CITIZENS CHOICE
HEALTHPLAN·HMO

Summary of Benefits 2013

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Introduction

Los Angeles, Orange, Riverside, San Bernardino and Stanislaus Counties

Thank you for your interest in Citizens Choice Healthplan (HMO). Our plan is offered by CITIZENS CHOICE HEALTHPLAN, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. 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 Citizens Choice Healthplan (HMO) 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 Citizens Choice Healthplan (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Citizens Choice Healthplan (HMO) 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 Citizens Choice Healthplan (HMO) 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.

Where is Honored Citizens Choice Healthplan, dba Citizens (HMO) available?

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

Los Angeles County

ALL ZIP CODES

Orange County

90620	92703	92833
90621	92704	92835
90623	92705	92840
90630	92706	92841
90631	92707	92843
90680	92708	92844
90720	92780	92845
90740	92782	92861
90742	92801	92862
90743	92802	92865
92626	92804	92866
92627	92805	92867
92646	92806	92868
92647	92807	92869
92648	92808	92870
92649	92821	92886
92655	92823	92887
92683	92831	
92701	92832	

Stanislaus County

ALL ZIP CODES

Riverside County

91752	92270	92522	92572
92028	92274	92530	92581
92201	92276	92531	92582
92202	92282	92532	92583
92203	92292	92536	92584
92210	92320	92539	92585
92211	92324	92543	92586
92220	92373	92544	92587
92223	92399	92545	92589
92230	92501	92546	92590
92234	92502	92548	92591
92235	92503	92549	92592
92236	92504	92551	92593
92240	92505	92552	92595
92241	92506	92553	92596
92247	92507	92554	92599
92248	92508	92555	92860
92253	92509	92556	92877
92254	92513	92557	92878
92255	92514	92561	92879
92258	92515	92562	92880
92260	92516	92563	92881
92261	92517	92564	92882
92262	92518	92567	92883
92263	92519	92570	
92264	92521	92571	

San Bernardino County

91701	92307	92342	92392
91708	92308	92344	92393
91709	92311	92345	92394
91710	92312	92346	92395
91729	92313	92347	92397
91730	92314	92350	92398
91737	92315	92352	92399
91739	92316	92354	92401
91743	92317	92356	92402
91758	92318	92357	92403
91761	92321	92358	92404
91762	92322	92359	92405
91763	92323	92365	92406
91764	92324	92366	92407
91784	92325	92368	92408
91785	92326	92369	92410
91786	92327	92371	92411
91798	92329	92372	92412
92252	92331	92373	92413
92256	92333	92374	92414
92268	92334	92375	92415
92277	92335	92376	92416
92278	92336	92377	92418
92284	92337	92378	92420
92285	92338	92382	92423
92286	92339	92385	92424
92301	92340	92386	92427
92305	92341	92391	

*denotes partial county

Who is eligible to join Honored Citizens Choice Healthplan, dba Citizens (HMO)?

You can join Citizens Choice Healthplan (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 Citizens Choice Healthplan (HMO) unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?

Citizens Choice Healthplan (HMO) 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 updated list, visit us at www.citizenschoicehealth.com. 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 the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

Where can I get my prescriptions if I join this plan?

Citizens Choice Healthplan (HMO) 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 www.citizenschoicehealth.com. Our customer service number is listed at the end of this introduction.

Does my plan cover Medicare Part B or Part D drugs?

Citizens Choice Healthplan (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What is a prescription drug formulary?

Citizens Choice Healthplan (HMO) 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 members 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.citizenschoicehealth.com/findadrug.aspx.

If you are currently taking a drug that is not on our formulary or subject to additional requirements 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 my prescription drug plan costs or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov

'Programs for People with Limited Income and Resources' in the publication Medicare & You.

- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue 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 Citizens Choice Healthplan (HMO), 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 Citizens Choice Healthplan (HMO), 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 Citizens Choice Healthplan (HMO) 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 Citizens Choice Healthplan (HMO) 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 osteoporosis drugs for some women.
- Erythropoietin (Epoetin Alfa 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 took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- 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 administered through Durable Medical Equipment.

Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Citizens Choice Healthplan for more information about Citizens Choice Healthplan (HMO).

