107 | 91108 | 91109 | 91110 | 91114 | 91115 | 91116 | 91117 | 91118 |
| 91121 | 91123 | 91124 | 91125 | 91126 | 91129 | 91131 | 91175 | 91182 |
| 91184 | 91185 | 91186 | 91187 | 91188 | 91189 | 91191 | 91199 | 91201 |
| 91202 | 91203 | 91204 | 91205 | 91206 | 91207 | 91208 | 91209 | 91210 |
| 91214 | 91221 | 91222 | 91224 | 91225 | 91226 | 91301 | 91302 | 91303 |
| 91304 | 91305 | 91306 | 91307 | 91308 | 91309 | 91310 | 91311 | 91312 |
| 91313 | 91316 | 91321 | 91322 | 91324 | 91325 | 91326 | 91327 | 91328 |
| 91329 | 91330 | 91331 | 91333 | 91334 | 91335 | 91337 | 91340 | 91341 |
| 91342 | 91343 | 91344 | 91345 | 91346 | 91350 | 91351 | 91352 | 91353 |
| 91354 | 91355 | 91356 | 91357 | 91361 | 91362 | 91363 | 91364 | 91365 |
| 91367 | 91371 | 91372 | 91376 | 91380 | 91381 | 91382 | 91383 | 91384 |
| 91385 | 91386 | 91387 | 91388 | 91390 | 91392 | 91393 | 91394 | 91395 |
| 91396 | 91399 | 91401 | 91402 | 91403 | 91404 | 91405 | 91406 | 91407 |
| 91408 | 91409 | 91410 | 91411 | 91412 | 91413 | 91416 | 91423 | 91426 |
| 91436 | 91470 | 91482 | 91495 | 91496 | 91497 | 91499 | 91501 | 91502 |
| 91503 | 91504 | 91505 | 91506 | 91507 | 91508 | 91510 | 91521 | 91522 |
| 91523 | 91526 | 91601 | 91602 | 91603 | 91604 | 91605 | 91606 | 91607 |
| 91608 | 91609 | 91610 | 91611 | 91612 | 91614 | 91615 | 91616 | 91617 |
| 91618 | 91702 | 91706 | 91709 | 91711 | 91714 | 91715 | 91716 | 91722 |
| 91723 | 91724 | 91731 | 91732 | 91733 | 91734 | 91735 | 91740 | 91741 |
| 91744 | 91745 | 91746 | 91747 | 91748 | 91749 | 91750 | 91754 | 91755 |
| 91756 | 91765 | 91766 | 91767 | 91768 | 91769 | 91770 | 91771 | 91772 |
| 91773 | 91775 | 91776 | 91778 | 91780 | 91788 | 91789 | 91790 | 91791 |
| 91792 | 91793 | 91795 | 91797 | 91799 | 91801 | 91802 | 91803 | 91804 |
| 91841 | 91896 | 91899 | 93243 | 93510 | 93532 | 93534 | 93535 | 93536 |
| 93539 | 93543 | 93544 | 93550 | 93551 | 93552 | 93553 | 93560 | 93563 |
| 93584 | 93586 | 93590 | 93591 | 93599 | ----- | ----- | ----- | ----- |

Introduction

*San Bernardino County – Partial County Coverage for the Following Zip Codes Only

| | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 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 | ----- |