Visit us at www.citizenschoicehealth.com or, call us:

Customer Service Hours for October 1 – February 14: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific

Customer Service Hours for February 15 – September 30: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific

Current members should call toll-free (866)-634-2247 for questions related to the Medicare Advantage Program. (TTY/TDD (866)-516-9366)

Prospective members should call toll-free (866)-646-2247 for questions related to the Medicare Advantage Program. (TTY/TDD (866)-516-9366)

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Current members should call locally (323)-728-7232 5550 for questions related to the Medicare Advantage Program. (TTY/TDD (866)-516-9366)

Prospective members should call locally (323)-728-7232 5551 for questions related to the Medicare Advantage Program. (TTY/TDD (866)-516-9366)

Current members should call toll-free (866)-634-2247 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-516-9366)

Prospective members should call toll-free (866)-646-2247 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-516-9366)

Current members should call locally (323)-728-7232 5550 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-516-9366)

Prospective members should call locally (323)-728-7232 5551 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-516-9366)

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 on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede ser disponibles on otro formato o lenguaje. Para mas información llame al Departamento de Membresía numero enlistado arriba.

Important Information

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
1-Premium and Other Important Information	In 2012 the monthly Part B Premium was $99.90 and may change for 2013 and the annual Part B deductible amount was $140 and may change for 2013. OR 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.	**General** $ 0 monthly plan premium in addition to your monthly Medicare Part B premium. 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. **In-Network** $3,400 out-of-pocket limit. All plan services included.	**General** $ 0 monthly plan premium in addition to your monthly Medicare Part B premium. 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. **In-Network** $3,400 out-of-pocket limit. All plan services included.
2-Doctor and Hospital Choice (For more information, see Emergency Care-#15 and Urgently Needed Care-#16)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).

Summary of Benefits

Inpatient Care

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
3-Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	In 2012 the amounts for each benefit period were: Days 1-60: $1156 deductible Days 61-90: $289 per day Days 91-150: $578 per lifetime reserve day These amounts may change for 2013. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: • Days 1-45: $0 copay per day • Days 46-60: $100 copay per day • Days 61-90: $0 copay per day $0 copay for each additional hospital day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: • Days 1-4: $75 copay per day • Days 5-10: $100 copay per day • Days 11-90: $75 copay per day $0 copay for each additional hospital day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Inpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
4-Inpatient Mental Health Care	In 2012 the amounts for each benefit period were: Days 1-60: $1156 deductible Days 61-90: $289 per day Days 91-150: $578 per lifetime reserve day These amounts may change for 2013. 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.	**In-Network** Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. $250 copay for each Medicare-covered hospital stay. For Medicare-covered hospital stays: • Days 1-10: $115 copay per day • Days 11-90: $0 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: • Days 1-60: $0 copay per day For additional hospital days: • Days 91-130: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. $250 copay for each Medicare-covered hospital stay. For Medicare-covered hospital stays: • Days 1-10: $115 copay per day • Days 11-90: $0 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: • Days 1-60: $0 copay per day For additional hospital days: • Days 91-130: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Summary of Benefits

Inpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
5-Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	In 2012 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: $144.50 per day These amounts may change for 2013. 100 days for each benefit period. 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.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For Medicare-covered SNF stays: • Days 1-20: $0 copay per day • Days 21-100: $85 copay per day $0 copay for additional SNF days	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For Medicare-covered SNF stays: • Days 1-20: $0 copay per day • Days 21-100: $100 copay per day $0 copay for additional SNF days

Inpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
6-Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.
7-Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Outpatient Care

8-Doctor Office Visits	20% coinsurance	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered primary care doctor visit. $0 copay for each Medicare-covered specialist visit.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered primary care doctor visit. $0 copay for each Medicare-covered specialist visit.

Summary of Benefits

Outpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
9-Chiropractic Services	Supplemental routine care not covered. 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 providers.	**General** Authorization rules may apply. **In-Network** $10 copay for each Medicare-covered chiropractic visit. 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.	**General** Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered chiropractic visit. 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.
10-Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered podiatry visits. Up to 6 supplemental routine podiatry visit(s) every year. Medicare-covered podiatry visits are for medically-necessary foot care.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered podiatry visits. Up to 6 supplemental routine podiatry visit(s) every year. Medicare-covered podiatry visits are for medically-necessary foot care.

Outpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
11-Outpatient Mental Health Care	35% coinsurance for most outpatient mental health services. Specified 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. "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.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual therapy visit. $40 copay for each Medicare-covered group therapy visit. $40 copay for each Medicare-covered individual therapy visit with a psychiatrist. $40 copay for each Medicare-covered group therapy visit with a psychiatrist. $75 copay for Medicare-covered partial hospitalization program services.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual therapy visit. $40 copay for each Medicare-covered group therapy visit. $40 copay for each Medicare-covered individual therapy visit with a psychiatrist. $40 copay for each Medicare-covered group therapy visit with a psychiatrist. $75 copay for Medicare-covered partial hospitalization program services.
12-Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual substance abuse outpatient treatment visits. $40 copay for Medicare-covered group substance abuse outpatient treatment visits.	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual substance abuse outpatient treatment visits. $40 copay for Medicare-covered group substance abuse outpatient treatment visits.

Summary of Benefits

Outpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
13-Outpatient Services	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered ambulatory surgical center visit. $75 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit. $50 copay for each Medicare-covered outpatient hospital facility visit.
14-Ambulance Services (Medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $75 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay $0 for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay $0 for Medicare-covered ambulance benefits.

Outpatient Care (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
15-Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care)	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. 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. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits. $20,000 plan coverage limit for suplemental emergency services outside the U.S. and its territories every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. $10,000 plan coverage limit for suplemental emergency services outside the U.S. and its territories every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.
16-Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area)	20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.	**General** $0 to $25 copay for Medicare-covered urgently-needed-care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.	**General** $0 to $25 copay for Medicare-covered urgently-needed-care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.
17-Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Occupational Therapy visits. $0 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Occupational Therapy visits. $0 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits.

Summary of Benefits

Outpatient Medical Services and Supplies

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
18-Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered durable medical equipment.	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered durable medical equipment.
19-Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices.
20-Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training $0 copay for Medicare-covered: • Diabetes monitoring supplies • Therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training $0 copay for Medicare-covered: • Diabetes monitoring supplies • Therapeutic shoes or inserts

Outpatient Medical Services and Supplies (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
21-Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services 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.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • Lab services • Diagnostic procedures and tests • X-rays • Diagnostic radiology services (not including X-rays) $50 copay for Medicare-covered: • Outpatient therapeutic radiology services	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • Lab services • Diagnostic procedures and tests • X-rays • Diagnostic radiology services (not including X-rays) $50 copay for Medicare-covered: • Outpatient therapeutic radiology services
22-Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services. 20% coinsurance for Pulmonary Rehabilitation services. 20% coinsurance for Intensive Cardiac Rehabilitation services. This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services

Summary of Benefits

Preventive Services, Wellness/Education and Other Supplemental Benefit Programs

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
23-Preventive Services, Wellness/ Education and other Supplemental Benefit Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk • HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** $0 copay for an annual physical exam. The plan covers the following supplemental education/wellness programs: • Health Education • Health Club Membership/ Fitness Classes	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** $0 copay for an annual physical exam. The plan covers the following supplemental education/wellness programs: • Health Education • Health Club Membership/ Fitness Classes

Preventive Services, Wellness/Education and Other Supplemental Benefit Programs (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
23-Preventive Services, Wellness/ Education and other Supplemental Benefit Programs (continued)	• Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. • Personalized Prevention Plan Services (Annual Wellness Visits). • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening. • Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.		

Summary of Benefits

Preventive Services, Wellness/Education and Other Supplemental Benefit Programs (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
23-Preventive Services, Wellness/ Education and other Supplemental Benefit Programs (continued)	• Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. • Screening for depression in adults. • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs. • Intensive behavioral counseling for Cardiovascular Disease (bi-annual). • Intensive behavioral therapy for obesity. • Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.		

Preventive Services, Wellness/Education and Other Supplemental Benefit Programs (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
24-Kidney Disease and Conditions	20% coinsurance for renal dialysis. 20% coinsurance for kidney disease education services.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered renal dialysis. $0 copay for Medicare-covered kidney disease education services	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered renal dialysis. $0 copay for Medicare-covered kidney disease education services

Prescription Drug Benefits

25-Outpatient Prescription Drugs	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.	**Drugs Covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.citizenschoicehealth.com/findadrug.aspx on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.	**Drugs Covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.citizenschoicehealth.com/findadrug.aspx on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.

Summary of Benefits

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network-pharmacy although you may have to pay additional charges. Contact the plan for details. Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Citizens Choice Healthplan (HMO) for certain drugs. 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.	Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network-pharmacy although you may have to pay additional charges. Contact the plan for details. Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Citizens Choice Healthplan (HMO) for certain drugs. 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.