*Orange County - Partial County Coverage for the Following Zip Codes Only

| | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90620 | 90621 | 90622 | 90623 | 90624 | 90630 | 90631 | 90632 | 90633 |
| 90638 | 90680 | 90720 | 90721 | 90740 | 90742 | 90743 | 92602 | 92603 |
| 92604 | 92605 | 92606 | 92612 | 92614 | 92615 | 92616 | 92617 | 92618 |
| 92619 | 92620 | 92623 | 92626 | 92627 | 92628 | 92646 | 92647 | 92648 |
| 92649 | 92650 | 92655 | 92683 | 92684 | 92685 | 92697 | 92701 | 92702 |
| 92703 | 92704 | 92705 | 92706 | 92707 | 92708 | 92711 | 92712 | 92725 |
| 92728 | 92735 | 92780 | 92781 | 92782 | 92799 | 92801 | 92802 | 92803 |
| 92804 | 92805 | 92806 | 92807 | 92808 | 92809 | 92811 | 92812 | 92814 |
| 92815 | 92816 | 92817 | 92821 | 92822 | 92823 | 92825 | 92831 | 92832 |
| 92833 | 92834 | 92835 | 92836 | 92837 | 92838 | 92840 | 92841 | 92842 |
| 92843 | 92844 | 92845 | 92846 | 92850 | 92856 | 92857 | 92859 | 92861 |
| 92862 | 92863 | 92864 | 92865 | 92866 | 92867 | 92868 | 92869 | 92870 |
| 92871 | 92885 | 92886 | 92887 | 92899 | ----- | ----- | ----- | ----- |

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

Who Is Eligible To Join Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP)?

You can join **CENTRAL HEALTH MEDICARE PLAN (HMO)** 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 (HMO) unless they are members of our organization and have been since their dialysis began.

You can join **CENTRAL HEALTH MEDI-MEDI PLAN (HMO SNP)** 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 generally are not eligible to enroll in Central Health Medi-Medi Plan (HMO SNP) unless they are members of our organization and have been since their dialysis began. You must also receive assistance from the state to join this plan. Please call the plan to see if you are eligible to join.

Can I Choose My Doctors?

Central Health Medicare Plan (HMO) and Central Health Medi-Medi Plan (HMO SNP) have 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.

Introduction

for an additional calendar year, 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 (HMO) or Central Health Medi-Medi Plan (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Central Health Medicare Plan (HMO) or Central Health Medi-Medi Plan (HMO SNP), 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. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we 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 (HMO) or Central Health Medi-Medi Plan (HMO SNP) 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 (HMO) or Central Health Medi-Medi Plan (HMO SNP) 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.

Summary of Benefits

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 |
|---|--|
| <p>1. Premium and Other Important Information</p> | <p>The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.*</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> |
| <p>2. Doctor and Hospital Choice</p> <p>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</p> | <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p> |

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>General</p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B Premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services.</p> | <p>General</p> <p>*Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Original Medicare services.</p> <p>**Please consult with your plan about cost sharing when receiving services from out-of-network providers.</p> <p>\$30.86 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>In-Network</p> <p>In this plan you will have no cost sharing responsibility for Medicare-covered services.</p> |
| <p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> | <p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> |