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		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. If you request a formulary exception for a drug and Citizens Choice Healthplan (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $3,500: **Retail Pharmacy** Tier 1: Generic • $0 copay for a one-month (30-day) supply of drugs in this tier • $0 copay for a two-month (60-day) supply of drugs in this tier • $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand • $15 copay for a one-month (30-day) supply of drugs in this tier	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. If you request a formulary exception for a drug and Citizens Choice Healthplan (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $3,500: **Retail Pharmacy** Tier 1: Generic • $0 copay for a one-month (30-day) supply of drugs in this tier • $0 copay for a two-month (60-day) supply of drugs in this tier • $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand • $15 copay for a one-month (30-day) supply of drugs in this tier

Summary of Benefits

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		• $30 copay for a two-month (60-day) supply of drugs in this tier • $45 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand • $60 copay for a one-month (30-day) supply of drugs in this tier • $120 copay for a two-month (60-day) supply of drugs in this tier • $180 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Injectable Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier • 25% coinsurance for a two-month (60-day) supply of drugs in this tier • 25% coinsurance for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** Tier 1: Generic • $0 copay for a one-month (31-day) supply of generic drugs in this tier	• $30 copay for a two-month (60-day) supply of drugs in this tier • $45 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand • $60 copay for a one-month (30-day) supply of drugs in this tier • $120 copay for a two-month (60-day) supply of drugs in this tier • $180 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Injectable Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier • 25% coinsurance for a two-month (60-day) supply of drugs in this tier • 25% coinsurance for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** Tier 1: Generic • $0 copay for a one-month (31-day) supply of generic drugs in this tier

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		Tier 2: Preferred Brand Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 3: Non-Preferred Brand Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 4: Injectable Drugs • 25% coinsurance for a one-month (31-day) supply of generic drugs in this tier Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 5: Specialty Tier • 33% coinsurance for a one-month (31-day) supply of generic drugs in this tier Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** Tier 1: Generic • $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand • $30 copay for a three-month (90-day) supply of drugs in this tier	Tier 2: Preferred Brand Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 3: Non-Preferred Brand Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 4: Injectable Drugs • 25% coinsurance for a one-month (31-day) supply of generic drugs in this tier Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 5: Specialty Tier • 33% coinsurance for a one-month (31-day) supply of generic drugs in this tier Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** Tier 1: Generic • $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand • $30 copay for a three-month (90-day) supply of drugs in this tier

Summary of Benefits

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		Tier 3: Non-Preferred Brand • $120 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Injectable Drugs • 25% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $3,500, 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 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750.	Tier 3: Non-Preferred Brand • $120 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Injectable Drugs • 25% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $3,500, 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 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750.

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		**Retail Pharmacy** Tier 1: Generic • $0 copay for a one-month (30-day) supply of all drugs covered in this tier • $0 copay for a two-month (60-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 **Long Term Care Pharmacy** Tier 1: Generic • $0 copay for a one-month (31-day) supply of all generic drugs covered in this tier **Mail Order** Tier 1: Generic • $0 copay for a three-month (90-day) supply of all drugs covered in this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you pay the following: Tier 1: Generic • 5% coinsurance for drugs in this tier Tier 2: Preferred Brand • 5% coinsurance for drugs in this tier	**Retail Pharmacy** Tier 1: Generic • $0 copay for a one-month (30-day) supply of all drugs covered in this tier • $0 copay for a two-month (60-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 **Long Term Care Pharmacy** Tier 1: Generic • $0 copay for a one-month (31-day) supply of all generic drugs covered in this tier **Mail Order** Tier 1: Generic • $0 copay for a three-month (90-day) supply of all drugs covered in this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you pay the following: Tier 1: Generic • 5% coinsurance for drugs in this tier Tier 2: Preferred Brand • 5% coinsurance for drugs in this tier

Summary of Benefits

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		Tier 3: Non-Preferred Brand • 5% coinsurance for drugs in this tier Tier 4: Injectable Drugs • 5% coinsurance for drugs in this tier Tier 5: Specialty Tier • 5% coinsurance for drugs in this tier **Out-of-Network** 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 Citizens Choice Healthplan (HMO). **Out-of-Network Initial Coverage** 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 $3,500: Tier 1: Generic • $0 copay for a (20-day) supply of drugs in this tier	Tier 3: Non-Preferred Brand • 5% coinsurance for drugs in this tier Tier 4: Injectable Drugs • 5% coinsurance for drugs in this tier Tier 5: Specialty Tier • 5% coinsurance for drugs in this tier **Out-of-Network** 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 Citizens Choice Healthplan (HMO). **Out-of-Network Initial Coverage** 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 $3,500: Tier 1: Generic • $0 copay for a (20-day) supply of drugs in this tier

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		Tier 2: Preferred Brand • $15 copay for a (20-day) supply of drugs in this tier Tier 3: Non-Preferred Brand • $60 copay for a (20-day) supply of drugs in this tier Tier 4: Injectable Drugs • 25% coinsurance for a (20-day) supply of drugs in this tier Tier 5: Specialty Tier • 33% coinsurance for a (20-day) supply of drugs in this tier **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	Tier 2: Preferred Brand • $15 copay for a (20-day) supply of drugs in this tier Tier 3: Non-Preferred Brand • $60 copay for a (20-day) supply of drugs in this tier Tier 4: Injectable Drugs • 25% coinsurance for a (20-day) supply of drugs in this tier Tier 5: Specialty Tier • 33% coinsurance for a (20-day) supply of drugs in this tier **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).

Summary of Benefits

Prescription Drug Benefits (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
25-Outpatient Prescription Drugs (continued)		You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Generic • $0 copay for a (20-day) supply of all drugs covered in this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Generic • 5% coinsurance for drugs in this tier Tier 2: Preferred Brand • 5% coinsurance for drugs in this tier Tier 3: Non-Preferred Brand • 5% coinsurance for drugs in this tier Tier 4: Injectable Drugs • 5% coinsurance for drugs in this tier Tier 5: Specialty Tier • 5% coinsurance for drugs in this tier	You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Generic • $0 copay for a (20-day) supply of all drugs covered in this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Generic • 5% coinsurance for drugs in this tier Tier 2: Preferred Brand • 5% coinsurance for drugs in this tier Tier 3: Non-Preferred Brand • 5% coinsurance for drugs in this tier Tier 4: Injectable Drugs • 5% coinsurance for drugs in this tier Tier 5: Specialty Tier • 5% coinsurance for drugs in this tier

Outpatient Medical Services and Supplies

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
26-Dental Services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** $0 copay for the following preventive dental benefits: • Up to 1 oral exam(s) every six months • $0 to $675 copay for Medicare-covered dental benefits • $0 to $54 copay for up to 1 cleaning(s) every six months • $0 to $20 copay for up to 1 fluoride treatment(s) every six months • $0 to $30 copay for up to 1 dental x-ray(s) every three years • $1,000 plan coverage limit for comprehensive dental benfits each year. Plan offers additional comprehensive dental benefits.	**General** Authorization rules may apply. **In-Network** $0 copay for the following preventive dental benefits: • Up to 1 oral exam(s) every six months • $0 to $675 copay for Medicare-covered dental benefits • $0 to $54 copay for up to 1 cleaning(s) every six months • $0 to $20 copay for up to 1 fluoride treatment(s) every six months • $0 to $30 copay for up to 1 dental x-ray(s) every three years • $1,000 plan coverage limit for comprehensive dental benfits each year. Plan offers additional comprehensive dental benefits.

Summary of Benefits

Outpatient Medical Services and Supplies (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
27-Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered diagnostic hearing exams. $0 copay for: • Up to 1 supplemental routine hearing exam(s) every year • Up to 1 fitting-evaluation(s) for a hearing aid every year $0 copay for up to 2 hearing aid(s) every year. $1,000 plan coverage limit for hearing aids every year.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered diagnostic hearing exams. $0 copay for: • Up to 1 supplemental routine hearing exam(s) every year • Up to 1 fitting-evaluation(s) for a hearing aid every year $0 copay for up to 2 hearing aid(s) every year. $1,000 plan coverage limit for hearing aids every year.
28-Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered diagnosis and treatment for diseases and conditions of the eye. • And up to 1 supplemental routine eye exam(s) every year $0 copay for: • One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • Up to 1 pair of glasses every two years • Up to 1 pair of contacts every two years	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered diagnosis and treatment for diseases and conditions of the eye. • And up to 1 supplemental routine eye exam(s) every year $0 copay for: • One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • Up to 1 pair of glasses every two years • Up to 1 pair of contacts every two years

Outpatient Medical Services and Supplies (continued)

BENEFIT	ORIGINAL MEDICARE	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
28-Vision Services **(continued)**		• up to 1 pair of lenses every two years • up to 1 frame every two years $100 plan coverage limit for eye wear every two years.	• up to 1 pair of lenses every two years • up to 1 frame every two years $100 plan coverage limit for eye wear every two years.
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**General** Authorization rules may apply. **In-Network** $0 copay for up to 15 round trip(s) to plan-approved location every year	**General** Authorization rules may apply. **In-Network** $0 copay for up to 15 round trip(s) to plan-approved location every year
Acupuncture and Reflexology	Not covered.	**In-Network** $0 copay for Acupuncture and Reflexology services. Citizens Choice Healthplan (HMO) covers a combined maximum of $10 per visit with up to 40 visits per year, for a total maximum benefit of $400 per calendar year.	**In-Network** $0 copay for Acupuncture and Reflexology services. Citizens Choice Healthplan (HMO) covers a combined maximum of $10 per visit with up to 40 visits per year, for a total maximum benefit of $400 per calendar year.