Summary of Benefits

INPATIENT CARE

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|--|---|
| <p>3. Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p> | <p>In 2011 the amounts for each benefit period were \$0 or: Days 1 - 60: \$1,132 deductible* Days 61 - 90: \$283 per day* Days 91 - 150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012.</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>4. Inpatient Mental Health Care</p> | <p>In 2011 the amounts for each benefit period were \$0 or: Days 1 - 60: \$1,132 deductible* Days 61 - 90: \$283 per day* Days 91 - 150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|---|---|
| <p>In-Network</p> <p>No limit to the number of days covered by the plan each hospital stay.</p> <p>\$0 copay</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | <p>In-Network</p> <p>No limit to the number of days covered by the plan each hospital stay.</p> <p>\$0 copay</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |
| <p>In-Network</p> <p>\$0 copay</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | <p>In-Network</p> <p>\$0 copay</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|---|
| <p>5. Skilled Nursing Facility (SNF)</p> <p>(in a Medicare-certified skilled nursing facility)</p> | <p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day* Days 21 - 100: \$0 or \$141.50 per day*</p> <p>These amounts may change for 2012.</p> <p>100 days for each 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>6. Home Health Care</p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>\$0 copay</p> |
| <p>7. Hospice</p> | <p>You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|--|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 - 14: \$0 copay per day Days 15 - 60: \$75 copay per day Days 61 - 100: \$0 copay per day</p> <p>\$3,400 out-of-pocket limit every year.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>\$0 copay for SNF services</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered home health visits.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered home health visits.*</p> |
| <p>General</p> <p>You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p> | <p>General</p> <p>You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits.*</p> <p>\$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.*</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.*</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered chiropractic visits.</p> <p>Medicare-covered chiropractic visits are 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 providers.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered chiropractic visits.*</p> <p>Medicare-covered chiropractic visits are 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 providers.</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|---|
| <p>10. Podiatry Services</p> | <p>Supplemental routine care not covered.</p> <p>0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> |
| <p>11. Outpatient Mental Health Care</p> | <p>0% or 40% coinsurance for most outpatient mental health services.</p> <p>Specific copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>0% or 40% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> |
| <p>12. Outpatient Substance Abuse Care</p> | <p>0% or 20% coinsurance</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|---|---|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered podiatry benefits.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered podiatry benefits.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$5 copay for each Medicare-covered individual therapy visit.</p> <p>\$5 copay for each Medicare-covered group therapy visit</p> <p>\$5 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$5 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$10 copay for Medicare-covered partial hospitalization program services</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered Mental Health visits.*</p> <p>\$0 copay for Medicare-covered partial hospitalization program services*</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$5 copay for Medicare-covered individual visits</p> <p>\$5 copay for Medicare-covered group visits</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered visits.*</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|--|
| <p>13. Outpatient Services/Surgery</p> | <p>0% or 20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>0% or 20% coinsurance for ambulatory surgical center facility services</p> |
| <p>14. Ambulance Services</p> <p>(medically necessary ambulance services)</p> | <p>0% or 20% coinsurance</p> |
| <p>15. Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p> | <p>0% or 20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient 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>16. Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p> | <p>0% or 20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|--|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</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> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</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> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$50 copay for Medicare-covered ambulance benefits.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered ambulance benefits.*</p> |
| <p>General</p> <p>\$65 copay for Medicare-covered emergency room visits.</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</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>General</p> <p>\$0 copay for Medicare-covered emergency room visits.*</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p> |
| <p>General</p> <p>\$0 copay for Medicare-covered urgently-needed-care visits</p> | <p>General</p> <p>\$0 copay for Medicare-covered urgently-needed-care visits.*</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|--|-----------------------|
| 17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy) | 0% or 20% coinsurance |