Summary of Benefits Overview

BENEFIT	CITIZENS CHOICE HEALTHPLAN HMO COPAY COSTS	
	LOS ANGELES, ORANGE, RIVERSIDE, SAN BERNARDINO	STANISLAUS
Health Plan Premium	$0	$0
Part D Premium	$0	$0
Primary Care Doctor Visits (1)	$0	$0
Specialist Doctor Visits (1)(2)	$0	$0
Inpatient Hospital Care (1)(2)	$0 (days 1-45)	$75 (days 1-4) $100 (days 5-10)
Podiatry Visits-Routine (up to 6 visits per year) (1)(2)	$0	$0
Outpatient Rehabilitation Services (1)(2) (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	$0	$0
Transportation Services –Routine (2)	$0 (30 one-way/15 round trips within a 15 mile radius)	$0 (30 one-way/15 round trips within a 15 mile radius)
Vision Services – Routine Eye Exams (1) (Must use network providers)	$0 (covered allowance up to $100 for eye glasses, contacts, frames and lenses every two years)	$0 (covered allowance up to $100 for eye glasses, contacts, frames and lenses every two years)
Hearing Services (1) (Must use network providers)	$1000 towards the purchase of up to 2 hearing aids every year.	$1000 towards the purchase of up to 2 hearing aids every year.
Generic Drugs-Tier 1 (30 days) Excludes Generic Injectable and Specialty drugs as listed in Tier 4 and 5. All other Generic Drugs are covered through the Coverage Gap	$0	$0
Preferred Brand Name Drugs – Tier 2 (30 days)	$15	$15
Non-Preferred Brand Name Drugs – Tier 3 (30 days)	$60	$60
Injectable Drugs – Tier 4 (30 days)	25% Co-insurance	25% Co-insurance
Specialty Drugs – Tier 5 (30 days)	33% Co-insurance	33% Co-insurance

(1) Must obtain services from a plan provider.
(2) May require prior authorization.

This is a summary of the benefits provided only, for more detailed description review Section II of the Summary of Benefits.

Citizens Choice Healthplan HMO is honored to provide you with the highest quality medical health care services. Our physicians are experienced in providing such care and are all within your community, making it easier for you to get the services you need.

As you have read in this Summary of Benefits, Citizens Choice Healthplan HMO offers a variety of benefits including, but not limited to:

- Fitness Program
- Vision Services
- Hearing Services
- Dental Services
- Transportation Services–Routine
- Health and Wellness Education Programs
- Worldwide Emergency Care
- Worldwide Urgently Needed Care
- Prescription Drug Coverage
- Podiatry–Routine
- Acupuncture/Reflexology

Additional services are also available to you through the health plan with no monthly premium and minimal copayments for specified services. These benefits are outlined in this section.

FITNESS PROGRAM

Fitness Clubs and Excercise Centers

It's easy to get fit, have fun and make friends with Citizens Choice Healthplan (CCHP) HMO and the **SilverSneakers® Fitness Program.** The SilverSneakers fitness membership is $0 cost to all CCHP members. As a member you will have **access to more than 11,000 participating locations** across the country. Locations offer amenities such as exercise equipment and SilverSneakers fitness classes designed specifically for people with Medicare and taught by certified instructors.

Once you become a member of Citizens Choice Healthplan HMO you will receive your SilverSneakers ID card in the mail. If you'd like to get started before your card arrives, call 1-888-423-4632 (TTY: 711) to request your SilverSneakers ID number and find a location. Take your ID number with you to the location's front desk to activate your SilverSneakers membership, tour the location and get started.

SilverSneakers® Online

CCHP members can also access SilverSneakers Online through their member website, silversneakers.com/member. SilverSneakers Online is an easy-to-use wellness resource where members can create exercise and nutrition plans, track fitness progress, and find health articles, recipes and more.

SilverSneakers® Steps

CCHP members also have access to SilverSneakers Steps which is a fitness program for members who don't have convenient access to a SilverSneakers location. After registering as a Steps member on silversneakers.com/member, you'll receive a kit with tools to help you get fit wherever you are.

SilverSneakers® is a registered mark of Healthways, Inc.

Additional Plan Information

VISION SERVICES

- Citizens Choice Healthplan HMO is pleased to offer one routine eye exam every year. Citizens Choice Healthplan HMO also covers up to $100 in eyewear (glasses, frames, lenses, or contacts) every two years.

To obtain a list of vision providers, please contact Citizens Choice Healthplan HMO Member Services at 1-866-634-CCHP (2247), Monday through Sunday 8:00 a.m. to 8:00 p.m. (including holidays), TTY users should call 1-866-516-9366. Or, visit our website at www.citizenschoicehealth.com.

HEARING SERVICES

Our goal at Citizens Choice Healthplan HMO is to ensure that you have the necessary equipment to assist you with the quality of your hearing needs. Citizens Choice Healthplan HMO covers up to $1,000 towards the cost of one par of hearing aids every year when services are received from Hearing Care Solutions.

Please contact Citizens Choice Healthplan HMO Member Services at 1-866-634-CCHP (2247), Monday through Sunday 8:00 a.m. to 8:00 p.m. (including holidays), for details TTY users should call 1-866-516-9366.

DENTAL SERVICES

Citizens Choice Healthplan HMO offers preventive dental benefits through Sunny Choice Dental Plan 800®-SC along with LIBERTY Dental Plan of California, Inc., which includes the following benefits:

- $0 copayment for 1 oral exam every six months
- $0 copayment for 1 fluoride treatment every six months
- $0 copayment for 1 cleaning every six months
- $0 copayment for 1 dental X-ray visit every three years (unless medically necessary)
- NO annual premium for additional comprehensive benefits as stated in the HMO Dental Directory

Additionally, you are able to receive a $1,000 allowance for any covered dental service. Simply provide your itemized receipt to CCHP HMO Member Services within 60 days of the date of service for reimbursement.

You may go to any contracted dental provider that is part of the LIBERTY Dental Plan of California, Inc. network. There are extra dental benefits that you may receive through Citizens Choice Healthplan HMO at a discounted copayment. Please consult with your LIBERTY Dental dentist for these covered benefits under Citizens Choice Healthplan HMO or contact our Member Services Department at 1-866-634-CCHP (2247), Monday through Sunday 8:00 a.m. to 8:00 p.m. (including holidays), for details TTY users should call 1-866-516-9366. Also, there is a listing of these comprehensive dental benefits in your Citizens Choice Healthplan HMO Dental Directory. Please visit our website at www.citizenschoicehealth.com to locate a dentist near you.

TRANSPORTATION SERVICES-ROUTINE

Citizens Choice Healthplan HMO provides routine transportation to and from your physician or specialist's office, lab or pharmacy within the plan's service area at NO COST to you. Members are allowed 30 one-way/15 round trips per year to a plan approved location (within 15 miles of your permanent address).

Citizens Choice Healthplan HMO defines "routine" transportation as transportation used for non-emergency medical appointments to plan approved providers which do not require the use of a gurney or for the member to be in a reclining position. Transportation drivers do not receive any form of medical training nor are they approved to provide any lifting or carrying of any members. They cannot provide assistance up or down stairs to members who are not ambulatory or in a wheelchair. All transportation services must be provided by Citizens Choice Healthplan HMO contracted transportation service vendors.

Transportation services (routine non-emergent) include:

- Routine ambulatory transportation for members who have the ability to travel in a vehicle unassisted. Citizens Choice Healthplan HMO allows its members to be accompanied by one escort – minimum age of 15 years).
- Routine wheelchair transportation for members in a standard sized wheelchair which must be in perfect working condition in order to be transported and initial pick-up location must have ramp access. Wheelchair transportation may also be available for members who use a cane or walker and need ramp access to travel in the vehicle with minor assistance.
- Curb to curb transportation service to and from the authorized pick-up and drop-off locations.

This unique benefit will give you the freedom of scheduling appointments at your convenience. Transportation must be scheduled 48 hours prior to the scheduled appointment date to ensure availability. To arrange transportation, simply call our Transportation Unit at 1-866-327-2247, Monday through Friday, 8:00 a.m. to 6:00 p.m. (excluding holidays). TTY users should call 1-866-516-9366. Transportation services are available to plan approved providers for your scheduled appointments Monday through Friday, excluding holidays, between the hours of 8:00 a.m. to 4:30 p.m. (extended hours may be available for dialysis treatment appointments only).

Upon arrival to your plan approved location, transportation providers will wait curbside for up to 10 minutes. Waiting time in excess of 10 minutes, unless pre-arranged with Citizens Choice Healthplan HMO, may result in a "No Show", and will count towards a trip against your benefit. If you cancel your appointment, please notify our Transportation Unit 24 hours prior to the scheduled trip. If you cancel your ride at the time of pick-up or on the day of the scheduled trip (less than 24 hours) this will also be considered a "No Show". Please remember that a "No Show" will count as one trip towards your routine transportation benefit.