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

| | |
|---|-----------------------|
| 18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.) | 0% or 20% coinsurance |
| 19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.) | 0% or 20% coinsurance |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered Occupational Therapy visits</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered Occupational Therapy visits.*</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.*</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% to 20% of the cost for Medicare-covered items.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered items.*</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% to 20% of the cost for Medicare-covered items.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered items.*</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|--|---|
| <p>20. Diabetes Programs and Supplies</p> | <p>0% or 20% coinsurance for diabetes self-management training</p> <p>0% or 20% coinsurance for diabetes supplies</p> <p>0% or 20% coinsurance for diabetic therapeutic shoes or inserts</p> |
| <p>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p> | <p>0% or 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 supplemental routine screening tests, like checking your cholesterol.</p> <p>0% or 20% coinsurance for the digital rectal exam and other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|--|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Diabetes self-management training</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Diabetes monitoring supplies • Therapeutic shoes or inserts | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Diabetes self-management training.*</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Diabetes monitoring supplies* • Therapeutic shoes or inserts* |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • Lab services • Diagnostic procedures and tests <p>0% of the cost for Medicare-covered X-rays</p> <p>0% of the cost for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • Lab services* • Diagnostic procedures and tests* • X-rays* • Diagnostic radiology services (not including X-rays)* • Therapeutic radiology services* |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|---|---|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services* • Medicare-covered Intensive Cardiac Rehabilitation Services* • Medicare-covered Pulmonary Rehabilitation Services* |
| <p>General</p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) | <p>General</p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|--|--|
| 24. Kidney Disease and Conditions | <p>0% or 20% coinsurance for renal dialysis</p> <p>0% or 20% coinsurance for kidney disease education services</p> |
| 25. Outpatient Prescription Drugs | <p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p> |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|--|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>20% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for renal dialysis*</p> <p>\$0 copay for kidney disease education services*</p> |
| <p>Drugs covered under Medicare Part B</p> <p>General</p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.centralhealthplan.com/Benefits/Formulary.aspx on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan’s service area (for instance when you travel).</p> | <p>Drugs covered under Medicare Part B</p> <p>General</p> <p>\$0 copay for Part B-covered drugs.</p> <p>\$0 annual deductible for Part B-covered drugs.*</p> <p>\$0 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs.*</p> <p>Drugs Covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.centralhealthplan.com/Benefits/Formulary.aspx on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Central Health Medicare Plan (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Central Health Medicare Plan (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug.</p> <p>The cost sharing for a partial fill of a new prescription will be prorated based on the cost sharing for a full fill of the same prescription.</p> | <p>the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Central Health Medi-Medi Plan (HMO SNP) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Central Health Medi-Medi Plan (HMO SNP) approves the exception, you will pay the generic cost share for generic drugs and the brand cost share for brand drugs.</p> <p>The cost sharing for a partial fill of a new prescription will be prorated based on the cost sharing for a full fill of the same prescription.</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>In-Network</p> <p>\$0 deductible.</p> <p>Supplemental drugs don't count toward your out-of-pocket drug costs.</p> <p>You are covered up to \$150 for these drugs.</p> <p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (30-day) supply of drugs in this tier • \$15 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (30-day) supply of drugs in this tier • \$75 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$50 copay for a one-month (30-day) supply of drugs in this tier • \$150 copay for a three-month (90-day) supply of drugs in this tier | <p>In-Network</p> <p>You pay a \$0 annual deductible.</p> <p>Supplemental drugs don't count toward your out-of-pocket drug costs.</p> <p>You are covered up to \$150 for these drugs.</p> <p>Initial Coverage</p> <p>Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 copay or • A \$1.10 copay or • A \$2.60 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • A \$0 copay or • A \$3.30 copay or • A \$6.50 copay. <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay a \$0 copay.</p> <p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$50 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier | <p>charge for the drug and submit documentation to receive reimbursement from Central Health Medi-Medi Plan (HMO SNP).</p> <p>Out-of-Network Initial Coverage</p> <p>Depending on your income and institutional status, you will be reimbursed by Central Health Medi-Medi Plan (HMO SNP) up to the plan's cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 copay or • A \$1.10 copay or • A \$2.60 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> • A \$0 copay or • A \$3.30 copay or • A \$6.50 copay <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed in full for drugs purchased out-of-network.</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|---|---|
| <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (30-day) supply of drugs in this tier • \$10 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (30-day) supply of drugs in this tier • \$50 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$50 copay for a one-month (30-day) supply of drugs in this tier • \$100 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Additional Coverage Gap</p> <p>You pay the following:</p> <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of all drugs covered in this tier • \$0 copay for a three-month (90-day) supply of all drugs covered in this tier | |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (30-day) supply of all drugs covered in this tier • \$15 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of all drugs covered in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of all drugs covered in this tier <p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of all drugs covered in this tier • \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (30-day) supply of all drugs covered in this tier • \$10 copay for a three-month (90-day) supply of all drugs covered in this tier <p>After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> | |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from Central Health Medicare Plan (HMO).</p> <p>Out-of-Network Initial Coverage</p> <p>You will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (30-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (30-day) supply of drugs in this tier | |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$50 copay for a one-month (30-day) supply of drugs in this tier <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>Additional Out-of-Network Coverage Gap</p> <p>You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of all drugs covered in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (30-day) supply of all drugs covered in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. • You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. | |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|---|-------------------|
| <p>25. Outpatient Prescription Drugs</p> <p>(continued)</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <ul style="list-style-type: none"> You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> 5% coinsurance, or \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> | |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|--|---|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • up to 1 fluoride treatment(s) every six months • up to 1 dental x-ray(s) every six months <p>Plan offers additional comprehensive dental benefits.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered dental benefits*</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • up to 1 fluoride treatment(s) every six months • up to 1 dental x-ray(s) every six months <p>Plan offers additional comprehensive dental benefits.</p> |
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • up to 1 supplemental routine hearing exam(s) every year • up to 1 fitting-evaluation(s) for a hearing aid every year <p>\$0 copay for up to 1 hearing aid(s) every year.</p> <p>\$500 plan coverage limit for hearing aids every year.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered diagnostic hearing exams*</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • up to 1 supplemental routine hearing exam(s) every year • up to 1 fitting-evaluation(s) for a hearing aid every year <p>\$0 copay for up to 1 hearing aid(s) every year.</p> <p>\$1,000 plan coverage limit for hearing aids every year.</p> |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|--|--|
| 28. Vision Services | <p>0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p> |
| 29. Over-the-Counter Items | Not covered. |
| 30. Transportation (Routine) | Not covered. |