Additional Plan Information

HEALTH AND WELLNESS EDUCATION PROGRAMS

Citizens Choice Healthplan HMO wants to ensure you have the opportunity to achieve and maintain a healthy lifestyle. A few of the programs available to you are a *smoking cessation* program so that when you are ready to quit, you have the resources and support available to be successful. Additionally, we have programs to help you monitor and control your diabetes including educational programs and materials, home monitoring equipment and doctor visit reminders.

If you were hospitalized with a diagnosis identified as a potential for re-admission, we may provide *post-discharge services* to assure you are able to maintain or adjust your lifestyle. CCHP wants to make sure you are not hospitalized and the services provided to ensure this include: arranging transportation to follow up doctor visits or a home visit from a licensed healthcare provider, providing assessment of your functional status, a review of the medications you are taking, performing a pain screening and reviewing your living situation to ensure your environment is safe.

WORLDWIDE EMERGENT AND URGENT CARE

As a member of Citizens Choice Healthplan HMO, you are covered for emergent and urgently needed care services worldwide. There is a $65 emergent care copayment if you are seen at the hospital and a $0 to $25 copayment for urgently needed care. However, if you are admitted within 24 hours for the same condition, this copayment is waived. Emergency care outside of the United States is limited to $20,000 per calendar year in Los Angeles, Orange, Riverside and San Bernardino counties, $10,000 per calendar year in Stanislaus County and is combined with urgently needed care. When traveling outside of the United States and you are in need of emergent or urgent care services, please be sure to present your Citizens Choice Healthplan HMO member ID card. If the provider does not accept your insurance, you may have to pay out-of-pocket for your services. Make sure you obtain a copy of the bill along with documentation of medical records and proof of payment so that you may submit the information to Citizens Choice Healthplan HMO for reimbursement. Citizens Choice Healthplan HMO requires that you submit the bill, along with documentation of medical records and any payments you have already made within 60 days of the date of service or discharge date, in order for us to consider the charges for reimbursement.

PRESCRIPTION DRUG COVERAGE

Citizens Choice Healthplan HMO offers outpatient prescription drug coverage at a $0 premium. Formulary Generic Drug coverage for a 30 day supply is offered at a Tier 1 $0 copayment and excludes Generic Injectables and Generic Specialty drugs. Preferred name brand drug coverage is offered at a Tier 2, $15 copayment for a 30 day supply.

Mail order prescriptions are also available in 90 day supplies with a $0 copayment for formulary generic drugs and $30 copayment for preferred brand name drugs.

After your total yearly drug costs (paid by both you and your plan) reach $3,500 you have reached the Initial Coverage Limit (ICL). At this point, you will enter the Coverage Gap. Citizens Choice Healthplan HMO covers all formulary generic drugs through the Coverage Gap. You are responsible for all other covered drugs at 100% until your yearly out-of-pocket drugs costs reach $4,750. Once you have reached your out-of-pocket costs of $4,750 you will move into Catastrophic coverage. In the Catastrophic coverage stage, you pay a 5% co-insurance for all covered drugs on the formulary.

ACUPUNCTURE/REFLEXOLOGY

Citizens Choice Healthplan HMO members may visit any acupuncturist or reflexologist of their choice. The plan covers a combined maximum of $10 per visit per day with up to 40 visits per calendar year (a total maximum benefit of $400 per calendar year). You, the acupuncturist or reflexologist may bill Citizens Choice Healthplan HMO directly and the plan will pay a maximum of $10 per visit to whom payment is due. If there is a balance that totals more than $10 you are responsible for the remaining balance. To obtain a list of acupuncturists or reflexologists, please contact our Member Services Department at 1-866-634-CCHP (2247), TTY users call 1-866-516-9366, Monday through Sunday, 8:00 a.m. to 8:00 p.m. (including holidays) or visit our website at www.citizenschoicehealth.com.

If the provider does not accept your insurance, you may have to pay out-of-pocket for your services. Make sure you obtain a copy of the bill, along with any payments you have already made within 60 days of the date of service, so that we may consider the charges for reimbursement. Reimbursement is subject to plan eligibility at the time of service.

CITIZENS CHOICE
HEALTHPLAN · HMO

1-866-646-CCHP (2247) | TTY: 1-866-516-9366

Monday through Sunday, 8:00 a.m. to 8:00 p.m.

www.citizenschoicehealth.com