Summary of Benefits

| BENEFIT CATEGORY | ORIGINAL MEDICARE |
|------------------|-------------------|
| 31. Acupuncture | Not covered. |

Section II

| CENTRAL HEALTH MEDICARE PLAN HMO LA, Partial Orange, Partial SB | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP LA, Partial SB |
|---|---|
| <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$10 copay per visit up to 6 visit(s) every year.</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for up to 24 visit(s) every year.</p> |

Additional Information

Comprehensive Written Statement for Prospective Enrollees

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Beneficiaries who qualify for Medicare and Medi-Cal are known as dual eligibles. As a dual eligible beneficiary, you are eligible for benefits not covered under Original Medicare. The following chart describes Medi-Cal benefits available to you as well as any similar benefits available under Central Health Medi-Medi Plan (HMO SNP).

Dual Eligibles

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|---|---|---|
| 1. Inpatient Hospital Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Inpatient Hospital Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 2. Outpatient Hospital Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Outpatient Hospital Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 3. Rural Health Clinic Services | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 4. Federally Qualified Health Center Services | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 5. Laboratory Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Laboratory Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 6. X-rays | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for X-rays, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 7. Skilled Nursing Facility Care for over 21 years of age - Subacute Care | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Skilled Nursing Facility Care, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |

Additional Information

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|--|---|--|
| 8. Pediatric Nursing Facility Care for under 21 years of age - subacute services (early & periodic screening, diagnosis, and treatment supplemental services) | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Pediatric Nursing Facility Care, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 9. Family Planning Services & Supplies | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 10. Physician Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Physician Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 11. Medical & Surgical Dental Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Medical and Surgical Dental Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 12. Ophthalmologist Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Ophthalmologist Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 13. Podiatry Services* | \$0 copay for Medicaid-covered services | You pay \$0 for Medicare-covered podiatry services limited to medically necessary foot care. |
| 14. Optometry Services* | \$0 copay for Medicaid-covered services | You pay \$0 for one routine eye exam every year. If you exhaust Medicare coverage for Optometry Services, you pay \$0 for Medi-Cal covered Optometry Services as long as you're fully covered by Medi-Cal. |

Dual Eligibles

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|--|---|---|
| 15. Chiropractic Services* | \$0 copay for Medicaid-covered services | You pay \$0 for Medicare-covered chiropractic services. |
| 16. Psychology Services* | \$0 copay for Medicaid-covered services | You pay \$0 for each Medicare-covered individual or group therapy visit. |
| 17. Nurse Anesthetist Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare-covered Nurse Anesthetist Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 18. Optician and Optical Fabricating Lab Services* | \$0 copay for Medicaid-covered services | You are covered up to \$300 for either one pair of eyeglasses (frame and lenses) or contact lenses every year. You may upgrade your eyewear by paying additional costs over the \$300 coverage limit. |
| 19. Medical Supplies (including incontinence creams and washes products) (*creams and washes only) | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Medical Supplies, you pay \$0 for Medi-Cal covered supplies as long as you are fully covered by Medi-Cal. Incontinence creams and washes are not covered. |
| 20. Durable Medical Equipment | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Durable Medical Equipment, you pay \$0 for Medi-Cal covered items as long as you are fully covered by Medi-Cal. |

Additional Information

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|--|---|--|
| 21. Hearing Aids | \$0 copay for Medicaid-covered services | You are covered up to \$1,000 for a hearing aid every year. If you exhaust Medicare coverage for Hearing Aids, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 22. Enteral Formulae | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Enteral Formulae, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 23. Acupuncture Services* | \$0 copay for Medicaid-covered services | You pay \$0 for up to 24 acupuncture visits every year. |
| 24. Licensed Midwife Services | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 25. Home Health Services through a Home Health Agency (including home health nursing and aide services, physical and occupational therapy, speech pathology and audiology services, intermittent nursing, home health aid care, medical supplies, equipment and appliances) | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Home Health Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 26. Physical Therapy and Related Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Physical Therapy, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |

Dual Eligibles

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|--|---|--|
| 27. Rehabilitation Facilities | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Rehabilitation Facilities, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 28. Private Duty Nursing (waiver only) | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 29. Clinic (Organized outpatient clinic, Indian Health Services, alternate birthing centers, ambulatory surgical centers) | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Clinic services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 30. Dental Services* | \$0 copay for Medicaid-covered services | <p>You pay \$0 for Medicare-covered dental services.</p> <p>You pay \$0 for diagnostic and preventive dental services including:</p> <ul style="list-style-type: none"> • 1 oral exam every six months • 1 cleaning every six months • 1 fluoride treatment every six months • 1 dental X-ray every six months <p>You pay \$0 for additional comprehensive dental services including:</p> <ul style="list-style-type: none"> • Restorative Services • Endodontic Services • Periodontic Services • Prosthodontic Services • Oral & Maxillofacial Surgery <p>Limitations and exclusions apply. Refer to the Dental Directory for more information.</p> |

Additional Information

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|--|--|---|
| 31. Occupational Therapy | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Occupational Therapy, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 32. Speech Pathology / Speech Therapy* | \$0 copay for Medicaid-covered services | You pay \$0 for Medicare-covered Speech Pathology / Speech Therapy services. |
| 33. Audiology Services* | \$0 copay for Medicaid-covered services | <p>You pay \$0 for Medicare-covered diagnostic hearing exams.</p> <p>You pay \$0 for one routine hearing exam every year.</p> <p>You pay \$0 for one hearing aid and one fitting evaluation for a hearing aid every year.</p> |
| 34. Pharmaceutical Services and Prescribed Drugs | \$0 copay for drugs excluded from Medicare Part D coverage | <p>You are covered up to \$25 each month for select over-the-counter drugs.</p> <p>You pay \$50 for each one-month supply of erectile dysfunction (ED) drugs. You are covered up to \$150 based on the cost of the ED drugs to the Plan.</p> <p>You pay \$0 for Medi-Cal covered drugs excluded from Medicare Part D coverage as long as you are fully covered by Medi-Cal.</p> |

Dual Eligibles

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|---|---|---|
| 35. Dentures* | \$0 copay for Medicaid-covered services | You pay \$0 for denture services. Limitations and exclusions apply. Refer to the Dental Directory for more information |
| 36. Prosthetic Appliances (Orthotic appliances) prosthetic eyes | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Prosthetic Appliances, you pay \$0 for Medi-Cal covered items as long as you are fully covered by Medi-Cal. |
| 37. Eyeglasses, other eye appliances* | \$0 copay for Medicaid-covered services | You are covered up to \$300 for either one pair of eyeglasses (frame and lenses) or contact lenses every year. You may upgrade your eyewear by paying additional costs over the \$300 coverage limit. |
| 38. Comprehensive Perinatal Services Program (Preventive services) | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 39. Adult Day Health Care | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 40. Chronic Dialysis Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Dialysis Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 41. Rehabilitation Services (ADHC, chronic dialysis, out-patient heroin detoxification, rehabilitative mental health, drug Medi-Cal, independent rehabilitation centers) | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Rehabilitation Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |

Additional Information

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|---|---|--|
| 42. Institutes for Mental Diseases (for under 21 years of age and over 65 years of age, including inpatient psychiatric care). | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Institutes for Mental Diseases, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 43. Intermediate Care Facility | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Intermediate Care Facility, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 44. Nurse Midwife | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Nurse Midwife, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 45. Hospice | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Hospice, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 46. TB-related Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for TB-related Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 47. Respiratory Care for Ventilator-Dependent Patients | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Respiratory Care, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 48. Family Nurse Practitioner | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Family Nurse Practitioner, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |

Dual Eligibles

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|--|---|--|
| 49. Home and Community Care for Functionally Disabled Elderly (Waiver only) | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 50. Community-Supported Living Arrangements (Waiver only) | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 51. Personal Care Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Personal Care Services, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 52. Rural Primary Care Hospital | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Rural Primary Care Hospital, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 53. Nonmedical Health Facilities | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Nonmedical Health Facilities, you pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 54. Emergency Hospital Services | \$0 copay for Medicaid-covered services | If you exhaust Medicare coverage for Emergency Hospital Services, you pay \$0 as long as you are fully covered by Medi-Cal. |
| 55. Transportation (State provides emergency and non-emergency medical transportation. Meets federal requirement for assurance of transportation to medically necessary services) | \$0 copay for Medicaid-covered services | You pay \$0 for up to 40 one-way trips to plan-approved location every year. If you exhaust Medicare coverage for Transportation, you pay \$0 for Medi-Cal covered Transportation as long as you're fully covered by Medi-Cal. |

Dual Eligibles

| BENEFIT CATEGORY | MEDICAID (MEDI-CAL) | CENTRAL HEALTH MEDI-MEDI PLAN HMO SNP |
|---|---|---|
| 61. Individual Nurse Provider Services (Early & periodic screening, diagnosis, and treatment services & waiver only) | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |
| 62. Nonmedical Services (Waiver only) | \$0 copay for Medicaid-covered services | You pay \$0 for Medi-Cal covered services as long as you are fully covered by Medi-Cal. |

*Recently enacted legislation added Section 14131.10 of the W&I Code to exclude several optional benefit categories from coverage under the Medi-Cal program to be implemented on July 1, 2009. The optional benefits indicated are excluded from coverage under the Medi-Cal program effective July 1, 2009. The optional benefits exclusion policy does not apply to the following beneficiaries: 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a skilled nursing facility (Nursing Facilities Level A and Level B, including subacute care facilities); 3) beneficiaries who are pregnant (pregnancy-related benefits and services; other benefits and services to treat conditions that, if left untreated, might cause difficulties for the pregnancy); 4) California Children's Services beneficiaries; and 5) beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly. Most claims for excluded optional benefit services billed by a physician or physician group remain reimbursable on or after July 1, 2009. However, these claims will be denied if the rendering provider is not a physician, but one of the optional benefit providers. More information on the reduced benefits and services affected by this new legislation is available on the California Department of Health Care Services website at www.dhcs.ca.gov.

